LEGISLATIVE DELIBERATIONS, LIFE AND DEATH ISSUES: NEW JERSEY DEBATES LIVING WILLS AND THE DECLARATION OF DEATH

I. Introduction

In keeping with its role as a leader in the area of bioethics law,[1] New Jersey is currently grappling with two vital issues regarding health care: the determination of when death occurs and; the legal effect of advance directives commonly referred to as living wills. This note will deal with the most recent attempts by the New Jersey Legislature to clarify the law on these important and highly sensitive issues. Two bills giving legal effect to advance directives[2] and codifying the definition of death currently recognized by the New Jersey Supreme Court[3] passed the State Senate by a narrow vote.[4] This note will examine the operative provisions of these bills and their potential ramifications for the future of health care decision-making in this state.

It is difficult to imagine an issue with greater potential to arouse emotions than the right to die. The right to individual self-determination, long recognized in New Jersey law,[5] when balanced against the inherent value granted to human life in our society, has led to repeated conflicts as medical technology has advanced. Consequently, the right of individuals to determine the course of their own health care has been an issue of substantial concern in recent years, leading to a variety of laws and a great deal of intense and often emotionally charged debate. In New Jersey, concern for the welfare, comfort, and dignity of the

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[1] *See* N.J. STAT. ANN. § 52:9Y-1(a) (West 1986).

[2] S. 3320, 203d Leg., 2d Sess. (Feb. 9, 1989).

[3] S. 2659, 203d Leg., 1st Sess. (June 16, 1988).

[4] Both bills were passed by the Senate on August 14, 1989. N.J. Legis. Index (Sept. 28, 1989). Each received the bare majority, 21 votes, required for passage. *Id.* One illustration of the amount of controversy surrounding these bills is the number of abstentions. *See id.* Eleven Senators voted against S. 3320, with eight abstaining or absent. *See id.* Seven voted against S. 2659, with twelve abstaining or absent. *See id.*

[5] *See In re* Conroy, 98 N.J. 321, 346, 486 A.2d 1209, 1221 (1985) (quoting Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891)).

elderly and infirm has led to both protective legislation[6] and the bills described herein. Although the state's general interest in preserving the sanctity of human life is unquestioned,[7] its actions may severely intrude on individuals' judicially recognized right to determine the course of their lives. Although it is the expressed policy of the New Jersey courts to err on the side of preserving life,[8] in reviewing decisions to forego or discontinue treatment, strict adherence to this principle may result in the infliction of extreme pain and discomfort on unwilling patients.[9]

In an attempt to balance these conflicting interests, a large majority of states have passed laws permitting competent adults to express their health care wishes through living wills.[10]

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6 *See, e.g.*, The Mandatory Reporting of Adult Abuse Law, N.J. STAT. ANN. §§ 52:27G-1 to -16 (West 1986).

7 *See Conroy*, 96 N.J. at 348-49, 486 A.2d at 1223 (citations omitted). As Justice Schreiber pointed out, the preservation of life is "commonly considered the most significant" of the state's interests "that may limit a person's right to refuse medical treatment. . . ." *Id.* at 348, 349, 486 A.2d at 1223.

8 *Id.* at 368, 486 A.2d at 1233 (citing *In re* Osborne, 294 A.2d 372, 374 (D.C. 1972)).

9 *See, e.g.*, *In re* Storar, 106 Misc. 2d 880, 433 N.Y.S. 2d 388 (Sup. Ct. 1980). Storar dealt with a severely retarded adult cancer patient confined to an institution. *Id.* at 880-81, 433 N.Y.S.2d at 390-91. The cited text related in graphic detail the suffering the patient endured while being treated. *Id.* at 881-82, 433 N.Y.S.2d 391-92. For a more extensive treatment of *Storar*, see Freamon, *Death With Dignity Laws: A Plea for Uniform Legislation*, 5 SETON HALL LEGIS. J. 105, 115-19 (1982) [hereinafter Freamon].

