SUPERIOR COURT OF NEW JERSEY
CHANCERY DIVISION
DOCKET NO. MER-C-53-19

Civil Action

JOSEPH GLASSMAN, M.D., AND MANISH PUJARA, R.PH.,

Plaintiffs,

v.

GURBIR S. GREWAL, Attorney General of the State of New Jersey,

Defendant.

MARGARET DORE'S MOTION FOR RECONSIDERATION, SEEKING TO OVERTURN MEDICAL AID IN DYING ACT AS UNCONSTITUTIONAL

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I. RELIEF REQUESTED

Margaret Dore moves for reconsideration of the Court's order dated April 1, 2020, which upheld the constitutionality of the Medical Aid in Dying for the Terminally Ill Act.[1]

II. THE ACT MUST BE SET ASIDE

The Court did not reach the Act's violation of the object in title rule, which is dispositive to set the Act aside. The Court should reach this issue now to overturn the Act.

The Court's order states that Dore asked the Court to declare the Act unconstitutional "on grounds not asserted by plaintiffs."[2] The plaintiffs, did, however, ask the Court to rule on the issue, stating:

> Ms. Dore's brief should be considered by the Court since if the law is unconstitutional under the single object rule, it should be the Court's responsibility to raise that issue *sua sponte* even if not raised by Ms. Dore or the Plaintiffs.[3]

The Legislature understood that it was enacting a strictly voluntary law limited to assisted suicide for dying patients.[4] The prior judge expressed a similar view. See, for example, the

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[1] The Act is attached in the Appendix at pages A-1 to A-15.

[2] The Order, page 35, attached hereto at page A-20.

[3] Letter from E. David Smith, Esq., to Judge Lougy, dated March 20, 2020, attached hereto at page A-23.

[4] See for example, the Order on Emergent Motion, Superior Court of New Jersey Appellate Division, August 27, 2019 ("the process is entirely voluntary on the part of all participants, including patients..."). Attached at A-63.

transcript from the hearing on August 14, 2019 ("This case is not about euthanasia").[5]

This case, however, is about euthanasia. The Act is also not limited to dying people. Patient voluntariness is allowed, but not required. These are material facts not disclosed by the Act's title and related findings. The Act is unconstitutional and must be set aside.

III. WHAT THE ACT DOES

A. The Act Allows Physician-Assisted Suicide, Which It Terms Medical Aid in Dying

Dictionary definitions of "assisted suicide," include "suicide committed by someone with assistance from another person especially: physician-assisted suicide."[6] Dictionary definitions of physician-assisted suicide include the following:

> [S]uicide by a patient facilitated by means (such as a drug prescription) or by information (such as an indication of a lethal dosage) provided by a physician aware of the patient's intent.[7]

Here, the Act allows this same practice, which it terms medical aid in dying. The Act, "Findings, Declarations Relative to Medical Aid in Dying for the Terminally Ill," states:

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[5] Attached hereto at A-62.

[6] Merriam-Webster, attached hereto at page A-27; https://www.merriam-webster.com/dictionary/assisted%20suicide?utm_campaign=sd&utm_medium=serp&utm_source=jsonld,

[7] Merriam-Webster, attached hereto at page A-28.

> [T]his State affirms the right of a qualified terminally ill patient, protected by appropriate safeguards, to obtain medication that the patient may choose to self-administer in order to bring about the patient's humane and dignified death. (Emphasis added).[8]

The Act also specifically describes physician involvement to write the prescription for the lethal dose.[9] The bottom line, the Act allows physician-assisted suicide as traditionally defined, which it terms medical aid in dying.

B. The Act Legalizes Assisted Suicide as a "Right"

Again, the Act states:

> [T]his State affirms the right of a qualified terminally ill patient, protected by appropriate safeguards, to obtain medication that the patient may choose to self-administer in order to bring about the patient's humane and dignified death. (Emphasis added).[10]

If for the purpose of argument, this provision is limited to allowing voluntary assisted suicide (because it says that the

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[8] The Act, Section C.26:16-2, attached hereto at A-1.

[9] The Act, Section C.26:16-6, states:

> The attending physician shall ensure that all appropriate steps are carried out in accordance with the provisions of [the Act] before writing a prescription for medication that a qualified terminally ill patient may choose to self-administer pursuant to [the Act].

Attached hereto at page A-4.

[10] The Act, page 1, attached hereto at page A-1

patient may chose to self-administer the lethal medication), the Act will nonetheless also allow euthanasia due to assisted suicide being described as a "right." This is true due to: (1) The New Mexico Supreme Court Decision, *Morris v. Brandenburg*, 376 P.3d 836 (2016); and (2) the Americans with Disability Act, both of which are discussed below.

1. Morris v. Brandenburg

The 5-0 decision states in part:

> [W]e agree with the legitimate concern that recognizing a right to physician aid in dying will lead to voluntary or involuntary euthanasia because if it is a right, it must be made available to everyone, even when a duly appointed surrogate makes the decision, and even when the patient is unable to self-administer the life-ending medication. (Emphasis added).[11]

2. The Americans With Disabilities Act (ADA)

The ADA is "a federal civil rights law that prohibits discrimination against individuals with disabilities in every day activities, including medical services."[12] "Medical care providers are required to make their services available in an accessible manner."[13] This includes:

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[11] *Morris v. Brandenburg*, 376 P.3d 836, 848 (2016).

[12] U.S. Department of Justice, Civil Rights Division, and the U.S. Department of Health and Human Services, Office for Civil Rights, "Americans with Disabilities Act: Access to Medical Care for Individuals with Mobility Disabilities," July 2010, available at https://www.ada.gov/medcare_mobility_ta/medcare_ta.htm

[13] Id.

> Reasonable modifications to policies, practices, and procedures to make healthcare services fully available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services (i.e., alter the essential nature of the services). (Emphasis added).[14]

Here, the Act legalized "medical aid in dying" as part of New Jersey healthcare.[15] If for the purpose of argument, the Act does in fact require self-administration, the ADA will require a reasonable accommodation for individuals unable to self-administer. This will mean administration by another person. The Act will thereby require euthanasia as traditionally defined.

IV. HOW THE ACT WORKS

The Act has an application process to obtain the lethal dose.[16] Once the lethal dose is issued by the pharmacy, there is no oversight.[17] No witness, not even a doctor, is required to present at the death.[18]

V. "ELIGIBLE" PERSONS MAY HAVE YEARS TO LIVE

The Act applies to "terminally ill" individuals. The Act states:

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[14] Id.

[15] The Act, Findings, attached hereto at A-1.

[16] See the Act, attached hereto at pp. A-3 to A-7.

[17] See the Act in its entirety, pp. A-1 to A-15.

[18] Id.

> "Terminally 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.[19]

Such persons may, in fact, have years or decades to live. This is true due to actual mistakes (the test results got switched), and because predicting life expectancy is not an exact science.[20] Also, sometimes doctors are wrong, as in way wrong.

Consider John Norton, diagnosed with ALS at age 18.[21] He was told that he would get progressively worse (be paralyzed) and die in three to five years.[22] Instead, the disease progression stopped on its own.[23] In a 2012 affidavit, at age 74, he states:

> If assisted suicide or euthanasia had been available to me in the 1950's, I would have missed the bulk of my life and my life yet to come.[24]

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[19] The Act, C.26:16-3, attached hereto at page A-3.

[20] Cf. Jessica Firger, "12 Million Americans Misdiagnosed Each Year," CBS NEWS, April 17, 2014, attached hereto at A-29; and Nina Shapiro, "Terminal Uncertainty — Washington's New 'Death with Dignity' Law Allows Doctors to Help People Commit Suicide — Once They've Determined That the Patient Has Only Six Months to Live. But What If They're Wrong?," *The Seattle Weekly*, 01/14/09, attached hereto at A-30 to A-33.

[21] Affidavit of John Norton, attached hereto at A-34 to A-36.

[22] Id., ¶ 1.

[23] Id., ¶ 4

[24] Id., ¶ 5.

VI. ELDER ABUSE

A. Elder Abuse Is a Problem in New Jersey; Perpetrators Are Often Family Members

Elder abuse is a problem in New Jersey and throughout the United States.[25] Nationwide, prominent cases include actor Mickey Rooney and New York philanthropist, Brooke Astor.[26]

Perpetrators are often family members.[27] They typically start out with small crimes, such as stealing jewelry and blank checks, before moving on to larger items or to coercing victims to change their wills or to liquidate their assets.[28] Amy Mix, of the AARP Legal Counsel of the Elderly, states:

> [Perpetrators] are family members, lots are

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[25] See e.g., Dansky Katz Ringold York, Attorneys at Law, Marlton New Jersey, "How to Spot and Prevent Elder Financial Abuse," April 27, 2016, at https://njlegalhelp.com/how-to-spot-and-prevent-elder-financial-abuse; and Beth Fitzgerald, "New Jersey Considers Law to Prevent 'Granny Snatching,'" New Jersey Spotlight, MAY 21, 2012 http://www.njspotlight.com/stories/12/0520/2037/,

[26] Tom Cohen, "Mickey Rooney tells [U.S.] Senate panel he was a victim of elder abuse," CNN, March 2, 2011, at http://www.cnn.com/2011/SHOWBIZ/03/02/rooney.elderly.abuse/index.html; Carole Fleck, "Brooke Astor's Grandson Tells Senate Panel of Financial Abuse," *AARP Bulletin Today*, 02/05/2015 ("The grandson of socialite Brooke Astor, who blew the whistle on his father for plundering millions from his grandmother's estate, told the Senate panel Wednesday that his grandmother's greatest legacy may be the national attention focused on elder financial abuse."), at https://blog.aarp.org/2015/02/05/brooke-astors-grandson-tells-senate-panel-of-financial-abuse; and Matthew Talbot, "Issues of Prosecuting Elder Abuse: The Casey Kasem Case," Talbot Law Group, PC, January 4, 2016, available at https://www.linkedin.com/pulse/issues-prosecuting-elder-abuse-casey-kasem-case-matthew-talbot/

[27] Id., MetLife Mature Market Institute, "Broken Trust: Elders, Family and Finances, A Study on Elder Abuse Prevention," March 2009, at http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-broken-trust.pdf

[28] Id.

> friends, often people who befriend a senior through church .... We had a senior victim who had given her life savings away to some scammer who told her that she'd won the lottery and would have to pay the taxes ahead of time.... The scammer found the victim using information in her husband's obituary.[29]

B. Elder Abuse Is Rarely Reported, Victims Don't Want to Report Their Children as Abusers

The vast majority of elder abuse cases are not reported to the authorities. Reasons include:

> [F]ear of retaliation, lack of physical and/or cognitive ability to report, or because they don't want to get the abuser (90% of whom are family members) in trouble. (Emphasis added).[30]

C. Elder Abuse Is Sometimes Fatal

In some cases, elder abuse is fatal. More notorious cases include California's "black widow" murders, in which two women took out life insurance policies on homeless men.[31] Their first victim was 73 year old Paul Vados, whose death was staged to look

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[29] Kathryn Alfisi, "Breaking the Silence on Elder Abuse," Washington Lawyer, February 2015, available at https://www.dcbar.org/bar-resources/publications/washington-lawyer/articles/february-2015-elder-abuse.cfm

[30] "Adult Protective Services: Facts and Fiction," Division of Aging Services, NJ Department of Human Services, available at http://www.nj.gov/humanservices/dmahs/home/Adult_Protective_Services_Training.pdf

[31] See *People v. Rutterschmidt*, 55 Cal.4th 650 (2012). See also https://en.wikipedia.org/wiki/Black_Widow_Murders

like a hit and run accident.[32] The women collected $589,124.93.[33]

Consider also, *People v. Stuart* in which an adult child killed her mother with a pillow, so as to inherit. The Court observed:

> Financial considerations [are] an all too common motivation for killing someone.[34]

VII. PENALTIES PROVIDE A DETERRENT; NOT THE ACT

While elder abuse is a largely uncontrolled problem, there are penalties for doing it and when perpetrators are caught, they can be punished. The California black widows and the adult child who killed her mother with a pillow, discussed above, served prison time. With a risk of punishment, there is a deterrent to protect other potential victims from harm.

This is in contrast to the Act, in which purported protections are illusory, which renders potential victims sitting ducks to their adult children and other predators, without recourse. See below.

VIII. THE ACT IS STACKED AGAINST THE INDIVIDUAL

A. "Even If a Patient Struggled, Who Would Know?"

The Act has no oversight over administration of the lethal

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[32] *Rutterschmidt*, at 652-3.

[33] Id. at 652.

[34] 67 Cal.Rptr.3d 129, 143 (2007), available at https://www.leagle.com/decision/200719667calrptr3d1291182

dose.[35] In addition, the drugs used are water and alcohol soluble, such that they can be injected into a sleeping or restrained person without consent.[36] Alex Schadenberg, Executive Director for the Euthanasia Prevention Coalition, puts it this way:

> With assisted suicide laws in Washington and Oregon [and with the Act], perpetrators can . . . take a "legal" route, by getting an elder to sign a lethal dose request. Once the prescription is filled, there is no supervision over administration. Even if a patient struggled, "who would know?" (Emphasis added).[37]

B. Someone Else Is Allowed to Communicate on the Patient's Behalf

The Act uses the word, "capable," which is specially defined to allow other people to communicate on the patient's behalf, as long as they are "familiar with the patient's manner of communicating." The Act states:

> "Capable" means having 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

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[35] See the Act in its entirety, attached hereto at A-1 to A-15.

[36] The drugs used include Secobarbital, Pentobarbital and Phenobarbital, which are water and/or alcohol soluble. See excerpt from Oregon's and Washington's annual reports, attached hereto at A-41 & A-42 (listing these drugs). See also http://www.drugs.com/pr/seconal-sodium.html, http://www.drugs.com/pro/nembutal.html and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2977013

[37] Alex Schadenberg, Letter to the Editor, "Elder abuse a growing problem," *The Advocate*, Official Publication of the Idaho State Bar, October 2010, page 14, available at http://www.margaretdore.com/info/October_Letters.pdf

those persons are available. (Emphasis added).[38]

Being familiar with a patient's manner of communicating is a very minimal standard. Consider, for example, a doctor's assistant who is familiar with a patient's "manner of communicating" in Spanish, but she herself does not understand Spanish. That, however, would be good enough for her to communicate on the patient's behalf during the lethal dose request process. The patient would not necessarily be in control of his or her fate.

C. Purported Protections Are Illusory

The Act says that the attending physician is to ensure that all "appropriate" steps are carried out in "accordance" with the Act as necessary. The Act states:

> The attending physician shall ensure that all appropriate steps are carried out in accordance with the provisions of [the Act] . . . including such actions as are necessary to: . . .
>
> (6) recommend that the patient participate in a consultation concerning concurrent or additional treatment opportunities . . . [and]
>
> (8) inform the patient of the patient's opportunity to rescind the request . . . . (Emphasis added).[39]

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[38] The Act, C.26:16-3, attached hereto at page A-2.

[39] Attached hereto at page A-4

The Act does not define "appropriate" or "accordance."[40] Dictionary definitions of appropriate include "suitable or proper" in the circumstances.[41] Dictionary definitions of accordance include "in the spirit of," meaning "in thought or intention."[42]

With these definitions, the attending physician's view of what is "suitable or proper" is enough for compliance with patient protections. The physician's "thought or intention" is similarly sufficient. The purported protections are neutralized to whatever an attending physician happens to feel is appropriate and/or had a thought or intention to do. The "protections" are unenforceable.

D. Deaths in Accordance With the Act Are "Natural" as a Matter of Law.

1. Action taken in accordance with the Act is not suicide or homicide

The Act states:

> Any action taken in accordance with the provisions of [the Act] shall not constitute patient abuse or neglect, suicide, assisted suicide, mercy killing, euthanasia, or homicide under any law of this State. (Emphasis added).[43]

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40 See the Act in its entirety, attached hereto at A-1 through A-15.

41 Attached hereto at A-43.

42 Attached hereto at A-44 and A-45.

43 The Act, C.26:16-17.a.(2), attached hereto at page A-9.

2. The Act requires deaths to be reported as "natural"

In New Jersey, death certificates have five categories for reporting the manner of death, four of which are substantive: (1) natural; (2) accident; (3) suicide; and (4) homicide.[44] The fifth category is "undetermined."[45]

As noted in the preceding section, a death occurring in accordance with the Act does not constitute suicide or homicide under any law of the State. The death is also not an accident due its having been an intended event. This leaves "natural." Deaths occurring pursuant to the Act are natural as a matter of law.

E. Dr. Shipman and the Call for Death Certificate Reform

Per a 2005 article in the UK's Guardian newspaper, there was a public inquiry regarding Dr. Harold Shipman, which determined that he had "killed at least 250 of his patients over 23 years."[46] The inquiry also found:

> that by issuing death certificates stating natural causes, the serial killer [Shipman]

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[44] Andrew L. Falzon, MD, and Sindy M. Paul, MPH, "Death Investigation and Certification in New Jersey," MD Advisor, a journal for the New Jersey medical community, 2016. (Attached hereto at page A-46).

[45] Id.

[46] David Batty, "Q & A: Harold Shipman," The Guardian, 08/25/05, at https://www.theguardian.com/society/2005/aug/25/health.shipman. (Attached hereto at A-47 to A-49).

was able to evade investigation by coroners. (Emphasis added).[47]

Per a subsequent article in 2015, proposed reforms included having a medical examiner review death certificates, so as to improve patient safety.[48] The New Jersey Act has instead moved in the opposite direction to require that deaths be reported as natural. Doctors and other perpetrators have been enabled to kill under mandatory legal cover.

