
Superior Court of New Jersey

Appellate Division

Docket No. A-003837-19T1

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| ANTHONY PETRO, YOSEF | : | CIVIL ACTION |
| GLASSMAN, M.D. and MANISH | : | |
| PUJARA, R.PH., | : | ON APPEAL FROM THE |
| | : | FINAL ORDER OF THE |
| <i>Plaintiffs-Appellants,</i> | : | SUPERIOR COURT |
| | : | OF NEW JERSEY, |
| | : | CHANCERY DIVISION – |
| vs. | : | GENERAL EQUITY, |
| | : | MERCER COUNTY |
| | : | |
| GURBIR SINGH GREWAL, | : | DOCKET NO. MER-C-53-19 |
| Attorney General of the State of | : | |
| New Jersey, | : | Sat Below: |
| | : | |
| <i>Defendant-Respondent.</i> | : | HON. ROBERT LOUGY, P.J.Ch. |
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BRIEF ON BEHALF OF AMICI CURIAE COMPASSION & CHOICES, LYNNE LIEBERMAN, AND DR. PAUL BRYMAN IN SUPPORT OF DEFENDANT-RESPONDENT

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I. Interests of Amicus Curiae

New Jersey's Medical Aid in Dying for the Terminally Ill Act ("Act") allows qualifying terminally ill patients the option to obtain a prescription that, if ingested, will peacefully end their suffering. The New Jersey legislature passed the Act after nearly seven years of debate. In the seven years from when the bill was introduced to its eventual passage, the New Jersey legislature carefully evaluated testimony and evidence provided by both those for and those against the law. After carefully weighing the arguments, the legislature passed the bill with bipartisan support, and New Jersey Governor Philip Murphy signed the bill into law.

Were this Court to overturn the lower court's decision, terminally ill patients like Ms. Lieberman would be limited in their constitutionally protected right to make informed healthcare decisions. Physicians like Dr. Bryman, fearing criminal or civil sanctions if the judgment is reversed, would be prevented from offering the option of medical aid in dying, diminishing the quality of care offered to patients. Similarly, a reversal would impede Compassion & Choices' efforts to ensure all options and the best care for terminally ill patients, including many of its supporters. Ms. Lynne Lieberman, Dr. Paul Bryman, and Compassion & Choices respectfully submit this brief in support of Defendant-Respondent, and along with Defendant-

Respondent, respectfully request that this Court uphold the judgment of the lower court.

1. Interests of Lynne Lieberman

Lynne Lieberman is a 76-year old retired social worker who lives in Absecon, New Jersey. In August 2019, Ms. Lieberman was diagnosed with stage-IV non-small cell lung cancer. Her cancer has metastasized and in March 2021, Ms. Lieberman was told by her doctors she has three to six months left to live. Ms. Lieberman will die from her cancer.

Ms. Lieberman is already experiencing painful symptoms, and she knows these symptoms will soon become debilitating. With her stage-IV diagnosis, Ms. Lieberman knows she must urgently plan for her end-of-life care. Now that New Jersey has passed medical aid in dying legislation, she finds comfort in being able to ask her doctor to prescribe the medication she could take to end her life peacefully, before her suffering inevitably becomes too unbearable. Ms. Lieberman was extremely distressed by the lower court's ruling to enjoin implementation of the Act in August 2019. Ms. Lieberman wants assurance that medical aid in dying will be available to her.

As an individual with stage-IV cancer, the outcome of this appeal will greatly affect Ms. Lieberman's ability to have a death in line with her individual values and beliefs. In March 2021, Ms. Lieberman began the process of obtaining medical aid

in dying so that, if her suffering becomes too great, she will have the option of a peaceful and painless death. If this Court overturns the judgment of the lower court, then Ms. Lieberman may not have the option of medical aid in dying and, because of her diagnosis, would likely die a very painful death.

2. Interests of Dr. Paul Bryman

Dr. Paul Bryman is a physician and geriatrician who lives in Pennsauken, New Jersey. Dr. Bryman practices medicine in New Jersey, is board certified in Internal Medicine, and holds a Certificate of Special Recognition in Geriatric Medicine. He was certified as a Diplomate of the American Board of Hospice and Palliative Medicine from 2007 to 2015. He is licensed to prescribe controlled substances.