10 As of this writing, 39 states and the District of Columbia have enacted some form of death with dignity law, giving legal effect to an individual's wish to forego or discontinue life-sustaining treatment under certain circumstances. *See* ALA. CODE §§ 22-8A-1 to -10 (1984); ALASKA STAT. §§ 18.12.010 to .12.100 (1988); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (1986); ARK. STAT. ANN. §§ 20-17.210 to .218 (Supp. 1987); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1989); COLO. REV. STAT. §§ 15-18-101 to -113 (1987); CONN. GEN. STAT. ANN. §§ 19a-570 to -575 (West Supp. 1989); DEL. CODE ANN. tit. 16, §§ 2501-2509 (1983); D.C. CODE ANN. §§ 6-2401 to -2430 (1989); FLA. STAT. ANN. §§ 765.01 to .15 (West 1986); GA. CODE ANN. §§ 31-32-1 TO -12 (1985); HAW. REV. STAT. §§ 3270-1 to -27 (Supp. 1988); IDAHO CODE §§ 39-4501 to -4508 (1985); ILL. ANN. STAT. ch. 110 1/2 §§ 701-710 (Smith-Hurd Supp. 1989); IND. CODE ANN. §§ 16-8-11-1 to -17 (West Supp. 1989); IOWA CODE ANN. §§ 144A.1 to .11 (West 1985); KAN. STAT. ANN. §§ 65-28,101 to ,109 (1980); LA. REV. STAT. ANN. §§ 1299.58.1 to .58.10 (West 1985 & Supp. 1989); ME. REV. STAT. ANN. tit. 22, §§ 2921-2931 (Supp. 1988); MD. HEALTH-GEN. CODE ANN. §§ 5-601 to -614 (Supp. 1988); MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1988); MO. ANN. STAT. §§ 459.010 to .055 (Vernon Supp. 1989); MONT. CODE ANN. §§ 50-9-101 to -111, 50-9-201 to -206 (1989); NEV. REV. STAT. ANN. §§ 449.540 to .690 (Michie 1986); N.H. REV. STAT. ANN. §§ 137-H:1 to -H:16 (Supp. 1988); N.M. STAT. ANN. §§ 24-7-1 to -11 (1978);

Although these statutes often vary significantly, they all recognize the legality of the living will under certain enumerated circumstances.[11]

Despite its reputation as a leader in the area of bioethics law, New Jersey has yet to enact living will legislation. This lack of direct action, however, has not prevented each branch of state government from addressing the issue in some way. The judiciary recognizes that competent adults have a common law right to determine the course of their medical treatment and has applied this principle to a number of factual situations on a case by case basis.[12] The legislature, in apparent response to repeated calls for guidance from the supreme court,[13] established the Commission on Legal and Ethical Problems in the Delivery of Health Care, better known as the Bioethics Commission, in 1985,[14] one

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N.C. GEN. STAT. §§ 90-320 to -323 (1988); N.D. CENT. CODE §§ 23-06.4-01 to .4-14 (Supp. 1989); OKLA. STAT. ANN. tit. 63, §§ 3101-3111 (West 1985 & Supp. 1989); OR. REV. STAT. §§ 97.050 to .090 (1979); S.C. CODE ANN. §§ 44-77-10 to -160 (Supp. 1988); TENN. CODE ANN. §§ 32-11-101 to -110 (Supp. 1988); TEX. REV. CIV. STAT. ANN. art. 4590h (Vernon Supp. 1988); UTAH CODE ANN. §§ 75-2-1101 to -1118 (Supp. 1989); VT. STAT. ANN. tit. 18, §§ 5251-5262 (1982); VA. CODE ANN. §§ 54-325.8:1 to .8:13 (1983); WASH. REV. CODE ANN. §§ 70.122.010 to .122.905 (Supp. 1989); W. VA. CODE §§ 16-30-1 to -10 (1984); WISC. STAT. ANN. §§ 154.01 to .15 (Supp. 1988). The proliferation of living will legislation has been concentrated in the last several years. For example, only twelve states had enacted such laws as of 1982. *See also* Freamon, *supra* note 9, at 111 n.78.

[11] A detailed description of state legislation concerning bioethics issues is beyond the scope of this Note. For a comprehensive treatment of many of the questions arising in this area of the law, see Freamon, *supra* note 9, at 105-47.

[12] *See In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987); *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987); *In re* Farrell, 108 N.J. 335, 529 A.2d 434 (1987); *In re* Conroy, 98 N.J. 321, 481 A.2d 1209 (1985); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976).

[13] *Farrell*, 108 N.J. at 341-43, 529 A.2d at 406-08; *Conroy*, 98 N.J. at 344-46, 486 A.2d at 1220-21 (1985).