F. The Act Renders New Jersey Residents Sitting Ducks to Their Heirs and Other Predators

New Jersey's slayer statute prevents a killer from inheriting from his or her victim. The statute states:

> [A]n individual who is responsible for the intentional killing of the decedent forfeits [his or her inheritance]."[49]

The rational is that a criminal should not be allowed to benefit from his or her crime.[50]

Under the Act, however, a person who intentionally kills another person is allowed to inherit. This is due to the deaths being certified as natural. With the passage of the Act, New Jersey residents with money, meaning the middle class and above,

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[47] Id., attached hereto at A-49.

[48] Press Association, "Death Certificate Reform Delays 'Incomprehensible," *The Guardian*, January 21, 2015, attached hereto at A-50 to A-51.

[49] NJ Rev Stat § 3B:7-1.1, attached in the appendix at pages A-52 and A-53.

[50] Cf. Ilene S. Cooper and Jaclene D'Agostino, "Forfeiture and New York's 'Slayer Rule', NYSBA Journal, March/April 2015, attached hereto at A-54.

have been rendered sitting ducks to their heirs and other predators.

IX. OTHER CONSIDERATIONS

A. My Clients Suffered Trauma in Oregon and Washington State

I have had two cases where my clients suffered trauma due to legal assisted suicide. In the first case, one side of my client's family wanted her father to take the lethal dose, while the other side did not. The father spent the last months of his life caught in the middle and torn over whether he should kill himself. My client was severely traumatized. The father did not take the lethal dose and died a natural death.

In the other case, my client's father died via the lethal dose at a suicide party. It's not clear, however, that administration of the lethal dose was voluntary. A man who was present told my client that his father had refused to take the lethal dose when it was delivered, stating: "You're not killing me. I'm going to bed." The man also said that my client's father took the lethal dose the next night when he (the father) was already intoxicated on alcohol. The man who told this to my client subsequently changed his story.

My client, although he was not present, was traumatized over the incident, and also by the sudden loss of his father.

B. In Oregon, Other Suicides Have Increased with Legalization of Physician-Assisted Suicide

Government reports from Oregon show a positive correlation between the legalization of physician-assisted suicide and an increase in other (conventional) suicides. This correlation is consistent with a suicide contagion in which legalizing physician-assisted suicide encouraged other suicides.[51]

C. The Felony for Undue Influence Is Illusory

The Act has a felony for "undue influence," which is not defined and has no elements of proof. The Act merely states:

> A person who . . . exerts undue influence on a patient to request medication pursuant to [the Act] or to destroy a rescission of a request is guilty of a crime of the third degree. (Emphasis added).[52]

The Act also specifically allows conduct normally used to prove undue influence. For example, the Act allows an infirm person with a terminal disease to request the lethal dose. Physical weakness is a factor generally used to PROVE undue influence.[53]

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[51] For a more information, see Margaret Dore, "In Oregon, Other Suicides Have Increased with Legalization of Assisted Suicide," August 18, 2017, attached hereto at A-55 to A-57, http://www.choiceillusionsouthdakota.org/2017/06/in-oregon-other-suicides-have-increased_18.html See also the Declaration of Williard Johnston, MD, attached hereto at A-58 to A-60.

[52] Attached hereto at A-10.

[53] Cf. *Neugebauer v. Neugebauer*, 804 N.W.2d 450, ¶17 (2011)("physical . . . weakness is always material upon the question of undue influence").

How do you prove that undue influence occurred when the Act does not define it, and the Act also allows conduct generally used to prove it? You can't. The felony for undue influence is illusory and unenforceable.

X. THE ACT VIOLATES THE OBJECT IN TITLE RULE

As noted supra, the New Jersey Constitution governs permissible legislative conduct when enacting legislation. To that end, the Constitution sets forth the object in title rule, as follows:

> To avoid improper influences which may result from intermixing in one and the same act such things as have no proper relation to each other, every law shall embrace but one object, and that [object] shall be expressed in the title. (Emphasis added).[54]

The rule is designed to protect against the misleading of the people. *State v Guida*, 119 N.J.L. 464, 465-466 (1938), states:

> The sole requirement is that [the title] 'shall express its object in a general way so as to be intelligible to the ordinary reader'; and it is the settled rule that a statute will not be judicially declared inoperative and unenforceable on this ground unless the deficiency plainly exists. (Emphasis added).

In the case at bar, the deficiency plainly exists. The Legislature, the Attorney General and the prior court were all

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[54] Article IV, Section VII, paragraph 4, attached hereto at A-61.

mislead by the Act's deceptive title, implying that the Act is limited to voluntary assisted suicide, when the Act also allows non-voluntary euthanasia. This Court has also been mislead. The Act must be set aside.

Respectfully submitted this 18th day of April 2020

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Appendix

Margaret Dore, Esq., MBA

Motion for Reconsideration

Glassman v. Grewal

April 18, 2020

CHAPTER 59

AN ACT concerning medical aid in dying for the terminally ill, supplementing Titles 45 and 26 of the Revised Statutes, and amending P.L.1991, c.270 and N.J.S.2C:11-6.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

C.26:16-1 Short title.

1. Sections 1 through 20 of P.L.2019, c.59 (C.26:16-1 et seq.) shall be known and may be cited as the "Medical Aid in Dying for the Terminally Ill Act."

C.26:16-2 Findings, declarations relative to medical aid in dying for the terminally ill.

2. The Legislature finds and declares that:

a. Recognizing New Jersey's long-standing commitment to individual dignity, informed consent, and the fundamental right of competent adults to make health care decisions about whether to have life-prolonging medical or surgical means or procedures provided, withheld, or withdrawn, this State affirms the right of a qualified terminally ill patient, protected by appropriate safeguards, to obtain medication that the patient may choose to self-administer in order to bring about the patient's humane and dignified death.

b. Statistics from other states that have enacted laws to provide compassionate medical aid in dying for terminally ill patients indicate that the great majority of patients who requested medication under the laws of those states, including more than 90 percent of patients in Oregon since 1998 and between 72 percent and 86 percent of patients in Washington in each year since 2009, were enrolled in hospice care at the time of death, suggesting that those patients had availed themselves of available treatment and comfort care options available to them at the time they requested compassionate medical aid in dying.

c. The public welfare requires a defined and safeguarded process in order to effectuate the purposes of this act, which will:

(1) guide health care providers and patient advocates who provide support to dying patients;

(2) assist capable, terminally ill patients who request compassionate medical aid in dying;

(3) protect vulnerable adults from abuse; and

(4) ensure that the process is entirely voluntary on the part of all participants, including patients and those health care providers that are providing care to dying patients.

d. This act is in the public interest and is necessary for the welfare of the State and its residents.

C.26:16-3 Definitions relative to medical aid in dying for the terminally ill.

3. As used in P.L.2019, c.59 (C.26:16-1 et al.):

"Adult" means an individual who is 18 years of age or older.

"Attending physician" means a physician licensed pursuant to Title 45 of the Revised Statutes who has primary responsibility for the treatment and care of a qualified terminally ill patient and treatment of the patient's illness, disease, or condition.

"Capable" means having 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.

"Consulting physician" means a physician licensed pursuant to Title 45 of the Revised Statutes who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a patient's illness, disease, or condition.

"Health care facility" means a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

"Health care professional" means a person licensed to practice a health care profession pursuant to Title 45 of the Revised Statutes.

"Health care provider" means a health care professional or health care facility.

"Informed decision" means a decision by a qualified terminally ill patient to request and obtain a prescription for medication that the patient may choose to self-administer to end the patient's life in a humane and dignified manner, which is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

(1) the patient's medical diagnosis;

(2) the patient's prognosis;

(3) the potential risks associated with taking the medication to be prescribed;

(4) the probable result of taking the medication to be prescribed; and

(5) the feasible alternatives to taking the medication, including, but not limited to, concurrent or additional treatment opportunities, palliative care, comfort care, hospice care, and pain control.

"Long-term care facility" means a nursing home, assisted living residence, comprehensive personal care home, residential health care facility, or dementia care home licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

"Medically confirmed" means that the medical opinion of the attending physician has been confirmed pursuant to section 7 of P.L.2019, c.59 (C.26:16-7) by a consulting physician who has examined the patient and the patient's relevant medical records.

"Mental health care professional" means a psychiatrist, psychologist, or clinical social worker licensed pursuant to Title 45 of the Revised Statutes.

"Participate in this act" means to perform the duties of a health care provider in accordance with the provisions of P.L.2019, c.59 (C.26:16-1 et al.), but does not include: making an initial determination that a patient is terminally ill and informing the patient of the medical prognosis; providing information about the provisions of P.L.2019, c.59 (C.26:16-1 et al.) to a patient upon the patient's request; or providing a patient, upon the patient's

request, with a referral to another health care provider.

"Patient" means a person who is under the care of a physician.

"Qualified terminally ill patient" means 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 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.

"Self-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 P.L.2019, c.59 (C.26:16-1 et al.).

"Terminally 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.

C.26:16-4 Conditions for request for medication.

4. A terminally ill patient may make a written request for medication that the patient may choose to self-administer pursuant to P.L.2019, c.59 (C.26:16-1 et al.), if the patient:

a. is an adult resident of New Jersey as demonstrated pursuant to section 11 of P.L.2019, c.59 (C.26:16-11);

b. is capable and has been determined by the patient's attending physician and a consulting physician to be terminally ill; and

c. has voluntarily expressed a wish to receive a prescription for medication pursuant to P.L.2019, c.59 (C.26:16-1 et al.).

C.26:16-5 Form for valid written request for medication.

5. a. A valid written request for medication under P.L.2019, c.59 (C.26:16-1 et al.) shall be in substantially the form set forth in section 20 of P.L.2019, c.59 (C.26:16-20), signed and dated by the patient and witnessed by at least two individuals who, in the patient's presence, attest that, to the best of their knowledge and belief, the patient is capable and is acting voluntarily to sign the request.

b. At least one of the witnesses shall be a person who is not:

(1) a relative of the patient by blood, marriage, or adoption;

(2) at the time the request is signed, entitled to any portion of the patient's estate upon the patient's death under any will or by operation of law; and

(3) an owner, operator, or employee of a health care facility, other than a long term care facility, where the patient is receiving medical treatment or is a resident.

c. The patient's attending physician at the time the request is signed shall not serve as a

witness.

C.26:16-6 Responsibilities of attending physician.

6. a. The attending physician shall ensure that all appropriate steps are carried out in accordance with the provisions of P.L.2019, c.59 (C.26:16-1 et al.) before writing a prescription for medication that a qualified terminally ill patient may choose to selfadminister pursuant to P.L.2019, c.59 (C.26:16-1 et al.), including such actions as are necessary to:

(1) make the initial determination of whether a patient is terminally ill, is capable, and has voluntarily made the request for medication pursuant to P.L.2019, c.59 (C.26:16-1 et al.);

(2) require that the patient demonstrate New Jersey residency pursuant to section 11 of P.L.2019, c.59 (C.26:16-11);

(3) inform the patient of: the patient's medical diagnosis and prognosis; the potential risks associated with taking the medication to be prescribed; the probable result of taking the medication to be prescribed; and the feasible alternatives to taking the medication, including, but not limited to, concurrent or additional treatment opportunities, palliative care, comfort care, hospice care, and pain control;

(4) refer the patient to a consulting physician for medical confirmation of the diagnosis and prognosis, and for a determination that the patient is capable and acting voluntarily;

(5) refer the patient to a mental health care professional, if appropriate, pursuant to section 8 of P.L.2019, c.59 (C.26:16-8);

(6) recommend that the patient participate in a consultation concerning concurrent or additional treatment opportunities, palliative care, comfort care, hospice care, and pain control options for the patient, and provide the patient with a referral to a health care professional qualified to discuss these options with the patient;

(7) advise the patient about the importance of having another person present if and when the patient chooses to self-administer medication prescribed under P.L.2019, c.59 (C.26:16-1 et al.) and of not taking the medication in a public place;

(8) inform the patient of the patient's opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind the request at the time the patient makes a second oral request as provided in section 10 of P.L.2019, c.59 (C.26:16-10); and

(9) fulfill the medical record documentation requirements of P.L.2019, c.59 (C.26:16-1 et al.).

b. The attending physician shall:

(1) dispense medication directly, including ancillary medication intended to facilitate the desired effect to minimize the patient's discomfort, if the attending physician is authorized under law to dispense and has a current federal Drug Enforcement Administration certificate of registration; or

(2) contact a pharmacist to inform the latter of the prescription, and transmit the written prescription personally, by mail, or by permissible electronic communication to the pharmacist, who shall dispense the medication directly to either the patient, the attending

physician, or an expressly identified agent of the patient.

Medication dispensed pursuant to this subsection shall not be dispensed to the patient by mail or other form of courier.

C.26:16-7 Conditions to be considered qualified terminally ill patient.

7. A patient shall not be considered a qualified terminally ill patient until a consulting physician has:

a. examined that patient and the patient's relevant medical records;

b. confirmed, in writing, the attending physician's diagnosis that the patient is terminally ill; and

c. verified that the patient is capable, is acting voluntarily, and has made an informed decision to request medication that, if prescribed, the patient may choose to self-administer pursuant to P.L.2019, c.59 (C.26:16-1 et al.).

C.26:16-8 Determination of capability of patient.

8. a. If, in the medical opinion of the attending physician or the consulting physician, a patient requesting medication that the patient may choose to self-administer pursuant to P.L.2019, c.59 (C.26:16-1 et al.) may not be capable, the physician shall refer the patient to a mental health care professional to determine whether the patient is capable. A consulting physician who refers a patient to a mental health care professional pursuant to this subsection shall provide written notice of the referral to the attending physician.

b. If a patient has been referred to a mental health care professional pursuant to subsection a. of this section, the attending physician shall not write a prescription for medication that the patient may choose to self-administer pursuant to P.L.2019, c.59 (C.26:16-1 et al.) unless the attending physician has been notified in writing by the mental health care professional of that individual's determination that the patient is capable.

C.26:16-9 Notification of next of kin required; exception.

9. A qualified terminally ill patient shall not receive a prescription for medication that the patient may choose to self-administer pursuant to P.L.2019, c.59 (C.26:16-1 et al.) unless the attending physician has recommended that the patient notify the patient's next of kin of the patient's request for medication, except that a patient who declines or is unable to notify the patient's next of kin shall not have the request for medication denied for that reason.

C.26:16-10 Oral, written request by patient, physician's actions.

10. a. In order to receive a prescription for medication that a qualified terminally ill

patient may choose to self-administer pursuant to P.L.2019, c.59 (C.26:16-1 et al.), the patient shall make two oral requests and one written request for the medication to the patient's attending physician, subject to the following requirements:

(1) at least 15 days shall elapse between the initial oral request and the second oral request;

(2) at the time the patient makes a second oral request, the attending physician shall offer the patient an opportunity to rescind the 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;

(4) the written request shall meet the requirements of section 5 of P.L.2019, c.59 (C.26:16-5);

(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 pursuant to P.L.2019, c.59 (C.26:16-1 et al.).

b. A qualified terminally ill patient may rescind the request at any time and in any manner without regard to the patient's mental state.

c. At the time the patient makes an initial oral request for medication that the patient may choose to self-administer pursuant to P.L.2019, c.59 (C.26:16-1 et al.), the patient's attending physician shall recommend to the patient that the patient participate in a consultation concerning concurrent or additional treatment opportunities, palliative care, comfort care, hospice care, and pain control options, and provide the patient with a referral to a health care professional qualified to discuss these options with the patient. If the patient chooses to participate in such consultation, the consultation shall include, to the extent the patient consents to share such information, consideration of: the patient's terminal illness; the patient's prognosis; current and past courses of treatment prescribed for the patient in connection with the patient's terminal illness, including the results of any such treatment; and any palliative care, comfort care, hospice care, and pain control treatment the patient is currently receiving or has received in the past.

d. The attending physician shall ensure that the following items are included in the patient's medical record:

(1) the determination that the patient is a qualified terminally ill patient and the basis for that determination;

(2) all oral and written requests by the patient to the attending physician for medication that the patient may choose to self-administer pursuant to P.L.2019, c.59 (C.26:16-1 et al.);

(3) the attending physician's diagnosis and prognosis, and determination that the patient is capable, is acting voluntarily, and has made an informed decision;

(4) the consulting physician's diagnosis and prognosis, and verification that the patient is capable, is acting voluntarily, and has made an informed decision;

(5) if applicable, a report of the determination made by a mental health care professional as to whether the patient is capable pursuant to section 8 of P.L.2019, c.59 (C.26:16-8);

(6) the attending physician's recommendation that the patient participate in a consultation concerning concurrent or additional treatment opportunities, palliative care, comfort care, hospice care, and pain control options; the referral provided to the patient with a referral to a

health care professional qualified to discuss these options with the patient; an indication as to whether the patient participated in the consultation; and an indication as to whether the patient is currently receiving palliative care, comfort care, hospice care, or pain control treatments;

(7) the attending physician's offer to the patient to rescind the patient's request at the time of the patient's second oral request; and

(8) a note by the attending physician indicating that all requirements under P.L.2019, c.59 (C.26:16-1 et al.) have been met and indicating the steps taken to carry out the patient's request for medication, including a notation of the medication prescribed.

C.26:16-11 Documentation of New Jersey residency.

11. A request for medication pursuant to P.L.2019, c.59 (C.26:16-1 et al.) shall not be granted unless the qualified terminally ill patient has documented that individual's New Jersey residency by furnishing to the attending physician a copy of one of the following:

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.

C.26:16-12 Disposal of medication if patients chooses not to self-administer.

12. Any medication dispensed pursuant to P.L.2019, c.59 (C.26:16-1 et al.) that a qualified terminally ill patient chooses not to self-administer shall be disposed of by lawful means, including, but not limited to, disposing of the medication consistent with State and federal guidelines concerning disposal of prescription medications, or surrendering the medication to a prescription medication drop-off receptacle. The patient shall designate a person who shall be responsible for the lawful disposal of the medication.