Dr. Bryman has been the Medical Director of Heartland Hospice in Laurel Springs, New Jersey and Northfield, New Jersey since 2013. He is also an Assistant Professor at the Rowan University School of Osteopathic Medicine in Stratford, New Jersey where he is a Course Director for the Death and Dying year 2 curriculum. As the Medical Director of Heartland Hospice, Dr. Bryman cares for approximately two-hundred terminally ill patients and has been actively involved in the care of at least four patients who have pursued aid in dying medication since the law has gone into effect. Before the law went into effect, Dr.

Bryman had patients ask about medical aid in dying, but he felt he could not discuss the option.

Dr. Bryman has practiced medicine for over three decades and has been a practitioner of palliative care for over two decades. A central tenet to the practice of medicine is the concept of bodily autonomy. Dr. Bryman strongly believes that each patient with capacity to make end-of-life decisions should be able to direct their treatment and to make decisions they deem to be in their own best interest, based on the values they hold dear.

In Dr. Bryman's judgment, depriving a patient of the choice of medical aid in dying diverges from the core principles of palliative care. A patient's knowledge that medical aid in dying is an option itself has a palliative effect: it reduces pain, suffering, and anxiety at the end of life even if the patient never ingests the medication. Dr. Bryman believes that only a dying patient can decide when their pain and suffering is too great to withstand. In Dr. Bryman's professional opinion, removing the option of medical aid in dying infringes on a patient's autonomy and, depending upon the individual patient's beliefs and health care needs, may well prevent a patient from dying comfortably and peacefully.

As a doctor, the state of legal limbo jeopardizes Dr. Bryman's ability to advise his patients whether, when the time

comes, they will have the option of medical aid in dying. This case has already directly interfered with Dr. Bryman's practice of medicine, and he worries about the effects any reversal of the lower court's decision would have on his patients. The very first day the law took effect, a qualifying terminally ill patient of Dr. Bryman's requested medical aid in dying. One day before Dr. Bryman could lawfully have written his patient a prescription for the aid in dying medication, the lower court enacted a temporary stay of the Act. Dr. Bryman's patient was devastated and suffered severe anxiety over the temporary injunction. Dr. Bryman wrote his patient a prescription for the medication as soon as the law was reinstated, but the uncertainty surrounding the law delayed the patient's pharmacy from filling the prescription for weeks. Dr. Bryman's patient ultimately obtained the prescription around a month later than he otherwise would have obtained it had the court not temporarily enjoined the law.

Dr. Bryman believes that patients and physicians deserve greater certainty about their right to end of life care. Sustaining the lower court's decision would mitigate the uncertainty that surrounds the legal challenges to the Act, would give terminally ill patients greater comfort and peace of mind, and would enable physicians like Dr. Bryman to carry out their professional duties.

3. Interests of Compassion & Choices

Compassion & Choices is the leading nonprofit organization dedicated to improving care and expanding choice at the end of life. It advocates for the rights of terminally ill patients and educates the public through its End-of-Life Information Center and End-of-Life Consultation Service. Compassion & Choices also advocates at the state and federal levels for policies that empower people to make their own healthcare decisions and to give patients facing the end of life access to information and options that allow those patients to live their last days to the fullest while adhering to their own personal values.

Compassion & Choices has a profound interest in preserving the rights granted to both patients and physicians by the Act. The supporters of Compassion & Choices who are terminally ill have pressing interests in securing the freedom to make all critical healthcare decisions that impact their bodily integrity and sense of self, including the option of medical aid in dying. They also need the security of knowing they can exercise their choices safely, effectively, legally, and in a humane manner, professionally assisted by physicians, as afforded by the Act. Similarly, physicians must be assured they will not face criminal or civil sanctions for advising and providing the option of medical aid in dying consistent with their professional judgment.

II. PROCEDURAL HISTORY AND STATEMENT OF FACTS

Ms. Lieberman, Dr. Bryman, and Compassion & Choices incorporate by reference the Procedural History and Statement of Facts set forth in the Brief on Behalf of Respondent Attorney General of the State of New Jersey dated February 18, 2021.

III. ARGUMENT

A. Appellants' Claims Are Based in Policy Not Law.

Legislatures debate policy. Courts decide disputes. Breaking from these norms, Appellants' objections to the Act sound in policy. The New Jersey State legislature was the proper forum for Appellants' objections to the Act, and the arguments made in that forum against the Act were ultimately rejected by the legislature.