[14] N.J. STAT. ANN. §§ 52:9Y-1 to -6 (West 1986). The statute makes express reference to several New Jersey Supreme Court decisions stating that the leadership responsibility conferred on the state by these decisions justifies the creation of the Commission. *Id.* § 52:9Y-1(a). The Bioethics Commission's statutory mission includes studying the issues raised by the court's pronouncements, gathering data, and suggesting changes in the law regarding health care. *Id.* § 52:9Y-3. The Commission was to issue a report to the Legislature and Governor by December 31, 1988, which has not yet been finalized. *See id.* § 52:9Y-6. The Commission is made up of 27 members: the Commissioners of Community Affairs and Health, the Commissioner of Human Services, the Public Advocate, the Ombudsman for the Institutionalized Elderly, two state senators and two assemblymen appointed on a bipartisan basis by the President of the Senate and Speaker of the Assembly, respec-

of only two such state bodies in the nation.[15] In addition, the State Department of Health promulgated guidelines dealing with the effectuation of advance directives in long-term care facilities in early 1989.[16] These guidelines were eventually rejected by the Health Care Administration Board.[17]

The definition of death is another critical issue currently being addressed by the legislature. As will be discussed more extensively, the current proposal would not alter the definition of death presently accepted by the state's courts.[18] The bill, however, contains several provisions that would effect the procedures employed in declaring death and would also accommodate various religious and moral beliefs.[19]

The current New Jersey law on these topics is discussed be-

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tively, fourteen public members and representatives from the New Jersey Hospital Association, the New Jersey Nurses' Association, the New Jersey Association of Health Care Facilities and the New Jersey Association of Nonprofit Homes for the Aging. *Id.* § 52:9Y-2. The Office of the Ombudsman for the Institutionalized Elderly was established by N.J. STAT. ANN. §§ 52:27G-1 to -16 (West 1986) and the Public Advocate by N.J. STAT. ANN. §§ 52:27G-20 to -47 (West 1986). The Bioethics Commission is responsible for the original formulation of both S. 3320, 203d Leg., 2d Sess. (Feb. 9, 1989) and S. 2659, 203d Leg., 1st Sess. (June 16, 1988).

15 The New York Task Force on Life and the Law is the other. Governor Mario Cuomo created the Task Force in 1984. N.Y. Exec. Order No. 56 (1984), *reprinted in* Official Compilation of Codes, Rules and Regulations of the State of New York tit. 9A, ch. 1, § 4.56.

16 M.J. COYE, COMM'R N.J. DEPT. OF HEALTH, GUIDELINES ON WITHHOLDING OR WITHDRAWAL OF LIFE-SUSTAINING TREATMENT FOR RESIDENTS IN LONG TERM FACILITIES (March 20, 1989).

17 Minutes of the New Jersey Health Care Administration Board 2-11 (April 13, 1989). Part of the Board's reasoning was that the legal effect of advance directives is an issue to be properly resolved by the legislature. *Id.* at 6-11. The promulgation of the guidelines by Health Commissioner, Molly Joel Coye, was closely tied to the controversy caused by an August 30, 1988 letter to nursing home administrators from Hector M. Rodriquez, then the State Ombudsman for the Institutionalized Elderly. Letter from Hector Rodriquez to Nursing Home Administrators (Aug. 30, 1988). That letter became the center of a widespread, and highly publicized, debate in the health care and legal communities. The Star-Ledger, July 23, 1989, § 1, at 56, col. 1. *See infra* note 78, and accompanying text.

18 The two grounds for death recognized by the New Jersey courts are the "irreversible cessation of circulatory and respiratory functions, or . . . irreversible cessations of all functions of the entire brain, including brain stem . . . ." Strachan v. John F. Kennedy Mem. Hosp., 109 N.J. 523, 533, 538 A.2d 346, 351 (1988) (quoting The Uniform Determination of Death Act § 1).

19 *See infra* section III.

low, in addition to descriptions of the pending legislation in each area.

II. Advance Directives

A. *Current Law*

Although the legislature has yet to decide how living wills will effect a patient's ability to refuse or terminate medical care, the New Jersey court system has had to repeatedly resolve difficult cases having life and death consequences.[20] The basic problem facing both the court and litigants was aptly stated by Justice Marie Garibaldi as follows: "Death comes to everyone. However, in our society, due to great advances in knowledge and technology over the last few decades, death does not come suddenly or completely unexpectedly to most people."[21] These technological advances, although providing cures to medical problems that were previously fatal, have also led to the prolongation of suffering for many hopelessly ill patients.[22] The wish of these patients, or their surrogates,[23] to forego or discontinue treatment has often led to complex and sometimes prolonged litigation.[24] The bulk of the court's pronouncements on medical treatment decision-making was set out in five seminal cases.