C.26:16-13 Reporting of information, statistical report.

13. a. The Commissioner of Health shall require that a health care professional report the following information to the Department of Health on a form and in a manner prescribed by regulation of the commissioner:

(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 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.

(3) In the event that anyone required to report information to the department pursuant to P.L.2019, c.59 (C.26:16-1 et al.) provides an inadequate or incomplete report, the department shall contact the person to request a complete report.

(4) To the maximum extent practicable and consistent with the purposes of this section, the department shall seek to coordinate the process for reporting information pursuant to this subsection with the process for reporting prescription monitoring information by a pharmacy permit holder pursuant to sections 25 through 30 of P.L.2007, c.244 (C.45:1-45 through C.45:1-50).

b. Any information collected pursuant to subsection a. of this section that contains material or data that could be used to identify an individual patient or health care professional shall not be included under materials available to public inspection pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.) and P.L.2001, c.404 (C.47:1A-5 et al.).

c. The department shall prepare and make available to the public on its Internet website an annual statistical report of information collected pursuant to subsection a. of this section.

C.26:16-14 Provisions in certain documents would not restrict request for medication.

14. a. A provision in a contract, will, insurance policy, annuity, or other agreement, whether written or oral, made on or after the effective date of P.L.2019, c.59 (C.26:16-1 et al.), shall not be valid to the extent that the provision would condition or restrict a person's decision to make or rescind a request for medication pursuant to P.L.2019, c.59 (C.26:16-1 et al.).

b. An obligation owing under a contract, will, insurance policy, annuity, or other agreement, made before the effective date of P.L.2019, c.59 (C.26:16-1 et al.), shall not be affected by: the provisions of P.L.2019, c.59 (C.26:16-1 et al.); a person's making or rescinding a request for medication pursuant to P.L.2019, c.59 (C.26:16-1 et al.); or any other action taken pursuant to P.L.2019, c.59 (C.26:16-1 et al.).

c. On or after the effective date of P.L.2019, c.59 (C.26:16-1 et al.), procurement or issuance of a life, health, or accident insurance policy or annuity, or the premium or rate charged for the policy or annuity, shall not be conditioned upon or otherwise take into account the making or rescinding of a request for medication pursuant to P.L.2019, c.59 (C.26:16-1 et al.) by any person.

C.26:16-15 Construction of act.

15. Nothing in P.L.2019, c.59 (C.26:16-1 et al.) shall be construed to:

a. authorize a physician or any other person to end a patient's life by lethal injection, active euthanasia, or mercy killing, or any act that constitutes assisted suicide under any law of this State; or

b. lower the applicable standard of care to be provided by a health care professional who participates in P.L.2019, c.59 (C.26:16-1 et al.).

C.26:16-16 Certain persons not authorized to take action on behalf of patient.

16. A person shall not be authorized to take any action on behalf of a patient for the purposes of P.L.2019, c.59 (C.26:16-1 et al.) by virtue of that person's designation as a guardian pursuant to N.J.S.3B:12-1 et seq., a conservator pursuant to N.J.S.3B:13A-1 et seq., a health care representative pursuant to P.L.1991, c.201 (C.26:2H-53 et seq.), or a patient's representative pursuant to P.L.2011, c.145 (C.26:2H-129 et al.), except for communicating the patient's health care decisions to a health care provider if the patient so requests.

C.26:16-17 Immunity.

17. a. (1) Except as provided in sections 18 and 19 of P.L.2019, c.59 (C.26:16-18 and C.26:16-19), a person shall not be subject to civil or criminal liability or professional disciplinary action, or subject to censure, discipline, suspension, or loss of any licensure, certification, privileges, or membership, for any action taken in compliance with the provisions of P.L.2019, c.59 (C.26:16-1 et al.), including being present when a qualified terminally ill patient self-administers medication prescribed pursuant to P.L.2019, c.59 (C.26:16-1 et al.), or for the refusal to take any action in furtherance of, or to otherwise participate in, a request for medication pursuant to the provisions of P.L.2019, c.59 (C.26:16-1 et al.). A person who substantially complies in good faith with the provisions of P.L.2019, c.59 (C.26:16-1 et al.) shall be deemed to be in compliance with its provisions.

(2) Any action taken in accordance with the provisions of P.L.2019, c.59 (C.26:16-1 et al.) shall not constitute patient abuse or neglect, suicide, assisted suicide, mercy killing, euthanasia, or homicide under any law of this State.

(3) A patient's request for, or the provision of, medication in compliance with the provisions of P.L.2019, c.59 (C.26:16-1 et al.) shall not constitute abuse or neglect of an elderly person or provide the sole basis for the appointment of a guardian or conservator.

b. The provisions of subsection a. of this section shall not apply to acts or omissions constituting gross negligence, recklessness, or willful misconduct.

c. Any action taken by a health care professional to participate in P.L.2019, c.59 (C.26:16-1 et al.) shall be voluntary on the part of that individual. If a health care professional is unable or unwilling to carry out a patient's request under P.L.2019, c.59 (C.26:16-1 et al.), and the patient transfers the patient's care to a new health care professional or health care facility, the prior health care professional shall transfer, upon request, a copy of the patient's relevant records to the new health care professional or health care facility.

C.26:16-18 Violations, degree of crime.

18. a. A person who, without authorization of the patient, and with the intent or effect of causing the patient's death, willfully alters or forges a request for medication pursuant to P.L.2019, c.59 (C.26:16-1 et al.) or conceals or destroys a rescission of that request, is guilty of a crime of the second degree.

b. A person who coerces or exerts undue influence on a patient to request medication pursuant to P.L.2019, c.59 (C.26:16-1 et al.) or to destroy a rescission of a request is guilty of a crime of the third degree.

c. Theft of medication prescribed to a qualified terminally ill patient pursuant to P.L.2019, c.59 (C.26:16-1 et al.) shall constitute an offense involving theft of a controlled dangerous substance as set forth in N.J.S.2C:20-2.

d. Nothing in P.L.2019, c.59 (C.26:16-1 et al.) shall limit liability for civil damages resulting from the negligence or intentional misconduct of any person.

e. The penalties set forth in this section shall not preclude the imposition of any other criminal penalty applicable under law for conduct that is inconsistent with the provisions of P.L.2019, c.59 (C.26:16-1 et al.).

C.26:16-19 Claims by governmental entity, certain circumstances.

19. Any governmental entity that incurs costs resulting from a qualified terminally ill patient choosing to self-administer medication prescribed pursuant to P.L.2019, c.59 (C.26:16-1 et al.) in a public place has a claim against the estate of the patient to recover those costs and reasonable attorneys' fees related to enforcing the claim.

C.26:16-20 Form for request of medication.

20. A written request for a medication as authorized by P.L.2019, c.59 (C.26:16-1 et al.) shall be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, ... , am an adult of sound mind and a resident of New Jersey.

I am suffering from . . . . . , which my attending physician has determined is a terminal illness, disease, or condition and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including concurrent or additional treatment opportunities, palliative care, comfort care, hospice care, and pain control.

I request that my attending physician prescribe medication that I may self-administer to end my life in a humane and dignified manner and to contact any pharmacist as necessary to fill the prescription.

INITIAL ONE:

. . . . I have informed my family of my decision and taken their opinions into consideration.

. . . . . I have decided not to inform my family of my decision.

. . . . . I have no family to inform of my decision.

INITIAL ALL THAT APPLY:

. . . . .My attending physician has recommended that I participate in a consultation concerning concurrent or additional treatment opportunities, palliative care, comfort care, hospice care, and pain control options, and provided me with a referral to a health care professional qualified to discuss these options with me.
. . . . .I have participated in a consultation concerning concurrent or additional treatment opportunities, palliative care, comfort care, hospice care, and pain control options.
. . . I am currently receiving palliative care, comfort care, or hospice care.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request, and I expect to die if and when I take the medication to be prescribed. I further understand that, although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full responsibility for my decision.

Signed:. . . . . .

Dated:. . . . . .

DECLARATION OF WITNESSES

By initialing and signing below on or after the date the person named above signs, we declare that the person making and signing the above request:

Witness 1 Witness 2

Initials Initials

. . . . . .
1. Is personally known to us or has provided proof of identity.
. . . . . .
2. Signed this request in our presence on the date of the person's signature.
. . . . . .
3. Appears to be of sound mind and not under duress, fraud, or undue influence.
. . . . . .
4. Is not a patient for whom either of us is the attending physician.
. . . . . .
Printed Name of Witness 1: . . . . . .
Signature of Witness 1/Date: . . . . . .
Printed Name of Witness 2: . . . . . .

Signature of Witness 2/Date: . . . . . .

NOTE: At least one witness shall not be a relative by blood, marriage, or adoption of the person signing this request, shall not be entitled to any portion of the person's estate upon death, and shall not own, operate, or be employed at a health care facility, other than a long term care facility, where the person is a patient or resident.

C.52:17B:139.13 Rules, regulations.

21. The Director of the Division of Consumer Affairs in the Department of Law and Public Safety, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to implement the provisions of sections 1 through 20 of P.L.2019, c.59 (C.26:16-1 et seq.), including the required reporting of information to the division by health care professionals pursuant to section 13 of P.L.2019, c.59 (C.26:16-13).

C.45:9-5.3 State Board of Medical Examiners; rules, regulations.

22. The State Board of Medical Examiners, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to implement the provisions of sections 1 through 20 of P.L.2019, c.59 (C.26:16-1 et seq.) concerning the duties of a licensed physician pursuant thereto.

C.45:14-47.1 New Jersey State Board of Pharmacy; rules, regulations.

23. The New Jersey State Board of Pharmacy, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to implement the provisions of sections 1 through 20 of P.L.2019, c.59 (C.26:16-1 et seq.) concerning the duties of a licensed pharmacist pursuant thereto.

C.45:14B-48 State Board of Psychological Examiners; rules, regulations.

24. The State Board of Psychological Examiners, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to implement the provisions of sections 1 through 20 of P.L.2019, c.59 (C.26:16-1 et seq.) concerning the duties of a licensed psychologist pursuant thereto.

C.45:15BB-11.2 State Board of Social Work Examiners; rules, regulations.

25. The State Board of Social Work Examiners, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to implement the provisions of sections 1 through 20 of P.L.2019, c.59 (C.26:16-1 et seq.) concerning the duties of a licensed clinical social worker pursuant thereto.

C.26:2H-5.33 Definitions relative to actions by health care facilities.

26. a. As used in this section:
"Health care facility" or "facility" means a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).
"Health care professional" means a person licensed to practice a health care profession pursuant to Title 45 of the Revised Statutes.

b. (1) The existing policies and procedures utilized by a health care facility shall, to the maximum extent possible, govern the taking of any action by a health care professional pursuant to sections 1 through 20 of P.L.2019, c.59 (C.26:16-1 et seq.) on the premises owned by, or under the direct control of, the facility, except as otherwise prescribed by regulation of the Commissioner of Health pursuant to paragraph (4) of this subsection.

(2) Any action taken by a health care facility to participate in P.L.2019, c.59 (C.26:16-1 et al.) shall be voluntary on the part of the facility.

(3) A health care facility shall not be subject to a licensure enforcement action by the Department of Health for any action taken in compliance with the provisions of P.L.2019, c.59 (C.26:16-1 et al.).

(4) The Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to implement the provisions of sections 1 through 20 of P.L.2019, c.59 (C.26:16-1 et seq.), concerning their application to a health care facility and any action taken by a health care professional on the premises owned by, or under the direct control of, the facility.

(5) The provisions of this subsection shall not preclude a health care facility or health care professional from providing to a patient any health care services to which the provisions of sections 1 through 20 of P.L.2019, c.59 (C.26:16-1 et seq.) do not apply

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27. Section 1 of P.L.1991, c.270 (C.2A:62A-16) is amended to read as follows:

C.2A:62A-16 Health care professionals, immunity from civil liability; duty to warn and protect.

1. a. Any person who is licensed in the State of New Jersey to practice psychology, psychiatry, medicine, nursing, clinical social work, or marriage and family therapy, whether or not compensation is received or expected, is immune from any civil liability for a patient's violent act against another person or against himself unless the practitioner has incurred a duty to warn and protect the potential victim as set forth in subsection b. of this section and fails to discharge that duty as set forth in subsection c. of this section.

b. A duty to warn and protect is incurred when the following conditions exist:

(1) The patient has communicated to that practitioner a threat of imminent, serious physical violence against a readily identifiable individual or against himself and the circumstances are such that a reasonable professional in the practitioner's area of expertise would believe the patient intended to carry out the threat; or

(2) The circumstances are such that a reasonable professional in the practitioner's area of expertise would believe the patient intended to carry out an act of imminent, serious physical

violence against a readily identifiable individual or against himself. A duty to warn and protect shall not be incurred when a qualified terminally ill patient requests medication that the patient may choose to self-administer in accordance with the provisions of P.L.2019, c.59 (C.26:16-1 et al.).

c. A licensed practitioner of psychology, psychiatry, medicine, nursing, clinical social work, or marriage and family therapy shall discharge the duty to warn and protect as set forth in subsection b. of this section by doing one or more of the following:

(1) Arranging for the patient to be admitted voluntarily to a psychiatric unit of a general hospital, a short-term care facility, a special psychiatric hospital, or a psychiatric facility, under the provisions of P.L.1987, c.116 (C.30:4-27.1 et seq.);

(2) Initiating procedures for involuntary commitment to treatment of the patient to an outpatient treatment provider, a short-term care facility, a special psychiatric hospital, or a psychiatric facility, under the provisions of P.L.1987, c.116 (C.30:4-27.1 et seq.);

(3) Advising a local law enforcement authority of the patient's threat and the identity of the intended victim;

(4) Warning the intended victim of the threat, or, in the case of an intended victim who is under the age of 18, warning the parent or guardian of the intended victim; or

(5) If the patient is under the age of 18 and threatens to commit suicide or bodily injury upon himself, warning the parent or guardian of the patient.

d. A practitioner who is licensed in the State of New Jersey to practice psychology, psychiatry, medicine, nursing, clinical social work, or marriage and family therapy who, in complying with subsection c. of this section, discloses a privileged communication, is immune from civil liability in regard to that disclosure.

e. In addition to complying with subsection c. of this section, a licensed practitioner shall notify the chief law enforcement officer of the municipality in which the patient resides or the Superintendent of State Police if the patient resides in a municipality that does not have a full-time police department that a duty to warn and protect has been incurred with respect to the patient and shall provide to the chief law enforcement officer or superintendent, as appropriate, the patient's name and other non-clinical identifying information. The chief law enforcement officer or superintendent, as appropriate, shall use that information to ascertain whether the patient has been issued a firearms purchaser identification card, permit to purchase a handgun, or any other permit or license authorizing possession of a firearm.

If the patient has been issued a firearms purchaser identification card, permit to purchase a handgun, or any other permit or license authorizing possession of a firearm, or if there is information indicating that the patient otherwise may have access to a firearm, the information provided may be used in determining whether the patient has become subject to any of the disabilities set forth in subsection c. of N.J.S.2C:58-3. If the chief law enforcement officer or superintendent, as appropriate, determines that the patient has become subject to any of the disabilities set forth in subsection c. of N.J.S.2C:58-3, any identification card or permit issued to the patient shall be void and subject to revocation by the Superior Court in accordance with the procedure established in subsection f. of N.J.S.2C:58-3. If the court determines that the patient is subject to any of the disabilities set forth in subsection c. of N.J.S.2C:58-3 and revokes the patient's firearms purchaser identification

card in accordance with the procedure established in subsection f. of N.J.S.2C:58-3, the court may order the patient to surrender to the county prosecutor any firearm owned by or accessible to the patient and order the prosecutor to dispose of the firearms. When the court orders the county prosecutor to dispose of the firearms, the prosecutor shall dispose of the firearms as provided in N.J.S.2C:64-6.

If the court, upon motion of the prosecutor, finds probable cause that the patient has failed to surrender any firearm, card, or permit, the court may order a search for and removal of these items at any location where the judge has reasonable cause to believe these items are located. The judge shall state with specificity the reasons and the scope of the search and seizure authorized by the order.

A firearm surrendered or seized pursuant to this subsection which is not legally owned by the patient shall be immediately returned to the legal owner of the firearm if the legal owner submits a written request to the prosecutor attesting that the patient does not have access to the firearm.

A law enforcement officer or agency shall not be held liable in any civil action brought by any person for failing to learn of, locate, or seize a firearm pursuant to this subsection. A patient who is determined to be subject to any of the disabilities established in paragraph (3) of subsection c. of N.J.S.2C:58-3 and submits a certificate of a medical doctor or psychiatrist licensed in New Jersey, or other satisfactory proof in accordance with that paragraph shall be entitled to the reinstatement of any firearms purchaser identification cards, permits to purchase a handgun, and any other permit or license authorizing possession of a firearm seized pursuant to this subsection.

28. N.J.S.2C:11-6 is amended to read as follows:

Aiding suicide.

2C:11-6. Aiding Suicide. A person who purposely aids another to commit suicide is guilty of a crime of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a crime of the fourth degree. Any action taken in accordance with the provisions of P.L.2019, c.59 (C.26:16-1 et al.) shall not constitute suicide or assisted suicide.

29. This act shall take effect on the first day of the fourth month next following the date of enactment, but the Director of the Division of Consumer Affairs in the Department of Law and Public Safety, the Commissioner of Health, the State Board of Medical Examiners, the New Jersey State Board of Pharmacy, the State Board of Social Work Examiners, and the State Board of Psychological Examiners may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act.

Approved April 12, 2019.