New Jersey courts consistently recognize that "the Legislature is better situated than the courts to make policy decisions regarding matters of health, safety and welfare." *Ortley Beach Prop. Owners Ass'n v. Fire Comm'rs of Dover Twp. Fire Dist. No. 1*, 320 N.J. Super. 132, 141 (Law. Div. 1998), *aff'd*, 330 N.J. Super. 358 (App. Div. 2000) (citing *Brown v. City of Newark*, 113 N.J. 565, 571 (1989)). "As an elected body, the legislature is better able than any other single institution to reflect the social values at stake. In addition, it has the resources and ability to synthesize vast quantities of data and opinions from a variety of fields and to formulate general

guidelines that may be applicable to a broad range of situations." *In re Conroy*, 98 N.J. 321, 344 (1985).

The New Jersey State legislature heard testimony from opponents of the Act and decided that it was in the best interest of the public to give qualifying terminally ill patients the option of medical aid in dying. Rather than set out any cognizable legal challenges, Appellants rehash the same policy arguments, including the potential for elder abuse in New Jersey, an unsubstantiated leap from alleged medical coercion to "killing" of patients by physicians, and philosophical tangents about voluntary behavior compared to acts of terrorism, murder, and genocide. Not only do Appellants link none of this conjecture to the Act, but their arguments are not supported by either factual or legal justification. At this point, any objection to the Act based on Appellants' policy arguments must be made through the legislative process, not through the courts. To the extent that Appellants' opposition to the Act reflects perceived societal values or public policy, the appropriate way to take up those policy debates is with the legislature, and not an appeal largely devoid of case law or legal arguments.

B. Medical Aid in Dying Is Completely Voluntary for Patients.

To the extent that examination of policy is appropriate on this appeal, it favors affirming the trial court's judgment. A

core tenet of medical aid in dying is that the patient, not the doctor, should control the care that the patient receives at the end of life. Voluntariness is integral to patient-centered care, and to medical aid in dying. The Act specifically protects a patient's choice, containing multiple safeguards throughout the medical aid in dying process to ensure that individuals requesting medical aid in dying are both able to make major medical decisions and to act on their own accord. These safeguards ensure that medical aid in dying meets the highest standard of care for all patients. David Orentlicher, MD, JD et al., *Clinical Criteria for Physician Aid in Dying*, 19 J. Palliat. Med. 259 (2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4779271/>. It is precisely because of these safeguards, which include strict eligibility requirements and self-administration standards, that medical aid in dying differs from euthanasia and assisted suicide.

1. The Safeguards Within the Act Protect All New Jerseyans.

Medical aid in dying is voluntary for patients. The Act's many safeguards protect a patient's choice and ensure that from first request to after receiving the prescription, the patient is exercising a voluntary decision in line with their values and beliefs. These safeguards work—in over 40 years of combined

experience in ten jurisdictions, there has been no confirmed case of any individual being coerced into requesting or ingesting medical aid in dying. See *infra* n.1 (annual reports from nine authorized jurisdictions regarding medical aid in dying laws show no confirmed cases of abuse or coercion).

The strict eligibility requirements of New Jersey's medical aid in dying law ensure that only mentally capable, terminally ill adults with a prognosis of six months or less who want the option of a peaceful death can request and obtain aid in dying medication. N.J.S.A. 26:16-4. No one can qualify for aid in dying medication based solely on their disability or age. N.J.S.A. 26:16-3.

There are many safeguards in place to ensure that a patient meets the Act's qualification standards. An attending physician must first determine a patient's eligibility before a consulting physician confirms eligibility. N.J.S.A. 26:16-6. Both physicians must also confirm that the requesting individual is acting voluntarily and has the capacity to make health care decisions. N.J.S.A. 26:16-8. If either provider doubts capacity, that provider must refer the patient to a psychiatrist, psychologist or licensed social worker for a capacity evaluation. *Id.* In such a scenario, a prescription cannot be written until the mental health professional first determines the individual is able to make their own decisions. *Id.*

A patient must make three requests—two verbal and one written—before receiving a prescription for medical aid in dying. N.J.S.A. 26:16-10. The written request must be made using the “Medication to End my Life in a Humane and Dignified Manner” form provided in the statute. N.J.S.A. 26:16-5. Two people who know the patient must see the patient make the written request and attest that the patient made the request voluntarily, fully informed and free of undue influence or coercion. *Id.*

Moreover, the Act builds ample time for reconsideration into the patient’s decision making. The minimum amount of time the process can take, from first request to written prescription, is 15 days. N.J.S.A. 26:16-10(a)(5). The patient can withdraw their request at any time. N.J.S.A. 26:16-10(b).