The New Jersey Supreme Court made its first major statement on the withdrawal of life-sustaining treatment in the 1976

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[20] *See In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987); *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987); *In re* Farrell, 108 N.J. 335, 529 A.2d 404 (1987); *In re* Conroy, 98 N.J. 321, 481 A.2d 1209 (1985); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976).

[21] *In re* Farrell, 108 N.J. 335, 340, 529 A.2d 404, 406 (1987) (citation omitted).

[22] *Id.* at 340-41, 529 A.2d at 406.

[23] The ability to have the right of self-determination exercised by another on one's behalf is an integral part of the court's treatment removal decisions. *See In re* Jobes, 108 N.J. 394, 415, 529 A.2d 434, 444-45 (1987); *In re* Peter, 108 N.J. 365, 372, 529 A.2d 419, 422-23 (1987); *In re* Conroy, 98 N.J. 321, 359-60; 486 A.2d 1209, 1229 (1985); *In re* Quinlan, 70 N.J. 10, 41-42, 355 A.2d 647, 664, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976). As will soon become obvious, *Quinlan* marked the genesis of the treatment removal issue in New Jersey.

[24] At least compared to the life expectancy of the patient. The supreme court has decided at least two treatment removal cases in which the patient has died while the case was pending. *Conroy*, 98 N.J. 321, 486 A.2d 1209; *Farrell*, 108 N.J. 335, 529 A.2d 404. In both instances, the court ruled that the patient's death did not moot the controversy since the issues raised were capable of being repeated while evading review. *Conroy*, 98 N.J. at 342, 486 A.2d at 1219; *Farrell*, 108 N.J. at 347, 529 A.2d at 410.

case of *In re Quinlan*.[25] Karen Ann Quinlan, a twenty-two year old woman attached to a respirator, was diagnosed as being in a persistent vegetative state.[26] Ms. Quinlan's condition, caused by "[s]evere brain and associated damage,"[27] was described by the court as debilitated and moribund, and beyond the ability of medical science to cure.[28] The court, after examining the request to withdraw treatment in the context of freedom of religion and cruel and unusual punishment,[29] determined that the patient had the right to refuse treatment based on her right to privacy.[30] Given both the extreme measures that were being used to sustain Ms. Quinlan and her slim chance for recovery, the court found that her right to have the treatment withdrawn overrode the state's interest in preserving life.[31]

The importance of *Quinlan* is not limited to the recognition of the right of an individual to forego treatment. The court's holding that this right may be asserted on behalf of an incompetent patient has proven essential to the advancement of the law in this area.[32] The right of an individual to forego treatment would be of little value without the ability to have it carried out by others.[33] The court stated that

> [i]f a putative decision by Karen to permit this non-cognitive existence to terminate by natural forces is regarded as a valuable incident of her right to privacy, as we believe it to be, then it should not be discarded solely on the basis that her condi-

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25 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976).

26 *Id.* at 24-25, 355 A.2d at 654-55.

27 *Id.* at 26, 355 A.2d at 655.

28 *Id.*

29 *Id.* at 35-38, 355 A.2d at 661-62. These arguments were quickly rejected. *Id.* After reviewing the precedents, the court stated that the free exercise of religion does not automatically overcome the state's interest in preserving life. *Id.* at 35-37, 355 A.2d at 661-62. The eighth amendment claim was rejected because Ms. Quinlan's attachment to the respirator was not a penal sanction. *Id.* at 37-38, 355 A.2d at 662.

30 *Id.* at 38-41, 355 A.2d at 662-64.

31 *See id.* The patient's chance for recovery is a key ingredient under this analysis. The court distinguished an earlier case in which surgery and a blood transfusion were given to a patient who, although unable to express her wishes, was likely to recover to "long life and vibrant health." *Id.* at 39, 355 A.2d at 663 (citing John F. Kennedy Mem. Hosp. v. Heston, 58 N.J. 576, 279 A.2d 670 (1971)).

32 *Id.* at 55, 355 A.2d 671-72.

33 *See id.* at 41, 355 A.2d at 664.

> tion prevents her conscious exercise of the choice. The only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render their best judgment, subject to the qualifications hereinafter stated, as to whether she would exercise it in these circumstances.[34]

Unlike some later cases,[35] the decision on the nature of Ms. Quinlan's rights was performed without evidence of her wishes.[36] Instead, the court conditioned the removal of the respirator on the concurrence of her family and attending physicians.[37] In addition, an opinion from the hospital ethics committee or similar body, that there was no reasonable possibility of a return to a cognitive sapient state, was required before removal of treatment was authorized.[38]

Although *Quinlan* is extremely important as an early statement on the right to die, its application has been largely confined to its facts.[39] This is indicative of the highly fact sensitive approach the court has utilized in treatment removal cases. The resulting law is very complex and involves many procedural and substantive issues which are beyond the scope of this section. For the purposes of this discussion, analysis of the cases will be limited to the role played by evidence of the patient's wishes in selecting the proper standard for treatment removal.