PREPARED BY THE COURT

ANTHONY PETRO, YOSEF GLASSMAN, M.D., and MANISH PUJARA, R.PH., Plaintiffs, v. GURBIR SINGH GREWAL, Attorney General of the State of New Jersey, Defendant.	SUPERIOR COURT OF NEW JERSEY CHANCERY DIVISION – GENERAL EQUITY MERCER COUNTY DOCKET NO. MER-C-53-19 CIVIL ACTION **ORDER**

THIS MATTER having come before the Court, the Hon. Robert Lougy, P.J. Ch., presiding, on the application of Defendant, Gurbir Singh Grewal, Attorney General of the State of New Jersey, represented by Deputy Attorney General Francis X. Baker, appearing, for an order dismissing Plaintiffs' complaint for failure to state a claim upon which relief may be granted; and Plaintiffs Anthony Petro, Yosef Glassman, M.D., and Manish Pujara, R.PH., represented by E. David Smith, Esq., appearing, seeking injunctive relief as specified in their Order to Show Cause; and Plaintiffs having filed opposition to the motion and Defendant having filed a brief that also opposes Plaintiffs' application for injunctive relief; and the Court having granted the application of Margaret Dore, Esq., a self-represented litigant, to appear as

amicus curiae; and the Court having granted the requests of the parties for oral argument; and oral argument having taken place with all parties participating remotely; and the Court having considered the parties' pleadings and arguments; and for the reasons as set forth below; and for good cause shown;

IT IS on this 1st day of April 2020 **ORDERED** that:

1. The application of Defendant for an order granting dismissal of Plaintiffs' Fourth Amended Complaint with prejudice is **GRANTED**.
2. The application of Plaintiffs for an order entering a preliminary injunction is **DENIED**.
3. A copy of this Order shall be deemed filed and served upon receipt from an authorized Judiciary (xxx@njcourts.gov) e-mail account.

/s/ Robert Lougy
ROBERT LOUGY, P.J. Ch.

Pursuant to Rules 1:6-2(f) and 1:7-4, the Court provides the following Statement of Facts and Conclusions of Law:

This matter comes before the Court on Plaintiffs' application for a preliminary injunction and Defendant's motion to dismiss the complaint for failure to state a claim upon which relief may be granted. The Court granted the parties' requests for oral argument. See R. 1:6-2(d) (stating that, upon request of a party in motions involving matters other than discovery or calendaring, request for oral argument "shall be granted as of right."); see also Raspantini v. Arocho, 364 N.J. Super. 528 (App. Div. 2003).

D. The Balancing of the Relative Hardships Weighs in Favor of the Public Interest.

Finally, the Crowe test for preliminary injunctive relief requires a balancing of the relative hardships to the parties in granting or denying relief. Crowe, 90 N.J. at 134 (citing Isolantite Inc. v. United Elec. Radio & Mach. Workers of Am., 130 N.J. Eq. 506, 515 (Ch. 1941), modified on other grounds, 132 N.J. Eq. 613 (E. & A. 1942)). The party moving for a temporary restraint or preliminary injunction must demonstrate that "the public interest will not be harmed." See Waste Mgmt., 399 N.J. Super. at 520. In some cases, such as when the public interest is greatly affected, a court may withhold relief despite a substantial showing of irreparable injury to the applicant. Ibid.

If the preliminary injunction is granted, the public interest will be harmed because qualified patients will be unable to utilize their rights granted by the Legislature. Thus, the public interest is greatly affected by this decision. Absent an injunction, Plaintiffs may feel morally opposed to the Act and may have to transfer patients, but they will not suffer actual hardship. The Act is voluntary; Plaintiffs need not participate in the Act's provisions. Therefore, the balance of the relative hardships weighs in favor of the public interest and against imposition of the injunction.

Plaintiffs fail to establish any of the Crowe factors by clear and convincing evidence. Accordingly, the Court denies Plaintiffs' application for injunctive relief.

XIV. The *amicus curiae* does not identify any constitutional infirmity in the Act.

Margaret Dore, Esq., appearing as a self-represented litigant, sought leave to appear as an *amicus curiae*, arguing that the Act violates the single object requirement of the New

Jersey Constitution. Defendant opposed the application, arguing that Dore sought to raise an issue not raised by Plaintiffs.

Rule 1:13-9 governs the Court's consideration of requests for leave to appear as amicus. The rule provides:

> An application for leave to appear as amicus curiae in any court shall be made by motion in the cause stating with specificity the identity of the applicant, the issue intended to be addressed, the nature of the public interest therein and the nature of the applicant's special interest, involvement or expertise in respect thereof. The court shall grant the motion if it is satisfied under all the circumstances that the motion is timely, the applicant's participation will assist in the resolution of an issue of public importance, and no party to the litigation will be unduly prejudiced thereby. The order granting the motion shall define with specificity the permitted extent of participation by the amicus and shall, where appropriate, fix a briefing schedule.
>
> [Ibid.]

"Traditionally, the role of amicus curiae was to be advisory rather than adverse." In re State ex rel. Essex Cty. Prosecutor's Off., 427 N.J. Super. 1, 5 (Law Div. 2012) (citing Casey v. Male, 63 N.J. Super. 255, 258 (Cty. Ct. 1960)). However, the Third Circuit has held that amicus need not be impartial, and that even when parties are very well represented, amicus "may provide important assistance to the court." Neonatology Assocs., P.A. v. Comm'r, 293 F.3d 128, 132 (3d Cir. 2002). Further, "Rule 1:13-9 has been interpreted as establishing 'a liberal standard for permitting amicus appearances.'" In re State ex rel. Essex Cty. Prosecutor's Off., 427 N.J. Super. at 5 (quoting Pfizer, Inc. v. Dir., Div. of Tax'n, 23 N.J. Tax 421, 424 (Tax 2007)).

It is well-established in this State that an amicus is constrained by the issues advanced by the parties. "'[A]s a general rule, an amicus curiae must accept the case before the court

as presented by the parties and cannot raise issues not raised by the parties.'" State v. O'Driscoll, 215 N.J. 461, 479 (2013) (quoting State v. Lazo, 209 N.J. 9, 25 (2012)); see also State v. J.R., 227 N.J. 393, 421 (2017) ("This Court does not consider arguments that have not been asserted by a party, and are raised for the first time by an amicus curiae."), Fed. Pac. Elec. Co. v. N.J. Dep't of Env'tl Prot., 334 N.J. Super. 323, 345 (App. Div. 2000) ("An *amicus curiae* may not interject new issues, but must accept the issues as framed and presented by the parties.").

Dore asks the Court to declare the statute unconstitutional on grounds not asserted by Plaintiffs, notwithstanding the four amended complaints. On this basis alone, the Court could reject her application. However, because she fails to identify any constitutional infirmity in the Act, the Court will consider the argument here solely for the purposes of completeness.

New Jersey's Constitution constrains the Legislature from grouping unrelated topics in the same piece of legislation. Specifically, it provides: "To avoid improper influences which may result from intermixing in one and the same act such things as have no proper relation to each other, every law shall embrace but one object, and that shall be expressed in the title." N.J. Const., art. IV, § VII. The purpose of the constitutional rule is to ensure relatedness in legislative acts. Cambria v. Soaries, 169 N.J. 1, 11 (2000). As Cambria explains:

> All that is required is that the act should not include legislation so incongruous that it could not, by any fair intendment, be considered germane to one general subject. The subject may be as comprehensive as the legislature chooses to make it, provided

> it constitutes, in the constitutional sense, a single subject, and not several.
>
> [Ibid. (quoting N.J. Ass'n on Corr., 80 N.J. at 215).]

Thus, to comport with the constitutional minimum, the statute's provisions must only meet a relatedness test. Id. at 12. The rule is intended to prevent against:

> the extreme, the "pernicious," the incongruous; the manifestly repugnant; the palpable contravention of the constitutional command; fraud or overreaching or misleading of the people; the inadvertent; the "discordant;" or "the intermixing in one and the same act [of] such things as have no proper relation to each other;" or matters which are "uncertain, misleading or deceptive."
>
> [Ibid. (quoting Lan, 80 N.J. at 212).]

The Court now applies this legal standard to amicus' arguments about the Act.

Ms. Dore argues that the Act is misleading because, although it is called the Medical Aid for the Terminally Ill in Dying Act, it allows for euthanasia and is not limited to dying people. Ms. Dore alleges that persons with chronic conditions, such as diabetes, may eventually qualify under the Act. Further, she argues that voluntariness is not assured because patients may have someone communicate on their behalves under N.J.S.A. 26:16-3 and because there is no oversight over self-administration.

X The Court finds that the Act meets the relatedness test set forth by the single object rule. The Act and its individual provisions all relate to providing medical aid in dying to the terminally ill. Further, the Court is not persuaded that the Act specifically provides for assisted suicide or euthanasia when Section 15 specifically states: "Nothing in [the Act] shall be construed to: authorize a physician or any other person to end a patient's life by lethal injection, active euthanasia, or mercy killing, or any act that constitutes assisted suicide under

any law of this State . . . ." Therefore, this Court does not find that the Act is unconstitutional under the single object rule.

XV. Conclusion

Plaintiffs' constitutional and other challenges to the Act all fail as a matter of law. Amicus' challenge fares no better. Accordingly, the Court dismisses the complaint with prejudice. Teamsters Local 97, 434 N.J. Super. at 413.

3/20/20

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March 20, 2020

VIA FACSIMILE TO (609) 376-0834 AND FEDERAL EXPRESS

Hon. Robert T. Lougy, P.J.Ch.
Superior Court of New Jersey, Mercer County
Chancery Division, General Equity Part
175 South Broad Street, 3rd Floor
Trenton, New Jersey 08608-2401

Re: Petro et al. vs. Grewal, Docket No. MER-C-53-19

Your Honor:

Reference is respectfully made to the amicus brief submitted by Margaret Dore, Esq. in the above-referenced matter.

Ms. Dore's brief should be considered by the Court since if the law is unconstitutional under the single object rule, it should be the Court's responsibility to raise that issue *sua sponte* even if not raised by Ms. Dore or the Plaintiffs.

Plaintiffs concur with Ms. Dore's brief as follows:

Providing a poison to promote the suicide of a patient is in no way "medical". To title the Act with the word medical is a manifest falsehood and deception. The "medicalization" of euthanasia under the aegis of doctors was a deception specifically used by the Nazi Party as described in Robert Lifton's book The Nazi Doctors: Medical Killing and the Psychology of Genocide as a central tenet for their euthanasia program.

Furthermore, the title of the Act implies that the patient is in the process of dying when, in fact, the statute only requires a "terminal" diagnosis which means an estimation (more appropriately, speculation) of six months or less to live based on statistical outcomes. There is no medical assurance that the person is actually dying or will die. Poisoning the patient is causing the dying, not aiding in dying.

Aid-in-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?

Creator:
CeloCruz, Maria T.

Bibliographic Citation:
American Journal of Law and Medicine. 1992; 18(4): 369-394.

Abstract:
Recent news stories, medical journal articles, and two state voter referenda have publicized physicians' providing their patients with aid-in-dying. This Note distinguishes two components of aid-in-dying: physician-assisted suicide and physician-committed voluntary active euthanasia. The Note traces these components' distinct historical and legal treatments and critically examines arguments for and against both types of action. This Note concludes that aid-in-dying measures should limit legalization initiatives to physician-assisted suicide and should not embrace physician-committed voluntary active euthanasia.

Date:
1992

Subject:
Active Euthanasia; Assisted Suicide; Autonomy; Criminal Law; Drugs; Economics; Euthanasia; Historical Aspects; Killing; Law; Legal Aspects; Legal Rights; Life; Liability; Patients; Physician's Role; Physicians; Public Policy; Rights; Suicide; Terminally Ill; Value of Life; Voluntary Euthanasia;

Collections:
BioethicsLine: 1972-1999

Related items

Model Aid-in-Dying Act

Creator:
Brandt, Craig A.

Bibliographic Citation:
Iowa Law Review. 1989 Oct; 75(1): 125-215.

Permanent Link:
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http://hdl.handle.net/10822/738671

Date:
1989-10

Subject:
Active Euthanasia; Adults; Advance Directives; Allowing to Die; Autonomy; Beneficence; Biomedical Technologies; Chronically Ill; Competence; Conscience; Counseling; Consent; Euthanasia; Government; Government Regulation; Health; Health Facilities; Informed Consent; Legal Aspects; Legal Liability; Legislation; Liability; Minors; Patient Advocacy; Records; Regulation; Right to Die; State Government; Suffering; Terminally Ill; Third Party Consent; Treatment Refusal; Withholding Treatment;

Collections:
BioethicsLine: 1972-1999

Metadata:
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Model Aid-in-Dying Act
Brandt, Craig A.; Cone, Patricia J.; Fontana, Angela L.; Hayes, Rachelle M., (1989-10)

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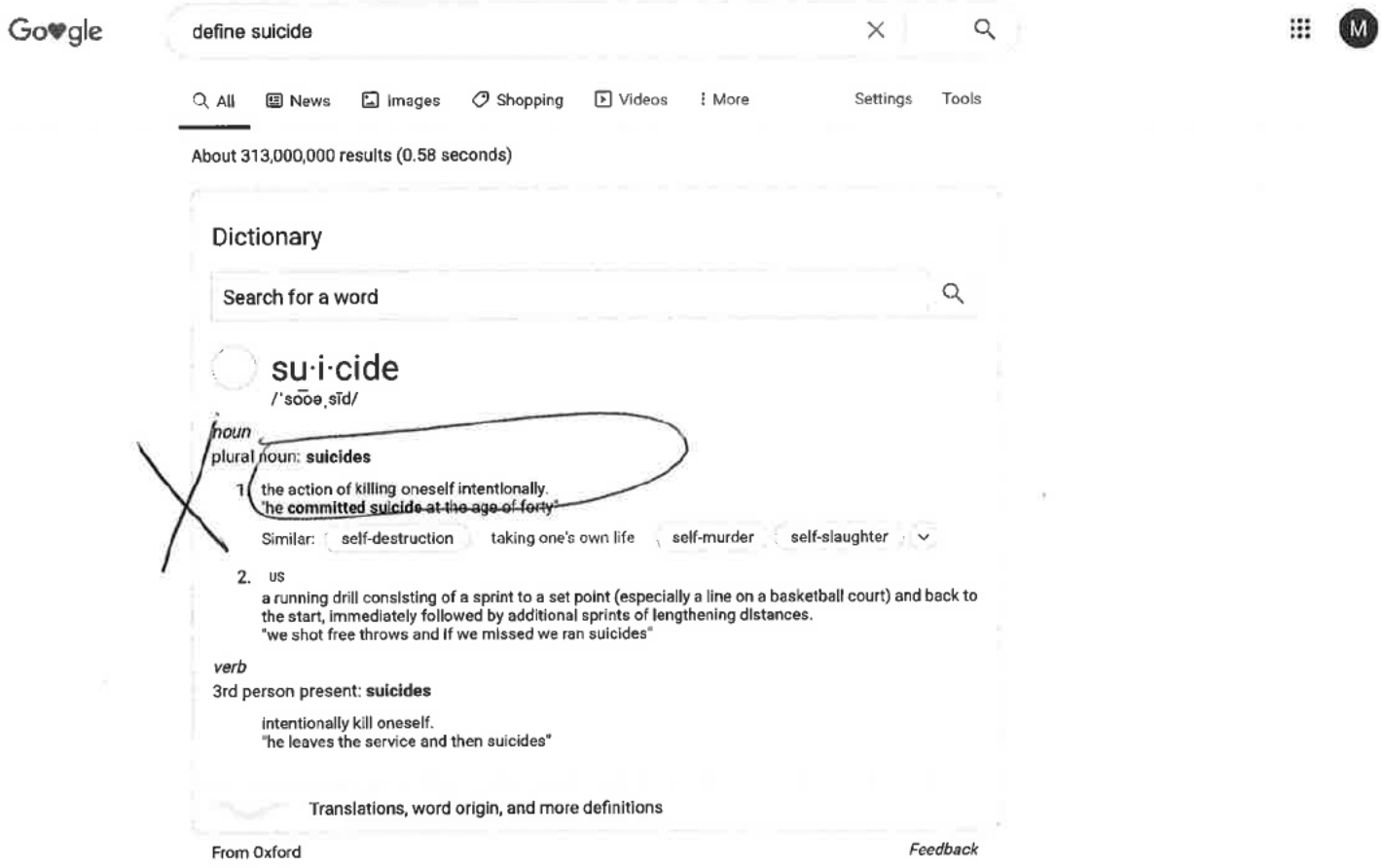

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Suicide | Definition of Suicide by Merriam-Webster

Medical **Definition** of **suicide** (Entry 1 of 2) 1 : the act or an instance of taking one's own life voluntarily and intentionally. 2 : a person who commits or attempts **suicide**. **suicide**.

Commit Suicide · Attempt Suicide · Suicide Pact · Suicide Bomber

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Suicide | Definition of Suicide at Dictionary.com

the intentional taking of one's own life. destruction of one's own interests or prospects: Buying that house was financial **suicide**. a person who intentionally takes ...

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Suicide - Wikipedia

Suicide is the act of intentionally causing one's own death. Mental disorders, including depression, bipolar disorder, schizophrenia, personality disorders, anxiety disorders, and substance abuse—including alcoholism and the use of benzodiazepines—are risk factors.