Patients derive peace of mind just from having the prescription even if they ultimately never ingest the medication. Kathy L. Cerminara & Alina Perez, *Therapeutic Death: A Look at Oregon’s Law*, 6 Psychol. Pub. Pol’y & L. 503, 517 (2000). Roughly one-third of patients who receive a prescription for medical aid in dying do not take the medication.¹ Individuals

¹ Currently, public health departments in nine authorized jurisdictions have issued reports regarding the utilization of medical aid in dying laws for a collective 42 years. The data from all such reports published through February 1, 2021 show that 6,669 individuals have received a prescription of medical aid in dying and 4,209 patients (63%) are confirmed to have died after ingesting the medication. See Oregon Health Authority, *Death with Dignity Act Annual Reports*, Oregon.gov,

who do avail themselves of medical aid in dying must self-administer the medication. N.J.S.A. 16:16-2(a).

The Act also ensures that, even if a patient obtains the prescription, they can choose not to take the medication. The statute requires the patient to designate an individual

<https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx> (last visited Feb, 24, 2021); Washington State Department of Health, *2018 Death with Dignity Act Report* (2019), <https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2018.pdf>; Vermont Department of Health, *Report Concerning Patient Choice at the End of Life* (2020), <https://legislature.vermont.gov/assets/Legislative-Reports/2020-Patient-Choice-Legislative-Report-2.0.pdf>; California Department of Public Health, *California End of life Option Act 2019 Data Report* (2020), https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPHEndofLifeOptionActReport2019%20_Final%20ADA.pdf; Colorado Department of Public Health and Environment, *Colorado End-of-Life Options Act, Year Three 2019 Data Summary, With 2017-2019 Trend and Totals*, <https://drive.google.com/file/d/1-gPiQos0ezHQrL6nMI1FZL8J3ODNkwrV/view> (last visited Feb. 24, 2021); Hawaii Department of Health, Office of Planning, Policy, and Program Development, *Report to the Thirtieth Legislature State of Hawaii 2020* (2019), <https://health.hawaii.gov/opppd/files/2020/01/OPPPD-Our-Care-Our-Choice-Act-Annual-Report-2019-1.pdf> (last visited Feb. 24, 2021); DC Health, *District of Columbia Death with Dignity Act 2018 Data Summary*, https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/DWD%20Report%202018%20Final%20%20%208-2-2019.pdf (last visited Feb. 24, 2021); Maine Department of Health and Human Services, *Patient-Directed Care at End of Life Annual Report* (2020), <https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/Death-with-Dignity-Legislative-Report-050420.pdf>. New Jersey Office of the Chief State Medical Examiner, *New Jersey Medical Aid in Dying for the Terminally Ill Act 2019 Data Summary*, https://www.nj.gov/health/advancedirective/documents/maid/2019_M_AID_DataSummary.pdf (last visited Feb. 24, 2021). Please note that Montana does not file annual reports.

responsible for the disposal of unused medication, and it is illegal for anyone else to use the medication. N.J.S.A. 26:16-12.

As a final safeguard, the Act includes criminal sanctions for anyone who abuses the Act. N.J.S.A. 26:16-18. These criminal sanctions extend to anyone who (1) forges or alters a request for medication, (2) conceals or destroys a rescission of that request, (3) coerces or exerts undue influence on a patient to request medication or destroys their rescission of a request, or (4) steals another's rightfully prescribed medication. *Id.* In addition to the penalties spelled out in the Act, the Act clarifies that individuals who abuse the Act remain subject to all other applicable penalties under New Jersey law. *Id.*

These safeguards protect all New Jerseyans. There is no evidence of heightened risk of abuse of medical aid in dying against marginalized populations, like those living with physical disabilities or chronic illness. Margaret P. Battin et al., *Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in "Vulnerable" Groups*, 33 J. Med. Ethics 591 (2007). Any argument that individuals with disabilities are at an increased risk of abuse because of the Act is unfounded. In fact, most individuals with disabilities living in New Jersey support medical aid in dying. Purple Insights, *Voter and Disabled Community, New Jersey*

Survey February 2014, https://compassionandchoices.org/wp-content/uploads/Purple_Strategies_2014_NJ-CT-MA-Combined_02-2020.pdf (last accessed Feb. 24, 2021).