The central premise of the court's holding in each of its subsequent cases is the same as that underlying *Quinlan*, simply that competent adults have a common law right to determine the course of their medical treatment.[40] This right, based largely on accepted common law doctrine, is also supported by the federal constitution.[41] Although the court points out that the right to self-determi-

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[34] *Id.*; *see also supra* note 23 and accompanying text.

[35] *See In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987); *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987); *In re* Farrell, 108 N.J. 335, 529 A.2d 404 (1987); *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

[36] *In re* Quinlan, 70 N.J. 10, 41, 355 A.2d 647, 664, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976).

[37] *Id.* at 54, 355 A.2d at 671.

[38] *Id.*

[39] Although the later cases all cite *Quinlan* for its holding on the general right to have treatment withheld or withdrawn, the application of its prognosis based test for effectuating that right is limited to cases in which the patient is in a persistent vegetative state. *See infra* notes 61, 81 and accompanying text.

[40] *See In re* Conroy, 98 N.J. 321, 346, 486 A.2d 1209, 1221-22 (1985).

[41] *Quinlan*, 70 N.J. at 38-42, 355 A.2d at 662-64. The *Quinlan* court based its analysis largely on the unwritten right to privacy. *Id. See also* Griswold v. Connecticut, 381 U.S. 479 (1965). Beginning with *Conroy*, however, the court framed its

nation is to be given considerable deference,[42] its exercise is always to be weighed against the state's interest in protecting the sanctity of human life, "preventing suicide, safeguarding the integrity of the medical profession, and protecting innocent third parties."[43]

The court acknowledges that the state's interests alone will rarely prevail over a competent adult's right to forego or withdraw treatment.[44] Few cases are this simple since most involve incompetent, permanently unconscious, or vegetative patients.[45] Thus, the judicial system is required to extensively inquire into the medical condition and wishes of an individual to insure that their rights are protected.[46] This sensitivity to the facts of each case has spawned numerous legal tests for treatment removal.[47]

In 1985, the supreme court built on the foundation laid in *Quinlan* in deciding *In re Conroy*,[48] which dealt with an attempt to remove a nasogastric tube from a seriously ill nursing home patient with a limited life expectancy.[49] The court's explanation of the scope of the right to refuse treatment[50] led to the establishment of three tests under which that right may be exercised on behalf of a patient in Claire Conroy's condition.[51]

The subjective test, as outlined in *Conroy*, is "to effectuate, insofar as possible, the decision that the patient would have made if

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decisions predominantly around common law notions of self-determination, bodily integrity, and informed consent/refusal. *In re* Conroy, 98 N.J. 321, 346-48, 486 A.2d 1209, 1221-22 (1985). The right to privacy, while certainly a consideration, was not strongly emphasized in *Conroy*. *Id.* at 348, 486 A.2d at 1222-23.

42 *See Conroy*, at 349-50, 486 A.2d at 1223.

43 *Id.* at 348-49, 486 A.2d at 1223.

44 *Id.* at 349, 486 A.2d at 1223. The state's interest will not prevail at least "[i]n cases that do not involve the protection of the actual or potential life of someone other than the decisionmaker." *Id.* at 350, 486 A.2d at 1223. As stated by the court: "On balance, the right of self-determination ordinarily outweighs any countervailing state interests, and competent adults are generally permitted to refuse medical treatment, even at the risk of death." *Id.* at 353, 486 A.2d at 1225. For an example of a legislative attempt to protect the balance of the rights of the decisionmaker against those of an unborn fetus, see *infra* note 145.

45 *See* cases cited *supra* note 20.

46 *See* cases cited *supra* note 20.

47 The intricacies of these tests and their operations are better left to a more comprehensive article. As previously stated, the treatment of these cases will be limited mostly to evidentiary issues.

48 98 N.J. 321, 486 A.2d 1209 (1985).

49 *Id.* at 355, 486 A.2d at 1226.

50 *Id.* at 346-48, 486 A.2d at 1221-23.