Causes: Hanging, pesticide poisoning, firearms **Usual onset**: >70 and 15–30 years old
Deaths: 793,000 / 1.5% of deaths (2016) **Frequency**: 12 per 100,000 per year

Risk factors · Prevention · Epidemiology · Social and culture

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suicide - Dictionary Definition : Vocabulary.com

assisted suicide

noun

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Definition of *assisted suicide*

: suicide committed by someone with assistance from another person especially : physician-assisted suicide

Examples of *assisted suicide* in a Sentence

a doctor who has been involved in several *assisted suicides* an opponent of *assisted suicide*
Recent Examples on the Web The law that was introduced to stop organized *assisted suicide* passed Parliament with a solid majority in 2015. — *New York Times*, "German Court Overturns Ban on Assisted Suicide," 26 Feb. 2020 Here's what else is happening Germany: The country's highest court overturned a ban on organized medically *assisted suicide*, an issue with special resonance in a country where Nazi doctors euthanized hundreds of thousands during World War II. — Tom Wright-piersanti, *New York Times*, "Coronavirus, Wisconsin Shooting, Syrian Refugees: Your Thursday Briefing," 26 Feb. 2020

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First Known Use of *assisted suicide*

1884, in the meaning defined above

physician-assisted suicide

noun

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Definition of *physician-assisted suicide*

: suicide by a patient facilitated by means (such as a drug prescription) or by information (such as an indication of a lethal dosage) provided by a physician aware of the patient's intent

First Known Use of *physician-assisted suicide*

1987, in the meaning defined above

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12 million Americans misdiagnosed each year

BY JESSICA FIRGER
APRIL 17, 2014 / 5:00 AM / CBS NEWS

Each year in the U.S., approximately 12 million adults who seek outpatient medical care are misdiagnosed, according to a new study published in the journal BMJ Quality & Safety. This figure amounts to 1 out of 20 adult patients, and researchers say in half of those cases, the misdiagnosis has the potential to result in severe harm.

Maryanne Clayton with her son, Eric, in the Fred Hutch waiting room: "I just kept going."

Terminal Uncertainty

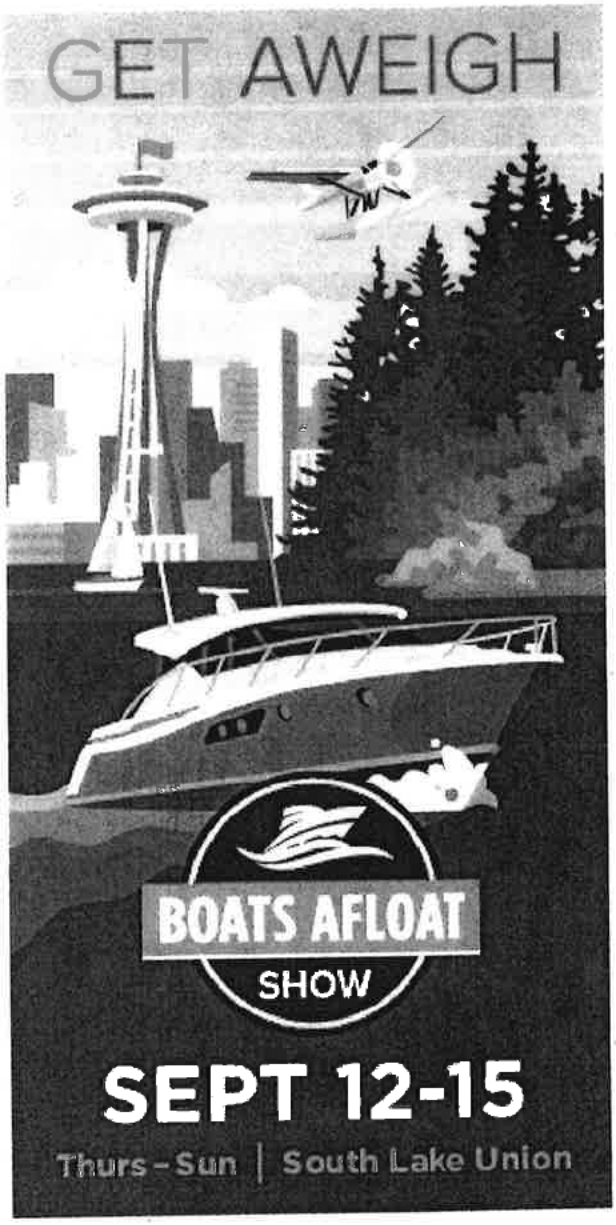
Washington's new "Death With Dignity" law allows doctors to help people commit suicide—once they've determined that the patient has only six months to live. But what if they're wrong?

By Nina Shapiro
Tuesday, January 13, 2009 12:00am NEWS & COMMENT

She noticed the back pain first. Driving to the grocery store, Maryanne Clayton would have to pull over to the side of the road in tears. Then 62, a retired computer technician, she went to see a doctor in the Tri-Cities, where she lived. The diagnosis was grim. She already had Stage IV lung cancer, the most advanced form there is. Her tumor had metastasized up her spine. The doctor gave Clayton two to four months to live.

That was almost four years ago.

Prodded by a son who lives in Seattle, Clayton sought treatment from Dr. Renato Martins, a lung cancer specialist at Fred Hutchinson Cancer Research Center. Too weak to endure the toxicity of chemotherapy, she started with radiation, which at first made her even weaker but eventually built her strength. Given dodgy prospects with the standard treatments, Clayton then decided to participate in the clinical trial of a new drug called pemetrexate.



Her response was remarkable. The tumors shrunk, and although they eventually grew back, they shrunk again when she enrolled in a second clinical trial. (Pemetrexate has since been approved by the FDA for initial treatment in lung cancer cases.) She now comes to the Hutch every three weeks to see Martins, get CT scans, and undergo her drug regimen. The prognosis she was given has proved to be "quite wrong."

"I just kept going and going," says Clayton. "You kind of don't notice how long it's been." She is a plain-spoken woman with a raspy voice, a pink face, and grayish-brown hair that fell out during treatment but grew back newly lustrous. "I had to have cancer to have nice hair," she deadpans, putting a hand to her short tresses as she sits, one day last month, in a Fred Hutchinson waiting room. Since the day she was given two to four months to live, Clayton has gone with her children on a series of vacations, including a cruise to the Caribbean, a trip to Hawaii, and a tour of the Southwest that culminated in a visit to the Grand Canyon. There she rode a hot-air balloon that hit a snag as it descended and tipped over, sending everybody crawling out.

"We almost lost her because she was having too much fun, not from cancer," Martins chuckles.

National Hospice and Palliative Care Organization, which in 2007 showed that 13 percent of hospice patients around the country outlived their six-month prognoses.

It's not that prognostication is completely lacking in a scientific basis. There is a reason that you can pick up a textbook and find a life expectancy associated with most medical conditions: Studies have followed *populations* of people with these conditions. It's a statistical average. To be precise, it's a median, explains Martins. "That means 50 percent will do worse and 50 percent will do better."

Doctors also shade their prognoses according to their own biases and desires. Christakis' study found that the longer a doctor knew a patient, the more likely their prognosis was inaccurate, suggesting that doctors who get attached to their patients are reluctant to talk of their imminent demise. What's more, Christakis says, doctors see death "as a mark of failure."

Oncologists in particular tend to adopt a cheerleading attitude "right up to the end," says Brian Wicks, an orthopedic surgeon and past president of the Washington State Medical Association. Rather than talk about death, he says, their attitude is "Hey, one more round of chemo!"

But it is also true that one more round of chemo, or new drugs like the one that helped Clayton, or sometimes even just leaving patients alone, can help them in ways that are impossible to predict. J. Randall Curtis, a pulmonary disease specialist and director of an end-of-life research program at Harborview Medical Center, recalls treating an older man with severe emphysema a couple of years ago. "I didn't think I could get him off life support," Curtis says. The man was on a ventilator. Every day Randall tested whether the patient could breathe on his own, and every day the patient failed the test. He had previously made it clear that he did not want to be kept alive by machines, according to Curtis, and so the doctor and the man's family made the wrenching decision to pull the plug.

But instead of dying as expected, the man slowly began to get better. Curtis doesn't know exactly why, but guesses that for that patient, "being off the ventilator was probably better than being on it. He was more comfortable, less stressed." Curtis says the man lived for at least a year afterwards.

Curtis also once kept a patient on life support against his better judgment because her family insisted. "I thought she would live days to weeks," he says of the woman, who was suffering from septic shock and multiple organ failure. Instead she improved enough to eventually leave the hospital and come back for a visit some six or eight months later.

"It was humbling," he says. "It was not amazing. That's the kind of thing in medicine that happens frequently."

Every morning when Heidi Mayer wakes up, at 5 a.m. as is her habit, she says "Howdy" to her husband Bud—very loudly. "If he says 'Howdy' back, I know he's OK," she explains.

"There's always a little triumph," Bud chimes in. "I made it for another day."

It's been like this for years. A decade ago, after clearing a jungle of blackberries off a lot he had bought adjacent to his secluded ranch house south of Tacoma, Bud came down with a case of pneumonia. "Well, no wonder he's so sick," Heidi recalls the chief of medicine saying at the hospital where he was brought. "He's in congestive heart failure."

Then 75, "he became old almost overnight," Heidi says. Still, Bud was put on medications that kept him going—long enough to have a stroke five years later, kidney failure the year after that, and then the onset of severe chest pain known as angina. "It was scary," says Heidi, who found herself struggling at 3 a.m. to find Bud's veins so she could inject the morphine that the doctor had given Bud for the pain. Heidi is a petite blond nurse with a raucous laugh. She's 20 years younger than her husband, whom she met at a military hospital, and shares his cigar-smoking habit. Bud was a high-flying psychiatrist in the '80s when he became the U.S. Assistant Secretary of Defense, responsible for all Armed Forces health activities.

After his onslaught of illnesses, Bud says, his own prognosis for himself was grim. "Looking at a patient who had what I had, I would have been absolutely convinced that my chance of surviving more than a few months was very slim indeed."

CANADA

COUR SUPÉRIEURE

PROVINCE DE QUÉBEC
DISTRICT DE TROIS-RIVIÈRES
No. : 400-17-002642-110

GINETTE LEBLANC,
demanderesse

c.

PROCUREUR GÉNÉRAL DU CANADA,
défendeur

et

PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

AFFIDAVIT OF JOHN NORTON IN OPPOSITION TO ASSISTED SUICIDE AND EUTHANASIA

THE UNDERSIGNED, being first duly sworn on oath, STATES:

1. I live in Florence Massachusetts USA. When I was eighteen years old and in my first year of college, I was diagnosed with Amyotrophic Lateral Sclerosis (ALS) by the University of Iowa Medical School. ALS is commonly referred to as Lou Gehrig's disease. I was told that I would get progressively worse (be paralyzed) and die in three to five years.

2. I was a very physical person. The diagnosis was devastating to me. I had played football in high school and was extremely active riding bicycles. I also performed heavy labor including road construction and farm work. I prided myself for my physical strength, especially in my hands.

3. The ALS diagnosis was confirmed by the Mayo Clinic in Rochester Minnesota. I was eighteen or nineteen years old at the

time. By then, I had twitching in both hands, which were also getting weaker. At some point, I lost the ability to grip in my hands. I became depressed and was treated for my depression. If instead, I had been told that my depression was rational and that I should take an easy way out with a doctor's prescription and support, I would have taken that opportunity.

4. Six years after my initial diagnosis, the disease progression stopped. Today, my condition is about the same. I still can't grip with my hands. Sometimes I need special help. But, I have a wonderful life. I am married to Susan. We have three children and one grandchild. I have a degree in Psychology and one year of graduate school. I am a retired bus driver (no gripping required). Prior to driving bus, I worked as a parole and probation officer. When I was much younger, I drove a school bus. We have wonderful friends. I enjoy singing tenor in amateur choruses. I help other people by working as a volunteer driver.

5. I will be 75 years old this coming September. If assisted suicide or euthanasia had been available to me in the 1950's, I would have missed the bulk of my life and my life yet to come. I hope that Canada does not legalize these practices.

SWORN BEFORE ME at
MASSACHUSETTS, USA
on, August 1st, 2012

JOHN NORTON

NAME: Heidi Pruzynski
A notary in and for the
State of ~~Washington~~ Massachusetts

ADDRESS: 85 Main St
Florence MA 01062
EXPIRY OF COMMISSION: June 22, 2018

PLACE SEAL HERE:

HEIDI PRUZYNSKI
MY COMMISSION EXPIRES
JUNE 22, 2018
COMMONWEALTH OF MASSACHUSETTS
NOTARY PUBLIC

BEFORE THE LEGISLATURE OF THE STATE OF NEW YORK

IN RE NEW YORK BILLS	**DECLARATION OF KENNETH STEVENS, MD**

I, Kenneth Stevens, declare the following under penalty of perjury.

1. I am a doctor in Oregon where physician-assisted suicide is legal. I am also a Professor Emeritus and a former Chair of the Department of Radiation Oncology, Oregon Health & Science University, Portland, Oregon. I have published articles in medical journals and written chapters for books on medical topics. This has been for both a national and international audience. I work in both hospital and clinical settings. I have treated thousands of patients with cancer.

2. In Oregon, our assisted suicide law applies to patients predicted to have less than six months to live. I write to clarify that this does not necessarily mean that patients are dying.

3. In 2000, I had a cancer patient named Jeanette Hall. Another doctor had given her a terminal diagnosis of six months to a year to live, which was based on her not being treated for

cancer. I understand that he had referred her to me.

4. At our first meeting, Jeanette told me plainly that she did not want to be treated and that was going to "do" our law, *i.e.*, kill herself with a lethal dose of barbiturates. It was very much a settled decision.

5. I, personally, did not and do not believe in assisted suicide. I also believed that her cancer was treatable and that her prospects were good. She was not, however, interested in treatment. She had made up her mind, but she continued to see me.

6. On the third or fourth visit, I asked her about her family and learned that she had a son. I asked her how he would feel if she went through with her plan. Shortly after that, she agreed to be treated and she is still alive today. Indeed, she is thrilled to be alive.

7. For Jeanette, the mere presence of legal assisted suicide had steered her to suicide.

8. I also write to clarify a difference between physician-assisted suicide and end-of-life palliative care in which dying patients receive medication for the intended purpose of relieving pain, which may incidentally hasten death. This is the principle of double effect. This is not physician-assisted suicide in which death is intended for patients who may or may not be dying anytime soon.

9. Finally, I have been asked to comment on generally accepted medical practice regarding the administration of prescription drugs to a patient.

10. Generally accepted medical practice allows a doctor, or a person acting under the direction of a doctor, to administer prescription drugs to a patient. Common examples of persons acting under the direction of a doctor, include: nurses and other healthcare professionals who act under the direction of a doctor to administer drugs to a patient in a hospital setting; parents who act under the direction of a doctor to administer drugs to their children in a home setting; and adult children who act under the direction of a doctor to administer drugs to their parents in a home setting.

Signed under penalty of perjury, this 6th day of January, 2016.

Kenneth Stevens Jr. MD

Kenneth Stevens, Jr., MD
Sherwood, Oregon

DECLARATION OF JEANETTE HALL

I, JEANETTE HALL, declare as follows:

1. I live in Oregon where assisted suicide is legal. Our law was enacted in 1997 via a ballot measure that I voted for.

2. In 2000, I was diagnosed with cancer and told that I had 6 months to a year to live. I knew that our law had passed, but I didn't know exactly how to go about doing it. I tried to ask my doctor, Kenneth Stevens MD, but he didn't really answer me. In hindsight, he was stalling me.

3. I did not want to suffer. I wanted to do our law and I wanted Dr. Stevens to help me. Instead, he encouraged me to not give up and ultimately I decided to fight the cancer. I had both chemotherapy and radiation. I am so happy to be alive!

4. It has now been 19 years since my diagnosis. If Dr. Stevens had believed in assisted suicide, I would be dead. Assisted suicide should not be legal.

I declare under penalty of perjury under the laws of the state of Oregon that the above is true and correct to the best of my knowledge.

Dated this 17th day of July, 2019.