Appellants' and Amicis' arguments that the Act permits abuse and coercion are not grounded in evidence. Their slippery slope arguments fail to account for the strict eligibility requirements and procedural safeguards in the Act. Their arguments rely on debunked anecdotes and biased reports, such as a report from the National Council on Disability—an organization that has opposed medical aid in dying before the first medical aid in dying law took effect and before there was any real-world evidence on which to base their case.² Importantly, the arguments and anecdotes in Appellants' and Amicis' briefs mirror those already made to the New Jersey Legislature, which carefully considered the arguments against medical aid in dying and nevertheless found it was in the best interest of New Jersey citizens to pass the Act, complete with numerous eligibility

² The National Council of Disability released their first opposition paper to medical aid in dying in March 1997, seven months before Oregon's medical aid in dying law—the first in the country—went into effect. See Robert L. Burgdof, Jr., *Assisted Suicide: A Disability Perspective Position Paper* (1997); Arthur Eugene Chin, M.D. et al., Dep't of Hum. Res. Or. Health Div. Ctr. for Disease Prevention & Epidemiology, *Oregon's Death with Dignity Act: The First Year's Experience* 1 (1999) <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year1.pdf> ("On October 27, 1997 physician-assisted suicide became a legal medical option for terminally ill Oregonians.").

requirements and procedural safeguards, and allow qualifying individuals the option of medical aid in dying at the end of life.

2. Medical Aid in Dying Is an Established, and Completely Voluntary, Medical Practice.

Medical aid in dying is an established medical practice that honors an individual's fundamental rights to dignity, autonomy and self-determination. The Act provides qualifying terminally ill patients the option to request a prescription from their doctor for medication they can choose to self-ingest so they may die peacefully. Appellants' attempts to characterize medical aid in dying as either euthanasia or assisted suicide is deliberately misguided.

Medical aid in dying is factually, legally, and medically distinct from euthanasia and assisted suicide. The Act itself specifically prohibits euthanasia and assisted suicide: "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." N.J.S.A. 26:16-15. Euthanasia and assisted suicide are illegal throughout the United States. Factually, euthanasia differs from medical aid in dying in several ways. With euthanasia, it is a third party who administers the medication to another. Euthanasia is not limited

to people who are terminally ill and can occur without an individual's informed consent. Likewise, medical aid in dying differs from assisted suicide. Assisted suicide remains a felony under New Jersey law and occurs when an individual "purposely aids another to commit suicide." N.J.S.A. 2C:11-6. Medical aid in dying is distinct from suicide. N.J.S.A. 26:16-17 (providing that "[a]ny action taken in accordance with [the Act] shall not constitute suicide"); see also Colleen Creighton et al., *Statement of the American Association of Suicidology: "Suicide" Is Not the Same as "Physician Aid in Dying"* (2017), <https://suicidology.org/wp-content/uploads/2019/07/AAS-PAD-Statement-Approved-10.30.17-ed-10-30-17.pdf>. Whereas suicide is often caused by an acute mental health crisis and is often an impulsive and violent act, medical aid in dying is planned, often supported by family and loved ones, and can be used only by a person dying of a terminal disease with the capacity to make major medical decisions. Medical aid in dying is voluntary, and at any time a patient can withdraw their request or decline to ingest the medication.

Not only is medical aid in dying a highly regulated practice, it also improves the quality of end-of-life healthcare across the board. Medical aid in dying encourages patients to discuss their end-of-life options, including hospice and palliative care, and increases use of those options. See Soumya

Karlamangla, *There's an Unforeseen Benefit to California's Physician-Assisted Death Law*, L.A. TIMES, Aug. 21, 2017, <https://www.latimes.com/health/la-me-end-of-life-care-20170821-htmlstory.html>. ("But physicians across the state say the conversations that health care workers are having with patients are leading to patients' fears and needs around dying being addressed better than ever before. They say the law has improved medical care for sick patients, even those who don't take advantage of it."); see also Susan W. Tolle, M.D. & Joan M. Teno, M.D., *Lessons from Oregon in Embracing Complexity in End-of-Life Care*, 376 New Eng. J. Med. 1078 (2017). The majority of individuals who request medical aid in dying are currently enrolled in hospice.³ Yet, good hospice services and palliative care do not eliminate the need for medical aid in dying as an end-of-life care option. Terminally ill patients should have a full-range of medical options at the end of life, whether it is disease-specific treatment, palliative care, the refusal of life-sustaining treatment, or medical aid in dying. Allowing