51 *Id.* at 360-61, 365-66, 486 A.2d at 1229, 1232.

competent."[52] Evidence of the patient's wishes is consequently of paramount importance in the application of this subjective test analysis. The first test bears most directly on the role of living wills, and allows treatment to be refused or withdrawn if such a clear desire, on the part of the incompetent patient, can be established.[53] This subjective test would be applied without regard to what a reasonable or average person would want under the circumstances.[54] The court acknowledges that living wills, although not legally binding, constitute relevant evidence of a patient's wishes regarding treatment removal.[55] In addition, oral expressions of treatment philosophy, religious beliefs, and other relevant evidence are to be considered.[56] Surrogate decision-makers are also required to consider the medical condition and prognosis of the incompetent patient in applying the subjective test.[57]

Treatment removal cases in which there is little or no evidence of the patient's wishes are decided under the two remaining tests. The limited objective test allows life-sustaining treatment to be withheld or withdrawn if there is some trustworthy evidence that the patient would have refused it.[58] In addition to meeting this evidentiary threshold, the test requires that the surrogate decision-maker be "satisfied that it is clear that the burdens of the patient's contin-

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52 *Id.* at 360, 486 A.2d at 1229.

53 *Id.* at 360-61, 486 A.2d at 1229.

54 *Id.*

55 *Id.* at 361, 486 A.2d at 1229.

56 *Id.* at 361-63, 486 A.2d at 1229-31. The court stated that all relevant evidence is to be considered, including hearsay accounts of statements made by the patient. *Id.* at 362, 486 A.2d at 1230. This represents a departure from *Quinlan*, in which such statements were held to lack sufficient probative value. *Id.* (citing *In re* Quinlan, 70 N.J. 10, 21, 41, 355 A.2d 647, 653, 664, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976)). The probative value of any prior statement may vary due to remoteness, consistency, thoughtfulness, and specificity. *Id.* at 362, 486 A.2d at 1230.

57 *Id.* at 363, 486 A.2d at 1231. In addition to establishing whether the patient is in Claire Conroy's position, medical information is essential to a proper application of the subjective test. *Id.* As stated by the court, "since the goal is to effectuate the patient's right of informed consent, the surrogate decision-maker must have a least as much medical information upon which to base his decision about what the patient would have chosen as one would expect a competent patient to have before consenting to or rejecting treatment." *Id.*

58 *Id.* at 366, 486 A.2d at 1232. This test is to be applied when the evidence, taken together, "would be too vague, casual, or remote to constitute the clear proof of the patient's subjective intent that is necessary to satisfy the subjective test. . . ." *Id.*

ued life with the treatment outweigh the benefits of that life. . . ."[59] As with the subjective test, medical evidence is an essential ingredient in meeting these requirements.[60]

The pure objective test permits life-sustaining treatment to be withheld or withdrawn from *Conroy* patients in the absence of any evidence of their wishes.[61] Withdrawal under this test would be limited to situations in which

> the net burdens of the patient's life with the treatment . . . clearly and markedly outweigh the benefits that the patient derives from life. Further, the recurring, unavoidable, and severe pain of the patient's life with the treatment should be such that the effect of administering life-sustaining treatment would be inhumane.[62]

Quinlan and *Conroy* firmly established the right to refuse treatment.[63] The court's justifiable concern with the particulars of each case caused the development of these new standards.

In 1987, the New Jersey Supreme Court decided three major cases involving withdrawal of treatment from patients suffering from irreversible and incurable illnesses.[64] Since factors such as variations in the place of residence, age, and physical and mental condition of each patient made strict adherence to the procedures of *Quinlan* and *Conroy* inappropriate, several new tests for treatment removal were formulated.

In re Farrell[65] presented the court with its first opportunity to rule on removal of treatment from a competent patient.[66] Kathleen Farrell was a thirty-seven year old woman suffering from amyotrophic lateral sclerosis living at home.[67] She had been sustained by

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59 *Id.* at 365, 486 A.2d at 1232.

60 *Id.* at 365-66, 486 A.2d at 1232.

61 *Id.* at 366, 486 A.2d at 1232. This test would apply where evidence of the patient's intent is not trustworthy or non-existent. *Id.* As with the other tests, the patient must fit the *Conroy* fact pattern. *See supra* note 57 and accompanying text.

62 *In re* Conroy, 98 N.J. 321, 366, 486 A.2d 1209, 1232 (1985). It should be noted that the court expressly rejected considerations of social utility in applying the limited objective and pure objective tests. *Id.* at 367, 486 A.2d at 1232-33.

63 *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976); *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

64 *In re* Farrell, 108 N.J. 335, 529 A.2d 404 (1987); *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987).

65 108 N.J. 335, 529 A.2d 404 (1987).

