

# The Truth About Medical Aid in Dying: A Compassionate End-of-Life Care Option for Terminally Ill in the Garden State

The New Jersey Medical Aid in Dying for the Terminally Ill Act, A1504/S1072 allows: A terminally ill, mentally capable adult with a prognosis of six months or less to live, the option to request, obtain and take medication — should they decide — to die peacefully in their sleep if their suffering becomes unbearable.

The bill is modeled after the [Oregon Death with Dignity Act](#), a law that has been in effect for [20 years](#) without a single substantiated instance of abuse or coercion. The New Jersey bill includes the same time-tested and proven safeguards, regulatory and procedural requirements that the Oregon bill authorizes, as well as the laws in six other authorized jurisdictions ([Washington](#), [Vermont](#), [California](#), [Colorado](#), [Hawai'i](#) and [Washington, D.C.](#)).

Opponents have been circulating false and misleading claims about this compassionate end-of-life care option.

Here's the TRUTH.

**FALSE CLAIM:** A six-month prognosis for a terminal illness is not always accurate.

**THE TRUTH:** Six months is a time frame that is already a part of the medical standard of care and is often used as a guide for treatment decisions; for example, it is the prognosis a person must have to be [eligible for hospice](#), so it is a useful benchmark legally and medically.

Generally speaking, [doctors overestimate the amount of time a person is likely to live](#). In fact, [one study](#) showed that physicians tend to overestimate how long someone is going to live by five times. That is why it is imperative that the dying person and only the dying person decides whether and when to voluntarily self-ingest the aid-in-dying medication. Only the individual alone can decide when their suffering is unbearable.

**MISLEADING CLAIM:** The cause of death should be listed as self-administered drugs that ended life, not the underlying terminal illness.

**THE TRUTH:** For legal and medical purposes, the terminal illness is treated as the cause of the death. This is consistent with [how doctors routinely report](#) other end-of-life decisions on a death certificate. For example, doctors don't list 'disconnecting the ventilator' or 'suffocation' as the cause of death for a person who had a massive stroke and was ultimately removed from life support. They list 'stroke' or 'cerebrovascular accident.' Likewise, when palliative sedation is administered by a doctor to a person with cancer, the cause of death is listed as cancer and not a 'physician administered drug overdose.'

Furthermore, listing medical aid in dying - or suicide - rather than the underlying terminal illness would sabotage the purpose of death certificates and skew data collection designed to improve healthcare. Since public health officials use death certificates to compile data on various disease statistics, including the leading causes of death and report that data to the [National Center for Health Statistics](#) based upon the [International Classification of Diseases \(ICD\)](#), the underlying terminal illness is the most accurate and relevant data to provide.

**MISLEADING CLAIM:** No physician is required to be present when the patient takes the lethal prescription.

**THE TRUTH:** Such a requirement is not only unnecessary to protect terminally ill individuals, but would violate their right to autonomy, self-determination and privacy in deciding the circumstances of their own death. Mandating a specific person be in attendance, especially if the witness is a government representative or a doctor is unnecessary to protect the patient. The legislation already requires two physicians to confirm the patient is mentally capable to make an informed decision and free from coercion before prescribing the medication. Such a new requirement also is inherently coercive.

Once arrangements are made and a specified attendant has arrived, the patient may feel obligated to ingest the medication. Patients should never feel obligated, but should feel completely free to delay or cancel their self-administration of aid-in-dying medication at any time. In fact, one-third of patients in Oregon who get the medication never fill their prescription or decide to take it, but they take comfort from knowing they have it if they need it, enabling them to live their remaining time as fully as possible.

**FALSE CLAIM:** Insurance companies can and have denied individuals healthcare coverage, but offered them low-cost drugs to end their life.

**THE TRUTH:** There is no connection between the denial of expensive or experimental treatments and the coverage of medical aid in dying as an end-of-life care option. Insurance providers cover treatments that are deemed effective and proven, and they deny coverage for those considered unnecessary, experimental or below the standard of care. Sometimes, insurance companies wrongly deny coverage for life-saving treatment and patients and their advocates spend an extraordinary amount of effort convincing them to reverse those decisions. This situation is true in every state, those that authorize medical aid in dying and those that do not. Furthermore, a [research article](#) from the New England Journal of Medicine concludes insurers have no financial incentive to pressure patients to accelerate their deaths because there are no substantial cost savings. The article was co-authored by an opponent of aid in dying to ensure objectivity. The common sense explanation is that 90 percent of people in Oregon who get aid-in-dying medication have decided to forego expensive treatments and enrolled in relatively inexpensive hospice care.

The reality is the aid-in-dying medical protocol is often expensive, with multiple consultations required and prescription medication that can cost several thousand dollars (up to \$5,000 for the medication alone). Some insurance companies cover these consultations and medications, and others do not. There is no evidence that medical aid-in-dying laws — or their absence — influence insurance company decisions about any medications that they cover.

**FALSE CLAIM:** Society should work to reduce the incidence of suicide.

**THE TRUTH:** There is absolutely no evidence that medical aid in dying impacts suicide rates. What we do know however, is that when medical aid in dying is an authorized end-of-life care option, individuals are not forced to resort to violent means to end their suffering from terminal illness. Even the authors of a 2015 [Southern Medical Journal article](#) who claimed that medical aid-in-dying laws increased suicides admitted that when they excluded medical aid-in-dying patients from the total suicides category, the results “were equivocal” and “no longer statistically significant.”