³ This percentage reflects data from all jurisdictions that report on hospice utilization. Currently, public health departments in nine authorized jurisdictions have issued reports regarding the utilization of medical aid in dying laws. See *supra* note 1. Vermont, Washington, D.C., New Jersey, and Maine do not provide data on hospice utilization in their reports on medical aid in dying. Colorado's report includes those not under hospice care and those whose hospice utilization is unknown as one aggregated category.

this spectrum of end-of-life care puts the decision-making power where it belongs: with the patient.

3. Medical Aid in Dying Is Completely Voluntary for Physicians While Also Respecting the Needs of Patients to Have Their Medical Records Transferred.

The statutory scheme both ensures that a physician's role in medical aid in dying is voluntary and that patients maintain access to their health care records regardless of their physician's beliefs, as a patient's right to informed consent is paramount. The Act specifically states that "any action taken by a health care professional to participate" in medical aid in dying "shall be voluntary" on the part of that health care professional. N.J.S.A. 26:16-17(3)(c). The New Jersey Health Care Facility Law reinforces this voluntariness: "[a] physician may decline to participate in the withholding or withdrawing of measures utilized to sustain life, in accordance with his sincerely held personal or professional convictions." N.J.S.A. 26:2H-62(b).

Both the Act and the New Jersey Health Care Facility Law are clear that if a health care professional is unable or unwilling to carry out a patient's medical aid in dying request, the appropriate thing for the physician to do is to transfer the patient's health care records to a new health care professional or health care facility. N.J.S.A. 26:16-17(3)(c); N.J.S.A.

26:2H-62(b). So while a physician may decline to qualify a patient or write a prescription for medical aid in dying, the patient's interests are vindicated by the Act. All a declining physician must do is "assure the timely transfer of the patient's medical records, including a copy of the patient's advance directive." N.J.S.A. 26:2H-62(b).

Any objection to transferring health care records is baseless. Every patient has a fundamental right to their health care records and access to records is part of every patients' fundamental rights to informed consent and self-determination. N.J.S.A. 26:2H-12.8, otherwise known as the Hospital Patients' Bill of Rights, states that every person admitted to a general hospital has the right:

To receive from the physician information necessary to give informed consent prior to the start of any procedure or treatment and which, except for those emergency situations not requiring an informed consent, shall include as a minimum the specific procedure or treatment, the medically significant risks involved, and the possible duration of incapacitation, if any, as well as an explanation of the significance of the patient's informed consent.

N.J.S.A. 26:2H-12.8(d).

A physician's refusal to transfer a patient's medical records would impede the patient's ability to access medical care and thus would deprive patients of their right to informed consent. In passing the Act, the New Jersey legislature explicitly acknowledged the Act "[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) (emphasis added).

This axiom is consistently present in New Jersey case law, with its emphasis on the physician's duty to disclose to enable a patient's self-determination. See *Largey v. Rothman*, 110 N.J. 204, 208 (1988) (the informed consent doctrine imposes on the physician a duty to disclose "such information as will enable the patient to make an evaluation of the nature of the treatment and of any attendant substantial risks, as well as of available options in the form of alternative therapies). The very "foundation for the physician's duty to disclose in the first place is found in the idea that 'it is the prerogative of the patient, not the physician, to determine for [her]self the direction in which [her] interests seem to lie.'" *Id.* at 214 (internal citation omitted).

Appellants make no argument for why their objections would cause more than *de minimis* harm, as determined by the trial court. Appellants' objections teem with inappropriate policy arguments that belong before the legislature. It is no surprise that Appellants resort to policy, as the law does not offer them support. Appellants suggest that patients cannot understand the

“burden” the Act creates or that it is tantamount to a “murder/suicide regime.” See Br. on Behalf of Pls.-Appellants 16. Yet New Jersey courts have refused this patronizing line of thinking and consistently affirmed that the burden of decision-making lies with the patient, not the doctor, as a patient has a “protectable interest” in self-determination. See *Canesi ex rel. Canesi v. Wilson*, 158 N.J. 490, 502 (1999) (“the doctor’s duty of disclosure must be sufficient to enable [a patient] to make an informed and meaningful decision concerning whether or not to continue the pregnancy”).