66 *Id.* at 341, 529 A.2d at 407.

67 *Id.* at 341, 529 A.2d at 407. Amyotrophic lateral sclerosis, ALS, commonly

a respirator which was connected during a hospital stay.[68] After an experimental treatment failed, Mrs. Farrell asked to be removed from the respirator.[69] A psychiatric examination revealed that she had made "an informed, voluntary and competent decision," and did not need psychiatric treatment.[70] The chancery division appointed Mrs. Farrell's husband as her guardian and granted him the authority to disconnect the respirator.[71] The guardian *ad litem* appointed for the Farrell children immediately petitioned the supreme court for direct certification.[72] The court affirmed the chancery division's order, ruling that Mrs. Farrell's right to self-determination outweighed the state interests set out in *Quinlan* and *Conroy*.[73]

Farrell demonstrates the court's willingness to respect the decision of a competent adult to have treatment withdrawn in the presence of sufficient evidence. Although Mrs. Farrell did not have a living will, she was able to testify at the trial about her decision.[74] This testimony allowed the court to avoid formulating a benefits/burdens test similar to those enunciated in the cases involving incompetent patients.[75]

In re Peter[76] involved an elderly nursing home patient in a persistent vegetative state who had expressed her wish to forego life-sustaining treatment. Prior to becoming incompetent, Ms. Peter executed a power of attorney, which authorized her friend, Eberhard Johanning, to "make all decisions with respect to [her] health," including consenting to medical treatment.[77] The chancery division

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known as Lou Gehrig's disease, is a disorder of the nervous system which results in muscle degeneration. *Id.* at 344, 529 A.2d at 408.

68 *Id.* at 344-45, 529 A.2d at 408.

69 *Id.* at 345, 529 A.2d at 408-09.

70 *Id.*, 529 A.2d at 409.

71 *Id.*

72 *Id.* at 346, 529 A.2d at 409.

73 *See id.* at 353, 529 A.2d at 413.

74 *Id.* at 346, 529 A.2d at 409. Part of the trial was conducted in the Farrell home. *Id.* at 345, 529 A.2d at 409. In addition to her testimony, the court noted that Mrs. Farrell refused a nasogastric tube and instructed the hospital staff not to resuscitate her. *Id.* n.3, 529 A.2d at 408 n.3.

75 *See id.* at 348-49, 529 A.2d at 410-11. The court's analysis here is similar to that of the *Conroy* subjective test. *See id.* The patient's rights to self-determination and privacy are balanced against the countervailing state interests, however, there is none of the benefits/burdens analysis of the limited objective and pure objective tests. *See id.*; *see also supra* notes 59, 62 and accompanying text.

76 108 N.J. 365, 370, 529 A.2d 419, 421-22 (1987).

77 *Id.* at 370-71, 529 A.2d at 422.

appointed Mr. Johanning as Ms. Peter's guardian, with the requirement that any " 'decisions to withhold or withdraw medical care or treatment' " be approved by the Office of the Ombudsman for the Institutionalized Elderly.[78]

Mr. Johanning made a written request to the Ombudsman for permission to remove Ms. Peter's nasogastric feeding tube.[79] The Ombudsman contested this action, despite agreeing that Ms. Peter was indeed incompetent and would have refused treatment under the circumstances.[80] The Ombudsman made that decision because he believed that the court's holding in *Conroy* precluded removal of the tube.[81]

In rejecting the Ombudsman's argument, the court held that the *Conroy* subjective test is to be applied in every surrogate refusal of treatment case where the patient leaves clear and convincing evidence of their wishes.[82] The patient's medical condition or life expectancy are irrelevant in these situations.[83] This burden was met

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78 *Id.* at 371, 529 A.2d at 422. The Office of the Ombudsman was the subject of a great deal of controversy during the Bioethics Commission's formulation of S. 3320. *See supra* note 17. In his August 30, 1988 letter to nursing home administrators, then Ombudsman Hector Rodriquez stated that the court's holding in *Peter* required that any attempted withdrawal of treatment from an elderly nursing home patient be approved by his office. *See* Letter from Hector Rodriquez to Nursing Home Administrators (Aug. 30, 1988). While this position is arguable in light of the Ombudsman's statutory mandate, N.J. STAT. ANN. § 52:27G-7.1 (West 1986), and *Peter*, legal considerations seemed to play a diminished role as the controversy grew. The more serious problem was the perceived hostility of the Ombudsman's office, which was increased by Rodriquez's public statement that nursing home patients in New Jersey suffer from terminal neglect. *See* Letter from Hector Rodriquez to Nursing Home Administrators (Aug. 30, 1988). A suit by the New Jersey Hospital Association and the State Medical Society was eventually dropped after the Ombudsman softened his position, when he said that the August 30th letter was not intended to be authoritative. The Star-Ledger, July 23, 1989, § 1, at 56, col. 1. Rodriquez resigned effective May 5, 1989, and the new Ombudsman has stated that he intends to change the office's public image. *Id.*

79 *In re* Peter, 108 N.J. 365, 371, 529 A.2d 419, 422 (1987).