Jeanette Hall

Jeanette Hall

\\Server\dox\ASE 2016 +\Oregon\Jeanette Hall Declaration.wpd

Characteristics	2018 (N=168)	Total (N=1,459)	1998-2002 (N=129)	2003-2007 (N=212)	2008-2012 (N=340)	2013-2017 (N=610)
Neurological disease (%)	**25 (14.9)**	**161 (11.0)**	**12 (9.3)**	**17 (8.0)**	**31 (9.1)**	**76 (12.5)**
Amyotrophic lateral sclerosis (%)	15 (8.9)	117 (8.0)	10 (7.8)	16 (7.5)	23 (6.8)	53 (8.7)
Other neurological disease (%)	10 (6.0)	44 (3.0)	2 (1.6)	1 (0.5)	8 (2.4)	23 (3.8)
Respiratory disease [e.g., COPD] (%)	**13 (7.7)**	**75 (5.1)**	**9 (7.0)**	**6 (2.8)**	**18 (5.3)**	**29 (4.8)**
Heart/circulatory disease (%)	**16 (9.5)**	**66 (4.5)**	**4 (3.1)**	**1 (0.5)**	**9 (2.6)**	**36 (5.9)**
Infectious disease [e.g., HIV/AIDS] (%)	**0 (0.0)**	**13 (0.9)**	**1 (0.8)**	**7 (3.3)**	**2 (0.6)**	**3 (0.5)**
Gastrointestinal disease [e.g., liver disease] (%)	**1 (0.6)**	**9 (0.6)**	**0 (0.0)**	**1 (0.5)**	**1 (0.3)**	**6 (1.0)**
Endocrine/metabolic disease [e.g., diabetes] (%)	**2 (1.2)**	**11 (0.8)**	**0 (0.0)**	**2 (0.9)**	**1 (0.3)**	**6 (1.0)**
Other illnesses (%)[3]	**6 (3.6)**	**17 (1.2)**	**1 (0.8)**	**0 (0.0)**	**4 (1.2)**	**6 (1.0)**
DWDA process						
Referred for psychiatric evaluation (%)	3 (1.8)	65 (4.5)	28 (22.8)	8 (3.8)	6 (1.8)	20 (3.3)
Patient informed family of decision (%)[4]	156 (94.0)	1,292 (93.7)	55 (94.8)	198 (94.3)	317 (93.5)	566 (93.4)
Patient died at						
Home (patient, family or friend) (%)	147 (88.6)	1,342 (92.4)	121 (93.8)	198 (93.4)	326 (96.7)	550 (90.3)
Assisted living or foster care facility (%)	12 (7.2)	72 (5.0)	4 (3.1)	11 (5.2)	10 (3.0)	35 (5.7)
Nursing home (%)	5 (3.0)	14 (1.0)	2 (1.6)	0 (0.0)	0 (0.0)	7 (1.1)
Hospital (%)	0 (0.0)	4 (0.3)	1 (0.8)	0 (0.0)	0 (0.0)	3 (0.5)
Hospice facility (%)	0 (0.0)	2 (0.1)	0 (0.0)	0 (0.0)	0 (0.0)	2 (0.3)
Other (%)	2 (1.2)	19 (1.3)	1 (0.8)	3 (1.4)	1 (0.3)	12 (2.0)
Unknown	*0*	*6*	*0*	*0*	*3*	*3*
Lethal medication						
Secobarbital (%)	92 (54.8)	846 (58.0)	86 (66.7)	91 (42.9)	223 (65.6)	354 (58.0)
Pentobarbital (%)	0 (0.0)	386 (26.5)	41 (31.8)	120 (56.6)	117 (34.4)	108 (17.7)
DDMP1 (%)[5]	10 (6.0)	67 (4.6)	0 (0.0)	0 (0.0)	0 (0.0)	57 (9.3)
DDMP2 (%)[5]	54 (32.1)	78 (5.3)	0 (0.0)	0 (0.0)	0 (0.0)	24 (3.9)
Phenobarbital compound (%)[5]	2 (1.2)	65 (4.5)	0 (0.0)	0 (0.0)	0 (0.0)	63 (10.3)
Other (%)	10 (6.0)	17 (1.2)	2 (1.6)	1 (0.5)	0 (0.0)	4 (0.7)

Table 3. Death with Dignity Act process for the participants who have died

	2017		2016		2015[1]	
	Number	%	Number	%	Number	%
Family and Psychiatric/Psychological involvement						
Referred for psychiatric/psychological evaluation[2]	4	2	11	5	8	4
Patient informed family of decision[3]	174	94	224	95	174	93
Medication[4]						
Secobarbital	66	34	77	32	109	51
Pentobarbital	0	0	2	1	4	2
Secobarbital/Pentobarbital Combination	0	0	0	0	0	0
Phenobarbital	0	0	2	<1	10	5
Phenobarbital/Chloral Hydrate Combination	0	0	106	44	88	41
Chloral Hydrate	0	0	1	<1		
Morphine sulfate	130	66	53	22	4	2
Other	0	0	1	<1	0	0
Timing						
Duration of patient-physician relationship[5]						
<25 weeks	94	51	125	52	99	49
25 weeks – 51 weeks	21	11	25	10	18	9
1 year or more	71	38	88	37	81	40
Unknown	0	0	2	1	4	2
Range (min – max)	<1 wk – 38 yrs		<1 wk – 31 yrs		<1 wk – 2 yrs	
Duration between first oral request and death[6]						
<25 weeks	167	90	209	88	164	81
25 weeks or more	18	10	28	12	33	16
Unknown	0	0	0	0	5	2
Range (min – max)	2 wks – 81 wks		2 wks – 112 wks		0 wks – 95 wks	

Drugs used

Notes:

1. Data published in 2016 report: http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/DeathwithDignityData.aspx.
2. Data are collected from the Attending Physician's Compliance form. At the time of publication, data are available for 186 of the 196 participants in 2017 who died.
3. Data are collected from the Written Request for Medication to End Life. At the time of publication, data are available for 185 of the 196 participants in 2017 who died.
4. Data are collected from the Pharmacy Dispensing Record Form. At the time of publication, data are available for all 196 participants in 2017 who received medication and died. Changes in medications from year to year reflect changes, updates, and developments of new medication combinations over time.
5. Data are collected from the After Death Reporting form. At the time of publication, data are available for 186 of the 196 participants in 2017 who died.
6. Data are collected from the After Death Reporting form and Attending physician Compliance Form. At the time of publication, data are available for 185 of the 196 participants in 2017 who died.

WA State Report - Drugs used

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Dictionary

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ap·pro·pri·ate

adjective
/əˈprōprēət/

suitable or proper in the circumstances.
"a measure appropriate to a wartime economy"
synonyms: suitable, proper, fitting, apt; More

verb
/əˈprōprēˌāt/

1. take (something) for one's own use, typically without the owner's permission.
"his images have been appropriated by advertisers"
synonyms: seize, commandeer, expropriate, annex, arrogate, sequestrate, sequester, take possession of, take over, assume, secure, acquire, wrest, usurp, claim, lay claim to, hijack More
2. devote (money or assets) to a special purpose.
"there can be problems in appropriating funds for legal expenses"
synonyms: allocate, assign, allot, earmark, set apart/aside, devote, apportion, budget
"there can be constitutional problems in appropriating funds for these expenses"

Translations, word origin, and more definitions

From Oxford

Feedback

Appropriate | Definition of Appropriate by Merriam-Webster
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appropriated; appropriating. **Definition of appropriate** (Entry 2 of 2) transitive verb. 1 : to take exclusive possession of : annex No one should **appropriate** a common benefit. 2 : to set apart for or assign to a particular purpose or use **appropriate** money for a research program.

APPROPRIATE | definition in the Cambridge English Dictionary
https://dictionary.cambridge.org › dictionary › english › appropriate
appropriate meaning: 1. **suitable** or right for a particular situation or occasion: 2. to take something for your own use, usually without permission: 3. to keep an ...

Appropriate | Definition of Appropriate at Dictionary.com
https://www.dictionary.com › browse › appropriate
adjective. **suitable** or fitting for a particular purpose, person, occasion, etc.: an **appropriate** example; an **appropriate** dress. belonging to or peculiar to a person; proper: Each played his **appropriate** part.

appropriate - Dictionary Definition : Vocabulary.com
https://www.vocabulary.com › dictionary › appropriate
The adjective **appropriate** is used when something is **suitable** or fitting. It comes from the Latin appropriare, which means "to make something fit, to make something one's own." Going back even further, **appropriate** is related to the Latin word proprius, "to belong to a person, thing, or group."

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ac·cord·ance

/əˈkôrdns/

noun

noun: **accordance**

in a manner conforming with.
"the product is disposed of in accordance with federal regulations"
synonyms: in agreement with, in conformity with, in line with, true to, in the spirit of, observing, following, heeding
"a ballot held in accordance with union rules"

Origin

OLD FRENCH acorder

OLD FRENCH acordance

ENGLISH accord

accordance

Middle English: from Old French *acordance*, from *acorder* 'bring to an agreement' (see accord).

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In Accordance With | Definition of In Accordance With by Merriam ...
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accordance. : agreement, conformity. : the act of granting something.

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1. conformity; agreement; accord (esp in the phrase in **accordance** with). 2. the act of granting; bestowal: **accordance** of rights. Collins English Dictionary ...

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in (or in the) spirit

phrase of spirit

1. in thought or intention though not physically.
"he couldn't be here in person, but he is with us in spirit"

Translations, word origin, and more definitions

Feedback

What's the meaning of "in the spirit of"? - English Language & Usage ...
https://english.stackexchange.com/questions/.../whats-the-meaning-of-in-the-spirit-of
Apr 22, 2014 - In the spirit of full disclosure, the texter in question turned out to be my editor at Salon. ... Source: http://imgtfy.com/?q=in+the+spirit+of+definition ...

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A force or principle believed to animate living beings. b. A force or principle believed to animate humans and often to endure after departing from the body of a person at death; the soul. 2. Spirit The Holy Spirit.

In the spirit of synonym | English synonyms dictionary | Reverso
dictionary.reverso.net/english-synonyms/in%20the%20spirit%20of
In the spirit of synonyms, antonyms, English dictionary, English language, definition, see also 'spirits',spirited',spiritual',spit', Reverso dictionary, English ...

Spirit | Definition of Spirit by Merriam-Webster
https://www.merriam-webster.com/dictionary/spirit
1 : an animating or vital principle held to give life to physical organisms. 2 : a supernatural being or essence: such as capitalized : holy spirit1b : soul 2ac : an often malevolent being that is bodiless but can become visible; specifically : ghost 2d : a malevolent being that enters and possesses a human being.

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What is Spirit? Definition and meaning:{article-text}

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www.dictionary.com/browse/spirit
Spirit definition, the principle of conscious life; the vital principle in humans, animating the body or mediating between body and soul. See more.

Deaths that occur within a healthcare facility are handled differently from those that occur outside a health facility or at home. When death occurs within a healthcare facility, the attending physician or designated covering physician should proceed without inordinate delay to the location of the presumed death and should make the proper determination and pronouncement of death. With the expansion of organ and tissue transplant programs and widespread use of mechanical ventilation, the determination of brain death has become the principal prerequisite for organ donation. Such certification should be made by a licensed physician who is professionally qualified by specialty or expertise, in accordance with New Jersey law (P.L. 2013, Chapter 185) and NJBME regulations (N.J.A.C. 13:35-6A.4 Standards for Declaration of Brain Death). Details of nationally recognized practice guidelines for determination of brain death have been adopted by the American Academy of Neurology and can be found at: www.neurology.org/content/74/23/1911.full.pdf+html.

DEATH CERTIFICATE COMPLETION

As discussed earlier, death certificates are a valuable source for state-based and national mortality statistics. Making death certificate information uniform, accurate and complete is crucial when comparing statistics from different sources. Physicians are expected to use medical training, available medical history, symptoms, diagnostic tests and hospital autopsy results (if available) to determine cause of death. The medical part of the certificate includes the following:

- Date and time of pronouncement (certifier may choose to list as "unknown" if the deceased is pronounced by someone else or information is unavailable)
- Date and time of death
- Cause of death, including the best medical judgment as to the cause of death and any contributing factors, manner of death ("Natural" in the case of physicians in clinical practice, all others referred to the Medical Examiner), tobacco use and female's pregnancy status
- Electronic signature of death certificate

DEATH CERTIFICATE TERMINOLOGY

The following are terms encountered when completing death certificates:

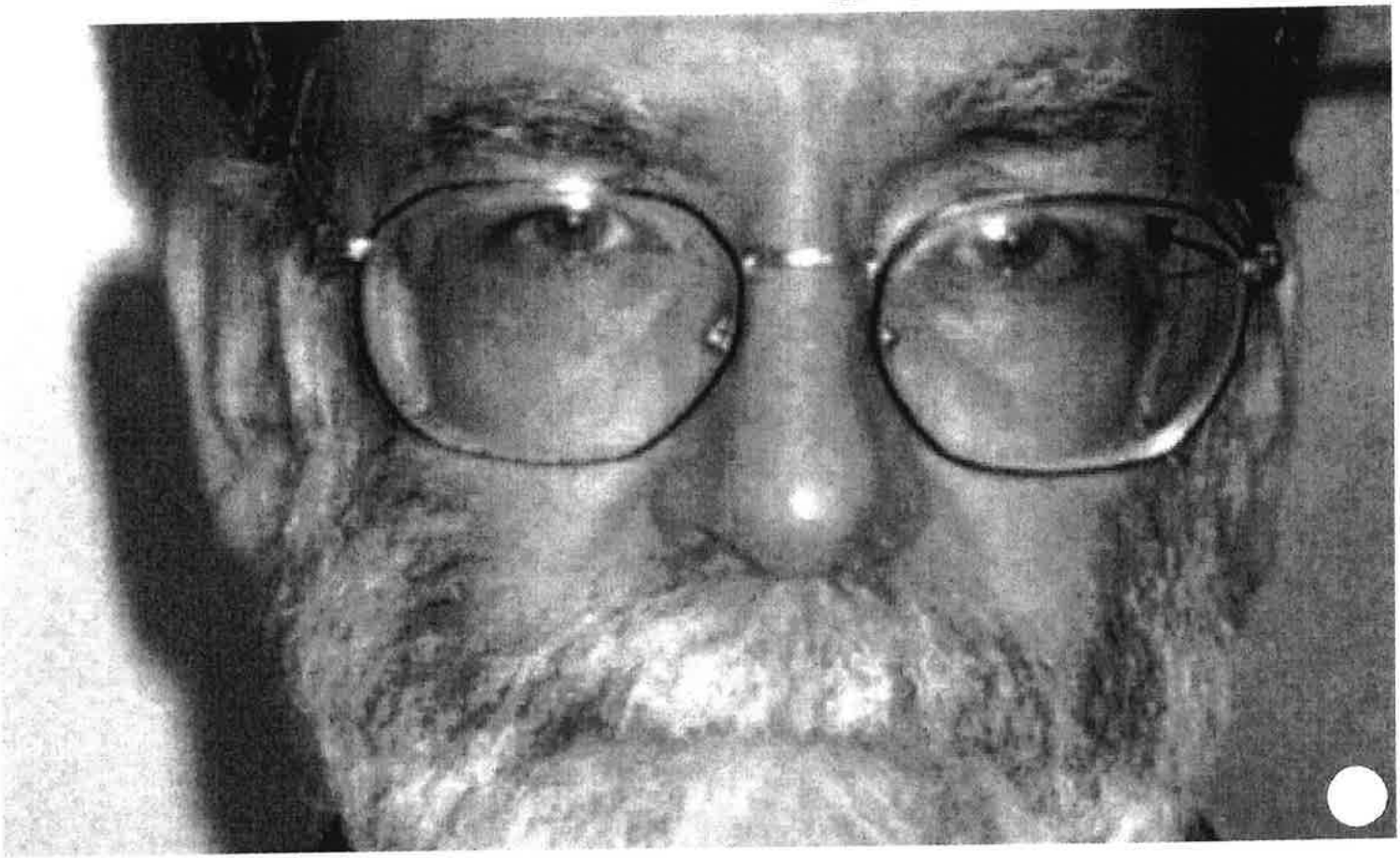
- *Cause of death:* the disease, injury or combination of conditions that leads to the death of an individual
- *Manner of death:* refers to how death occurred; options available include *natural, accident, suicide, homicide or undetermined*
- *Certifier of death:* physician, Medical Examiner or Advanced Practice Nurse completing the cause of death information and signing the certificate
- *Underlying cause of death:* the disease or condition that started the sequence of events leading to death
- *Immediate cause of death:* the terminal condition resulting from the underlying condition and immediately resulting in death
- *Other significant condition:* a condition that contributes to death but is not directly related to the underlying cause of death

When properly completed, the cause of death statement will communicate the same crucial information provided by a case history. As an example, when atherosclerotic coronary artery disease is the underlying cause of death, and cardiac tamponade is the immediate cause of death, the cause of death statement may read: "Cardiac tamponade due to ruptured myocardial infarct, due to atherosclerotic coronary artery disease. Other significant condition: Hypertension with cardiomegaly." The statement clearly outlines the sequence of events. In the case of death due to upper gastrointestinal hemorrhage, if the cause of death is listed as "Rupture of esophageal varices due to cirrhosis of the liver," the underlying condition (namely, what caused the cirrhosis) remains unknown. If the etiology is known, it should be specified, such as "chronic ethanol abuse" or "hepatitis C infection." In the event it is unknown, this should be documented by stating "of unknown etiology." Therefore, non-specific processes, such as pulmonary thromboembolism, pneumonia or cirrhosis, may be listed as the cause of death, but any underlying condition must be specified. Terminal events such as cardiopulmonary arrest, respiratory failure and electro-

Andrew Falzon, MD & Sindy M. Paul, MD, MPH
1" Death Investigation and Certification in
New Jersey, MD Advisor, Summer 2016

CME

The Guardian



Q&A: Harold Shipman

A report has found that the prison where Britain's most prolific serial killer hanged himself 'could not have prevented' his death. David Batty explains the background of the case

David Batty

Thu 25 Aug 2005 10.19 EDT

Who was Harold Shipman?

Harold Shipman was Britain's most prolific serial killer. According to the public inquiry into his crimes, the former family doctor killed at least 250 of his patients over 23 years. He was found dead in his cell at Wakefield prison on January 13 2004, having hanged himself. The 57-year-old was serving 15 life sentences.

What triggered the inquiry?

Shipman was convicted at Preston crown court in January 2000 of the murder of 15 elderly patients with lethal injections of morphine. A public inquiry was launched in June 2001 to investigate the extent of his crimes, how they went undetected for so long, and what could be done to prevent a repeat of the tragedy.

What do we know about his crimes?

His first victim, Eva Lyons, was killed in March 1975 on the eve of her 71st birthday while Shipman

was working at the Abraham Ormerod medical practice in Todmorden. The following year the first clues emerged that Shipman was no ordinary respectable GP. In February 1976, he was convicted of obtaining the morphine-like drug pethidine by forgery and deception to supply his addiction to the drug. Later that year, in the name of a dying patient, he obtained enough morphine to kill 360 people. After receiving psychiatric and drug treatment in York, he re-emerged as a GP in Hyde, Greater Manchester. His method of murder was consistent: a swift injection of diamorphine - pharmaceutical heroin. He killed 71 patients while at the Donnebrook practice in the town and the remainder while a single-handed practitioner at his surgery in Market Street. The majority of his victims - 171 - were women, compared with 44 men. The oldest was 93-year-old Anne Cooper and the youngest 41-year-old Peter Lewis.

How did he get away with it?