Finally, Appellants’ contention that the Act impedes their First Amendment rights is incorrect. The Act is a valid and neutral law of general applicability and is not targeting religious individuals, as evidenced by the grant of immunity to physicians who are unwilling or unable to prescribe medical aid in dying. N.J.S.A. 26:16-17(3)(c). The law requires only that health care professionals transfer a patient’s records if needed. *Id.* Indeed, this duty is not new as preexisting law mandates the transfer of medical records. N.J.S.A. 26:2H-62(b). The intent of the Act is to give terminally ill individuals the right to medical aid to experience a peaceful death. The Act is voluntary for all participants, including physicians and pharmacists, and is not intended to burden religious groups. Accordingly, the requirement to transfer records has only an

incidental effect on freedom of religion and does not violate Appellants' First Amendment Rights. See *Employment Division v. Smith*, 494 U.S. 872, 878-79 (1990) (where a "valid and neutral law of general applicability" has the "incidental effect" of burdening the free exercise of religion or freedom of the press, "the First Amendment has not been offended").⁴

4. New Jersey Has Long Recognized an Individual's Right to Engage in End-of-Life Decision Making.

New Jersey courts have long recognized an individual's right to direct their own medical decisions at the end of life. Medical aid in dying adheres to the Court's precedent and allows terminally ill patients to exercise their fundamental right of self-determination in their final days.

Over four decades ago, the court in *In re Quinlan*, 70 N.J. 10 (1976), held that an individual's constitutionally protected right of privacy extends to a patient's decision to refuse medical treatment at the end of life. *Id.* at 41. The court reinforced this holding in *State v. Pelham*, 176 N.J. 448 (2003), explaining again that "[i]t is beyond dispute that individuals have the right to self-determination in respect of medical care

⁴ The 1993 Religious Freedom Restoration Act attempted to supersede *Smith*. However, the Supreme Court subsequently held that the Religious Freedom Restoration Act is unconstitutional as applied to state and local governments. *City of Boerne v. Flores*, 521 U.S. 507, 532-36 (1997). Accordingly, this Court should apply the *Smith* test to Appellants' claim that the Act impedes their First Amendment rights.

generally and, specifically, in respect of rejecting or removing life support devices or techniques." *Id.* at 451. The courts have repeatedly underscored the principle that people should make their own end-of-life decisions: "insofar as the 'sanctity of individual free choice and self-determination [are] fundamental constituents of life,' the value of life may be lessened rather than increased 'by the failure to allow a competent human being the right of choice.'" *In re Conroy*, 98 N.J. at 350 (quoting *Superintendent of Belchertown State Sch. v. Saikewicz*, 373 Mass. 728, 742, 370 N.E.2d 417, 426 (1977)).

The doctrine of informed consent is intrinsic to the right to make one's own medical decisions and is necessary "to protect this personal interest in the integrity of one's body." *Id.* at 346. In defining the roles of the doctor and patient in obtaining informed consent, "[i]n general, it is the doctor's role to provide the necessary medical facts and the patient's role to make the subjective treatment decision based on his understanding of those facts." *Id.* at 347. It is not the doctor's role to make medical decisions for a patient, nor to foreclose medical options for a patient because the doctor disagrees with the patient's choice—"indeed, if the patient's right to informed consent is to have any meaning at all, it must be accorded respect even when it conflicts with the advice of the doctor or the values of the medical profession as a whole."

Id. at 352-53; see also *In re Peter ex rel. Johanning*, 108 N.J. 365, 373 (1987) (“[Medical choices] are not to be decided by societal standards of reasonableness or normalcy. Rather, it is the patient’s preferences—formed by his or her unique personal experiences—that should control.”)

Appellants call on this Court to upend well-established precedent by limiting an individual’s right to self-determine their end-of-life medical care and altering the traditional patient-physician relationship in obtaining informed consent. This notion contravenes New Jersey courts’ long-established recognition of an individual’s right to make their own end-of-life choices, even when those choices diverge from the advice of a physician. Appellants may disagree with the end-of-life choices granted by the Act, but those choices are the individual’s alone to make.

CONCLUSION

Ms. Lieberman, Dr. Bryman, and Compassion & Choices respectfully request that the Court affirm the trial court’s April 1, 2020 Order.

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Respectfully submitted,



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