When Shipman was fired from the Todmorden medical practice for forging prescriptions, he received a heavy fine but was not struck off by the General Medical Council (GMC), the regulatory body for doctors. Instead, it sent him a stiff warning letter and allowed him to carry on practising. This meant that from this point any employer or patients who asked about Shipman would probably not have been told about his conviction. By the late 1990s, his crime was forgotten and he appeared to be a dedicated, caring professional. But in 1998, Hyde undertakers became suspicious at the number of his patients who were dying, and the neighbouring medical practice discovered that the death rate of Shipman's patients was nearly 10 times higher than their own. They reported their concerns to the local coroner who in turn called in Greater Manchester police. But the police investigation failed to carry out even the most basic checks, including whether Shipman had a criminal record. Nor did they ask the GMC what was on his file. Neither Shipman himself not relatives of the dead patients were contacted. The officers did ask the local health authority to check the records of 19 deceased patients for any inconsistencies between the medical notes and the cause of death on the death certificate. But the medical adviser was unaware that the doctor he was investigating had a history of forging documents - and Shipman had added false illnesses to his victims' records to cover his tracks. As a result the investigation found no cause for concern and the GP was free to kill three more of his patients before finally being arrested in February 1999.

What led to his conviction?

Shipman's crimes were finally uncovered after he forged the will of one of his victims, Kathleen Grundy, leaving him everything. Having administered a lethal dose of morphine to the 81-year-old former mayoress on June 24 1998, he ticked the cremation box on the will form. But she was buried. Her daughter, Angela Woodruff, was alerted about the will by Hyde solicitors Hamilton Ward. She immediately suspected foul play and went to the police. Mrs Grundy's body was exhumed on August 1 1998 and morphine was found in her muscle tissues. Shipman was arrested on September 7 1998. The bodies of another 11 victims were exhumed over the next two months. Meanwhile a police expert checked Shipman's surgery computer and found that he had made false entries to support the causes of death he gave on his victims' death certificates.

Why did he kill his patients?

Various theories have been put forward to explain why Shipman turned to murder. Some suggest that he was avenging the death of his mother, who died when he was 17. The more charitable view is that he injected old ladies with morphine as a way of easing the burdens on the NHS. Others suggest that he simply could not resist playing God, proving that he could take life as well as save it.

What is the scope of the inquiry?
The inquiry, chaired by Dame Janet Smith, was split into two parts. The report of the first part examined the individual deaths of Shipman's patients. The second part is examining the systems in place that failed to identify his crimes during the course of his medical career.The inquiry team is also carrying out a separate investigation into all deaths certified by Shipman during his time as a junior doctor at Pontefract General infirmary, West Yorkshire, between 1970 and 1974. A separate investigation by the prisons and probation ombudsman, Stephen Shaw, concluded that Shipman's death "could not have been predicted or prevented".

What are its findings?
The inquiry has published six reports. The first concluded that Shipman killed at least 215 patients. The second found that his last three victims could have been saved if the police had investigated other patients' deaths properly. The third report found that by issuing death certificates stating natural causes, the serial killer was able to evade investigation by coroners. The fourth report called for stringent controls on the use and stockpiling of controlled drugs such as diamorphine.

The fifth report on the regulation and monitoring of GPs criticised the General Medical Council (GMC) for failing in its primary task of looking after patients because it was too involved in protecting doctors. The sixth and final report, published in January 2005, concluded that Shipman had killed 250 patients and may have begun his murderous career at the age of 25, within a year of finishing his medical training.

Could this happen again?
A range of measures is being considered to improve checks on doctors. The government is considering piloting schemes to monitor GPs' patient death rates. These might include recording causes of death, each patient's age and sex, the time of death and whether other people were present. The fourth report called for stringent controls on the use and stockpiling of controlled drugs such as diamorphine. The fifth report recommends an overhaul of the GMC's constitution to ensure it is more focused on protecting patients than doctors. It proposes that the body is no longer dominated by its elected medical members and should be directly accountable to parliament.

Topics
- Harold Shipman
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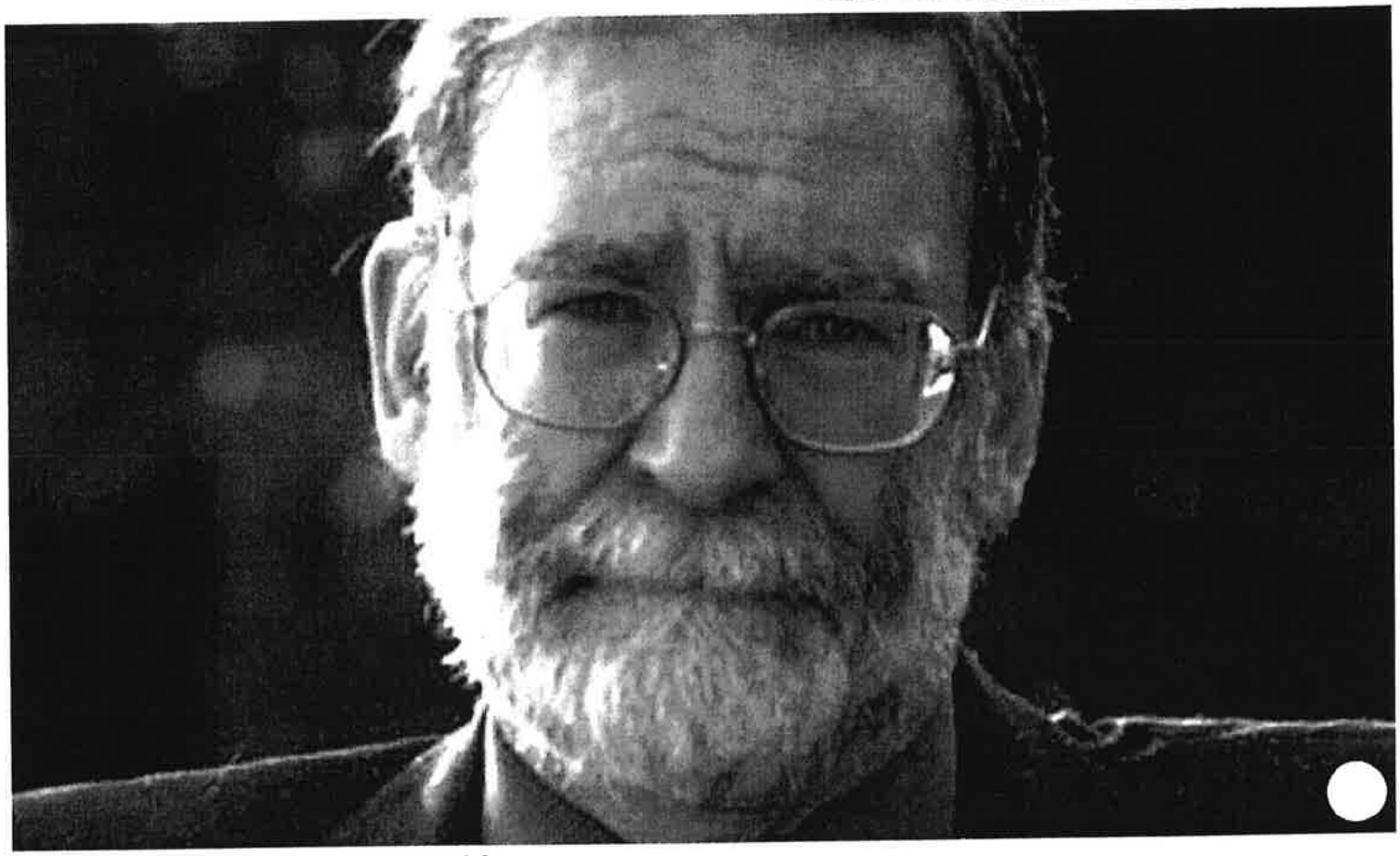
The Guardian



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Death certificate reform delays 'incomprehensible'

Royal College of Pathologists president Dr Suzy Lishman says changes to system for recording deaths are long overdue

Press Association

Wed 21 Jan 2015 05.09 EST

A senior pathologist has criticised the lack of reform to the death certificate system 15 years after the conviction of serial killer Dr Harold Shipman.

Dr Suzy Lishman, president of the Royal College of Pathologists, said changes to the system for recording deaths in England and Wales were long overdue and it was incomprehensible they had not happened.

Family doctor Shipman covered his tracks by signing the death certificates of his victims himself, avoiding the involvement of a coroner.

Chris Bird, whose mother, Violet, was murdered by Shipman, said the delay in implementing the changes was "criminal".

A-50

Lishman said changes that would see a medical examiner review death certificates had not been implemented, possibly because of confusion created by the coalition government's NHS shakeup.

She told BBC Radio 4's Today programme: "I think it appears that the introduction of medical examiners may have got lost in the NHS reforms. Primary care trusts, for example, were initially meant to employ medical examiners and they were abolished in the latest reconfiguration.

"I know there were also concerns about funding mechanisms, but medical examiners in the pilot schemes have been shown to save money so this shouldn't really be an obstacle."

Lishman said in the pilot areas it cost less to pay a medical examiner to scrutinise all deaths than it cost for the cremation form system that relatives pay for following a bereavement.

"It also saves money because the pilot schemes found there is much less litigation," she added. "If bereaved relatives get the answers that they need around the time of death, if all their questions are answered then, then they don't feel the need to sue the NHS to get the answers they deserve."

She said the legislation had been passed, and Prof Peter Furness was in place as the interim chief medical examiner "sitting there waiting to take on this role".

Bird told Today: "Dr Lishman said in her statement today this was 'incomprehensible'. It's not, it is criminal. There is government stalling on implementing something like this that can save millions of lives."

Shipman, who died in 2004, was jailed for life in 2000 for murdering 15 patients using the drug diamorphine while working in Hyde, Greater Manchester.

An official report later concluded he killed between 215 and 260 people over a 23-year period.

A Department of Health spokesman said: "We are committed to reforming the system of death certification. We now have working models of the medical examiner service in Sheffield and Gloucester and will be working to review how they fit with other developments on patient safety. The reforms will proceed in light of that review."

Topics

- Harold Shipman
- Doctors
- Health
- news

2013 New Jersey Revised Statutes Title 3B - ADMINISTRATION OF ESTATES--DECEDENTS AND OTHERS Section 3B:7-1.1 - Effect of intentional killing on intestate succession, wills, trusts, joint assets, life insurance and beneficiary designations.

Universal Citation: NJ Rev Stat § 3B:7-1.1 (2013)

3B:7-1.1 Effect of intentional killing on intestate succession, wills, trusts, joint assets, life insurance and beneficiary designations.

58.Effect of intentional killing on intestate succession, wills, trusts, joint assets, life insurance and beneficiary designations.

a.An individual who is responsible for the intentional killing of the decedent forfeits all benefits under this title with respect to the decedent's estate, including an intestate share, an elective share, an omitted spouse's, domestic partner's or child's share, exempt property and a family allowance. If the decedent died intestate, the decedent's intestate estate passes as if the killer disclaimed his share.

b.The intentional killing of the decedent:

(1)revokes any revocable (a) disposition or appointment of property made by decedent to the killer in a governing instrument and any disposition or appointment created by law or in a governing instrument to a relative of the killer, (b) provision in a governing instrument conferring a general or special power of appointment on the killer or a relative of the killer, and (c) nomination in a governing instrument of the killer or a relative of the killer, nominating or appointing the killer or a relative of the killer to serve in any fiduciary or representative capacity; and

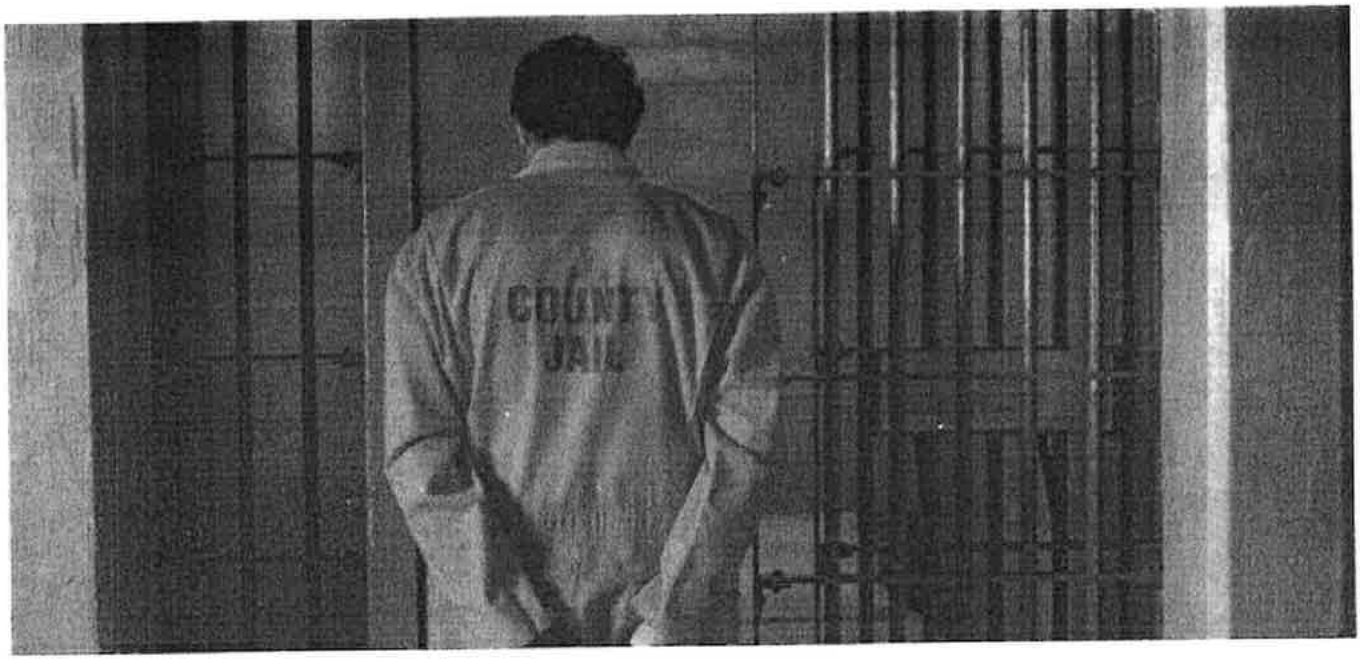
(2)severs the interests of the decedent and the killer in property held by them at the time of the killing as joint tenants with the right of survivorship or as tenants by the entireties, transforming the interests of the decedent and killer into tenancies in common.

c.For purposes of this chapter: (1) "governing instrument" means a governing instrument executed by the decedent; and (2) "relative of the killer" means an individual who is related to the killer by blood, adoption or affinity and who is not related to the decedent by blood or adoption or affinity.

L.2004,c.132,s.58; amended 2005, c.160, s.8; 2005, c.331, s.6.

Forfeiture and New York's "Slayer Rule"

By Ilene S. Cooper and Jaclene D'Agostino



New York's "slayer rule" essentially provides that an individual who kills another person forfeits any interest in the victim's estate. The rationale is simple – no one should financially benefit from his or her own crime.

This long-standing rule has never been codified in New York, but it is a common law principle emanating from the 1889 Court of Appeals decision in *Riggs v. Palmer*.[1] There, a grandson, who intentionally killed his grandfather to ensure his inheritance, was barred from profiting from his own wrong. The Court stated:

> Palmer cannot take any of this property as heir. Just before the murder he was not an heir, and it was not certain that he ever would be. He might have died before his grandfather [the murdered man], or might have been disinherited by him. He made himself an heir by the murder, and he seeks to take property as the fruit of his crime. What has before been said as to him as legatee applies to him with equal force as an heir. He cannot vest himself with title by crime.[2]

Application of the slayer rule is generally straightforward, but in certain cases, the lines can become blurred. This was evidenced this past year in *In re Edwards*,[3] in which the killer sought to inherit from his victim's estate, indirectly, through the estate of his post-deceased spouse, and in the cases of *In re Demesyeux*,[4] and *In re Ledson*,[5] wherein the killers were determined not responsible for their actions by reason of mental disease or defect.

In *Edwards*, the decedent's son-in-law, Brandon, pleaded guilty to manslaughter. Brandon's wife, Deanna, was the decedent's only child, and sole beneficiary of her estate. Less than a year later – and before Brandon's guilty plea – Deanna died intestate, as a result of an accidental drug overdose. Brandon was Deanna's sole distributee and thus stood in a position to inherit his mother-in-law's entire estate indirectly through his wife's estate. In a 2012 decision, Surr. John M. Czygier, Surrogate's Court, Suffolk County, opined that the slayer rule should be extended upon equitable principles to prohibit Brandon from inheriting.[6] The Appellate Division, Second Department recently affirmed.[7]

Acknowledging that this was a case of first impression, the Second Department was guided largely by its decision in *Campbell v. Thomas*.[8] There, the court held that a surviving spouse forfeited her elective share as a result of her own wrongdoing, having knowingly taken

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IT'S GREAT TO BE ALIVE!

Jeanette Hall, 12 years after her doctor talked her out of assisted suicide in Oregon - Click photo to read her story.

ISSUES BY STATE & COUNTRY

AK AL AR AS **AZ CA CO**
CT DC DE FL GA GU **HI**
IA ID IL IN KS KY LA
MA MD ME MI **MN MO** MP
MS **MT** NC ND NE **NH NJ**
NM NV NY OH OK **OR PA**
PR **RI** SC **SD** TN TX **UT**
VA VI **VT WA WI** WV WY
AUSTRALIA CANADA
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A LAW ENFORCEMENT VIEWPOINT

Philip Tummarello, retired Sergeant Inspector - click on photo to see video

Margaret Dore Blog

Friday, August 18, 2017

In Oregon, Other Suicides Have Increased with the Legalization of Physician-Assisted Suicide

By Margaret K. Dore, Esq.

Since the passage of Oregon's law allowing physician-assisted suicide, other suicides in Oregon have steadily increased. This is consistent with a suicide contagion in which the legalization of physician-assisted suicides has encouraged other suicides. In Oregon, the financial and emotional impacts of suicide on family members and the broader community are devastating and long-lasting.[1]

A. Suicide is Contagious

It is well known that suicide is contagious. A famous example is Marilyn Monroe.[2] Her widely reported suicide was followed by "a spate of suicides."[3]

With the understanding that suicide is contagious, groups such as the National Institute of Mental Health and the World Health Organization have developed guidelines for the responsible reporting of suicide, to prevent contagion. Key points include that the risk of additional suicides increases:

> [W]hen the story explicitly describes the suicide method, uses dramatic/graphic headlines or images, and repeated/extensive coverage sensationalizes or glamorizes a death.[4]

B. Physician-Assisted Suicide in Oregon

In Oregon, prominent cases of physician-assisted suicide include Lovelle Svart and Brittany Maynard.

Lovelle Svart died in 2007.[5] *The Oregonian*, which is Oregon's largest paper, violated the recommended guidelines for the responsible reporting of suicide by explicitly describing her suicide method and by employing "dramatic/graphic images." Indeed, visitors to the paper's website were invited "to hear and see when Lovelle swallowed the fatal dose."[6] Today, ten years later, there are still photos of her online, lying in bed, dying.[7]

Brittany Maynard reportedly died from physician-assisted suicide in Oregon, on November 1, 2014. Contrary to the recommended guidelines, there was "repeated/extensive

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VOICES AGAINST ASSISTED SUICIDE & EUTHANASIA:

- "I was afraid to leave my husband alone"
- "If Dr. Stevens had believed in assisted suicide, I would be dead"
- "It wasn't the father saying that he wanted to die"
- "He made the mistake of asking about assisted suicide"
- "This is how society will pay you back? With non-voluntary or involuntary euthanasia"

MONTANA'S LAW PROTECTED ME

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MONTANA LAW

- A Short History of Assisted Suicide and Euthanasia in Montana
- Laws Against Assisted Suicide are Constitutional
- Montana Constitution has No Right to Die

JULIE BROWN

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MORE REFERENCES

- Assisters Can Have Their Own Agenda
- "If Kress had been my doctor in 2000, I would be dead."
- MD responds to opinion piece supporting assisted suicide
- What People Mean When They Say They Want to Die
- Terminal Uncertainty
- Why do so many disability groups oppose assisted suicide?


House Chamber

JULIE BROWN


Julie's Sign: "No assisted suicide. No assisted elder abuse. Preserve choice for seniors."

BLOG ARCHIVE

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coverage" in multiple media, worldwide.[8] This coverage is ongoing, albeit on a smaller and less intense scale.

C. The Young Man Wanted to Die Like Brittany Maynard

A month after Ms. Maynard's death, Dr. Will Johnston was presented with a twenty year old patient during an emergency appointment.[9] The young man, who had been brought in by his mother, was physically healthy, but had been acting oddly and talking about death.[10]

Dr. Johnston asked the young man if he had a plan.[11] The young man said "yes," that he had watched a video about Ms. Maynard.[12] He said that he was very impressed with her and that he identified with her and that he thought it was a good idea for him to die like her.[13] He also told Dr. Johnston that after watching the video he had been surfing the internet looking for suicide drugs.[14] Dr. Johnston's declaration states:

> He was actively suicidal and agreed to go to the hospital, where he stayed for five weeks until it was determined that he was sufficiently safe from self-harm to go home.[15]

The young man had wanted to die like Brittany Maynard.

D. In Oregon, Other Suicides Have Increased with Legalization of Physician-Assisted Suicide

Oregon government reports show the following positive correlation between the legalization of physician-assisted suicide and an increase in other suicides. Per the reports:

- Oregon legalized physician-assisted suicide "in late 1997."[16]
- By 2000, Oregon's conventional suicide rate was "increasing significantly."[17]
- By 2007, Oregon's conventional suicide rate was 35% above the national average.[18]
- By 2010, Oregon's conventional suicide rate was 41% above the national average.[19]
- By 2012, Oregon's conventional suicide rate was 42% above the national average.[20]
- By 2014, Oregon's conventional suicide rate was 43.1% higher than the national average.[21]

E. The Financial and Emotional Cost of Suicide in Oregon

Oregon's report for 2012 describes the cost of suicide as "enormous." The report states:

> Suicide is the second leading cause of death among Oregonians aged 15 to 34 years, and the eighth leading cause of death among all ages in Oregon. The cost of suicide is enormous. In 201[2] alone, self-inflicted injury hospitalization charges in Oregon exceeded $54 million; and the estimate of total lifetime cost of suicide in Oregon was over $677 million. The loss to families and communities broadens the impact of each death. (footnotes omitted).[22]

F. The Significance for Montana

In Montana, the law on assisted suicide is governed by the Montana Supreme Court decision, *Baxter v. State*, 354 Mont. 234 (2009). *Baxter* gives doctors who assist a suicide a potential defense to criminal prosecution.[23] *Baxter* does not legalize assisted suicide by giving doctors or anyone else immunity.[24]

No Assisted Elder Abuse

SENATOR SHOCKLEY WARNS AGAINST ABUSE BY HEIRS


Click on photo to see video

HISTORICAL DOCUMENTS

- Legal Analysis of SB 220 (2013)
- Montana Lawyer Article (2011)
- Baxter Case Analysis (2010)

The decision, however, is also confusing so that it can be read different ways. More importantly, some doctors are claiming to have assisted suicides in Montana. If nothing is done to clarify the law, there will at some point be *de facto* legality.

Montana already has a higher suicide rate than Oregon.[25] If *Baxter* is not overturned and/or the law clarified that assisted suicide is not legal, the suicide problem in Montana will only get worse. Montana does not need the Oregon experience.

Footnotes:

[1] Shen X., Millet L., Suicides in Oregon: Trends and Associated Factors. 2003-2012, *Oregon Health Authority*, Portland Oregon, p.3, Executive Summary.
[2] Margot Sanger-Katz, "The Science Behind Suicide Contagion," *The New York Times*, August 13, 2014.
[3] Id.
[4] "Recommendations for Reporting on Suicide," *The National Institute of Mental Health*. See also "Preventing Suicide: A Resource for Media Professionals," World Health Organization, at http://www.who.int/mental_health/prevention/suicide/resource_media.pdf.
[5] Ed Madrid, "Lovelle Svart, 1945 - 2007, *The Oregonian*, September 28, 2007.
[6] Id.
[7] The still shots at this link, are still up today, July 7, 2017.
[8] The worldwide coverage of Ms. Maynard in multiple media started with an exclusive cover story in People Magazine. Other coverage has included TV, radio, print, web and social media.
[9] Declaration of Williard Johnston, MD, May 24, 2015.
[10] Id.
[11] Id.
[12] Id.
[13] Id.
[14] Id.
[15] Id.
[16] Oregon's Death with Dignity report for 2016, p. 4, first line.
[17] Oregon Health Authority News Release, September 9, 2010, at https://choiceisanillusion.files.wordpress.com/2017/07/news-release-09-09-10.pdf ("After decreasing in the 1990s, suicide rates have been increasing significantly since 2000").
[18] Suicides in Oregon: Trend and Risk Factors, issued September 2010 (data through 2007).
[19] Suicides in Oregon: Trends and Risk Factors, 2012 Report (data through 2010).
[20] Suicides in Oregon: Trends and Associated Factors, 2003-2012 (data through 2012).
[21] Oregon Vital Statistics Report 2015 (data through 2014; at page 6-26, third full paragraph)
[22] See https://choiceisanillusion.files.wordpress.com/2017/07/suicides-in-oregon-2003-2012-p-6.pdf
[23] Greg Jackson, Esq. & Matt Bowman, Esq., "Analysis of Implications of the *Baxter* Case on Potential Criminal Liability," April 2010.
[24] State Senator Jim Shockley and Margaret Dore, Esq., "No, physician-assisted suicide is not legal in Montana: It's a recipe for elder abuse and more," *The Montana Lawyer*," The State Bar of Montana, November 2011.
[25] CDC Centers For Disease Control and Prevention, "QuickStats: Age Adjusted Suicide Rates by State, United States, 2012," published on November 14, 2014.

Johnston

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Appearing pro se

YOSEF GLASSMAN, M.D. and MANISH PUJARA, R.PH., Plaintiffs, vs. GURBIR SHINGH GREWAL, ATTORNEY GENERAL OF THE STATE OF NEW JERSEY, Defendant

SUPERIOR COURT OF NEW JERSEY
CHANCERY DIVISION

DOCKET NO.: MER-C-53-19

CIVIL ACTION

CERTIFICATION OF WILLIARD JOHNSTON, MD

I Williard Johnston MD, being of full age, hereby certify as follows:

1. I am a physician in Vancouver, British Columbia, Canada, licensed since 1981. I am currently a family practice doctor, including obstetrics. I have four years experience as an emergency room doctor. I am also a clinical assistant professor with the Department of Family Practice, University of British Columbia.

2. It is well known that suicide is contagious. I am writing to describe the damaging impact of the highly publicized case of Brittany Maynard, on my young adult patient who became actively suicidal after watching videos concerning her planned assisted suicide in Oregon.

3. Ms. Maynard died via legal assisted suicide in November 2014. A month later, I was presented with my young adult patient during an emergency appointment. He was physically healthy. His mother told me that he had been acting oddly and talking about death.

4. I asked the young man if he had a plan. He said "yes," that he had watched a video about Ms. Maynard. He said that he was very impressed with her and that he identified with her and that he thought it was a good idea for him to die like her. He also told me that after watching the video he had been surfing the Internet looking for ways to obtain suicide drugs.

5. He was actively suicidal and agreed to go to the hospital, where he stayed for five weeks until it was determined that he was sufficiently safe from self-harm to go home.

6. Legal assisted suicide sends the wrong message to young people.

Williard Johnston, MD, being of full age, hereby certifies as follows:

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Dated: 12/18/19

/s/ see attached

Williard Johnston, MD

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4. I asked the young man if he had a plan. He said "yes," that he had watched a video about M. Maynard. He said that he was very impressed with her and that he identified with her and that he thought it was a good idea for him to die like her. He also told me that after watching the video he had been surfing the Internet looking for ways to obtain suicide drugs.

5. He was actively suicidal and agreed to go to the hospital, where he stayed for five weeks until it was determined that he was sufficiently safe from self-harm to go home.

6. Legal assisted suicide sends the wrong message to young people.

Willard Johnston, MD being of full age, hereby certifies as follows:

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Dated: 2019-12-18

Willard Johnston, MD

and operation, under regulation and control by the State, of gambling houses or casinos within the boundaries, as heretofore established, of the city of Atlantic City, county of Atlantic, and to license and tax such operations and equipment used in connection therewith. Any law authorizing the establishment and operation of such gambling establishments shall provide for the State revenues derived therefrom to be applied solely for the purpose of providing funding for reductions in property taxes, rental, telephone, gas, electric, and municipal utilities charges of eligible senior citizens and disabled residents of the State, and for additional or expanded health services or benefits or transportation services or benefits to eligible senior citizens and disabled residents, in accordance with such formulae as the Legislature shall by law provide. The type and number of such casinos or gambling houses and of the gambling games which may be conducted in any such establishment shall be determined by or pursuant to the terms of the law authorizing the establishment and operation thereof.

It shall also be lawful for the Legislature to authorize by law wagering at casinos or gambling houses in Atlantic City on the results of any professional, college, or amateur sport or athletic event, except that wagering shall not be permitted on a college sport or athletic event that takes place in New Jersey or on a sport or athletic event in which any New Jersey college team participates regardless of where the event takes place;

E. It shall be lawful for the Legislature to authorize, by law, (1) the simultaneous transmission by picture of running and harness horse races conducted at racetracks located within or outside of this State, or both, to gambling houses or casinos in the city of Atlantic City and (2) the specific kind, restrictions and control of wagering at those gambling establishments on the results of those races. The State's share of revenues derived therefrom shall be applied for services to benefit eligible senior citizens as shall be provided by law; and

F. It shall be lawful for the Legislature to authorize, by law, the specific kind, restrictions and control of wagering on the results of live or simulcast running and harness horse races conducted within or outside of this State. The State's share of revenues derived therefrom shall be used for such purposes as shall be provided by law.

It shall also be lawful for the Legislature to authorize by law wagering at current or former running and harness horse racetracks in this State on the results of any professional, college, or amateur sport or athletic event, except that wagering shall not be permitted on a college sport or athletic event that takes place in New Jersey or on a sport or athletic event in which any New Jersey college team participates regardless of where the event takes place.

Article IV, Section VII, paragraph 2 amended effective December 5, 2013.

3. The Legislature shall not pass any bill of attainder, ex post facto law, or law impairing the obligation of contracts, or depriving a party of any remedy for enforcing a contract which existed when the contract was made.

4. To avoid improper influences which may result from intermixing in one and the same act such things as have no proper relation to each other, every law shall embrace but one object, and that shall be expressed in the title. This paragraph shall not invalidate any law adopting or enacting a compilation, consolidation, revision, or rearrangement of all or parts of the statutory law.

5. No law shall be revived or amended by reference to its title only, but the act revived, or the section or sections amended, shall be inserted at length. No act shall be passed which shall provide that any existing law, or any part thereof, shall be made or deemed a part of the act or which shall enact that any existing law, or any part thereof, shall be applicable, except by inserting it in such act.

6. The laws of this State shall begin in the following style: "Be it enacted by the Senate and General Assembly of the State of New Jersey."

7. No general law shall embrace any provision of a private, special or local character.

VJ State Constitution

Updated through amendments adopted in Nov. 2019

actually going to the next step and euthanizing their patients.

THE COURT: Well, wait. That's not what this is about.

MR. SMITH: Well --

THE COURT: This case is not about euthanasia.

MR. SMITH: Well, Your Honor --

THE COURT: This case is about the statute that I have before me --

MR. SMITH: I -- I --

THE COURT: -- which is the statute passed by the legislature of New Jersey, signed by the governor, giving individuals the right to make a decision about whether or not the individual wishes to continue when the individual has been diagnosed as being terminally ill. Isn't that what the statute says?

MR. SMITH: Your Honor, I respectfully disagree, because in the Quinlan case the Court said --

THE COURT: You disagree that that's what the statute says?

MR. SMITH: It -- yes, Your Honor, because the -- the Court in Quinlan said that in allowing the removal of assisted life-supporting assistance, that it clearly said that there's no right to assisted suicide.

There is no right for doctors -- a doctor -- medicine must be used for healing and not for ending life, and that it cannot be used to justify euthanasia.

So if we're going to -- if the Court is going to allow the abrogation of -- of Quinlan, which Quinlan is just stating.

THE COURT: Quinlan -- Quinlan -- Quinlan did not address the issue before this Court.

MR. SMITH: Yes -- yes, it did, Your Honor. We bought quotes, clear quotes.

THE COURT: No, it did not. Quinlan addressed the issue about continuing a -- a -- continuing life-sustaining measures for a person who is deemed not to be able to continue. That's what Quinlan is about.

MR. SMITH: Your Honor, your --

THE COURT: Whether or not -- that whether or not --

MR. SMITH: -- Quinlan --

THE COURT: -- the Court should intervene and require life-sustaining measures to be taken for the patient. That's what Quinlan was about.

MR. SMITH: Your Honor, Quinlan was in the context of a much bigger question.

THE COURT: You're talking about dicta in

More than four months ago, on April 12, 2019, Governor Philip Murphy signed the Act with an effective date of August 1, 2019. In doing so, New Jersey joined seven other jurisdictions in permitting those defined as "qualified terminally[-]ill patients" to end their lives by self-administering medication under the protocol detailed in the Act.

In passing the Act, the Legislature specifically concluded that it was "in the public interest and . . . necessary for the welfare of the State and its residents." See N.J.S.A. 26:16-2(d). The Act further "[r]ecogniz[es] New Jersey's long-standing commitment to individual dignity, informed consent, and the fundamental right of competent adults to make health care decisions about whether to have life-prolonging medical or surgical means or procedures provided, withheld, or withdrawn." N.J.S.A. 26:16-2(a). The Act also expresses New Jersey's "right of a qualified terminally[-]ill patient, protected by appropriate safeguards, to obtain medication that the patient may choose to self-administer in order to bring about the patient's humane and dignified death." Ibid.

In order to effectuate its purpose, while also protecting the public welfare, the Act provides for a "safeguarded process." See N.J.S.A. 26:16-2(c). That process "guide[s] health care providers and patient advocates who provide support to dying patients"; "assist[s] capable, terminally[-] ill patients who request compassionate medical aid in dying"; "protect[s] vulnerable adults from abuse"; and "ensure[s] that the process is entirely voluntary on the part of all participants, including patients and those health care providers that are providing care to dying patients." Ibid.

The "safeguarded process" includes a detailed protocol to assist health care providers and patients to ensure that a terminally-ill patient's decision is knowing and voluntary. By way of example only, before a patient can receive life-ending medication, he or she must qualify as terminally ill, which is defined in the Act to include only adult, New Jersey residents capable and determined to be terminally ill and who have voluntarily asked to receive life-ending medication. See N.J.S.A. 26:16-3. "Terminally ill" is defined to include only a patient "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." Ibid. Further, a patient will not be deemed a qualified terminally-ill patient based solely on "the person's age or disability or diagnosis of any specific illness, disease, or condition." Ibid.

In addition, before a patient can receive and self-administer medication, the patient must make two separate oral requests, at least fifteen days apart, and a written request. N.J.S.A. 26:16-10(a). Further, the patient's attending physician is obligated to ensure that a patient's records memorialize the voluntary nature of the patient's decision to terminate his or her life, as well as the patient's capacity, diagnosis, and prognosis. See N.J.S.A. 26:16-10(d)(3). The attending

Order on Emergent Motion, p. 2
Filed Clerk of the Appellate Division, 8/27/19