80 *Id.* at 371-72, 529 A.2d at 422.

81 *Id.* The court held the *Conroy* limited objective and pure objective tests inapplicable here, since Ms. Peter was in a persistent vegetative state. *Id.* at 374, 375, 529 A.2d at 424. Thus, Ms. Peter was unable to interact with her environment to the limited extent that Claire Conroy was able to. *Id.* at 374, 529 A.2d at 424. In the alternative, the court stated that the prognosis based approach of *Quinlan* would apply in this case in the absence of sufficient evidence of Ms. Peter's wishes. *See Peter*, 108 N.J. at 377, 529 A.2d at 425.

82 *Peter*, at 377-78, 384-85, 529 A.2d 425, 429.

83 *Id.*

by Ms. Peter's appointment of Mr. Johanning as guardian and nine hearsay accounts of Ms. Peter's wishes.[84] Perhaps most importantly, for the purposes of this discussion, the court stated that living wills are "[c]learly the best evidence" of a patient's treatment wishes.[85]

The third case in the trilogy, *In re Jobes*,[86] involved a request by a husband to remove a feeding tube from his comatose wife. Nancy Ellen Jobes was severely injured in an automobile accident in 1980.[87] Mrs. Jobes suffered massive and irreversible brain damage during surgery and never regained consciousness.[88] At the time the supreme court decided her case, she was thirty-one years old and living in a nursing home.[89] Although there was some conflict in the testimony, the court concluded that the evidence supported a finding that she was in a persistent vegetative state.[90]

Several friends and relatives testified that Mrs. Jobes would have refused the treatment if competent.[91] The supreme court, after concluding that this evidence was insufficient to satisfy the *Conroy* subjective test, modified the chancery division order to allow application of the *Quinlan* substituted judgment standard.[92] The order, as changed, permitted Mrs. Jobes' family, or a close friend, to authorize removal of the tube upon adequate confirmation that she was in a persistent vegetative state.[93]

There is no question that the New Jersey Supreme Court has conscientiously undertaken its role as policy-maker in treatment removal cases.[94] It is equally clear that the court recognizes its limitations in this area, and would enthusiastically welcome a legislative

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84 *Id.* at 379, 529 A.2d at 426. The court began considering hearsay evidence in *Conroy*. *In re* Conroy, 98 N.J. 321, 362, 486 A.2d 1209, 1230 (1985).

85 *In re* Peter, 108 N.J. 365, 378, 529 A.2d 419, 426 (1987).

86 108 N.J. 394, 400, 529 A.2d 434, 437 (1987).

87 *Id.* at 401, 529 A.2d at 437.

88 *Id.*, 529 A.2d at 437-38.

89 *Id.* at 401-02, 529 A.2d at 437-38.

90 *Id.* at 408, 529 A.2d at 441.

91 *Id.* at 409-11, 529 A.2d at 442-43.

92 *Id.* at 413, 424-26, 529 A.2d at 443, 450.

93 *Id.* at 420, 529 A.2d at 447.

94 The exhaustive analysis and painstaking attention to the facts of each case provide considerable support to this statement. In addition, four dissenting members of the Bioethics Commission favor the court's approach to the proposed legislation. MINORITY REPORT, NEW JERSEY COMMISSION ON THE LEGAL AND TECHNICAL PROBLEMS IN THE DELIVERY OF HEALTH CARE: PROPOSED ADVANCE DIRECTIVES FOR HEALTH CARE ACT (Feb. 16, 1989) [hereinafter MINORITY REPORT]. Their report stated that: "our [s]tate's jurisprudence in this area has been hailed internationally

endorsement of living wills.[95] As Justice Garibaldi stated in *Jobes*:

> Courts are not the proper place to resolve the agonizing personal problems that underlie these cases. Our legal system cannot replace the more intimate struggle that must be borne by the patient, those caring for the patient, and those who care about the patient. . . . As we have previously explained, the Legislature is better equipped than the judiciary to frame comprehensive guidelines and procedures for the withdrawal of life-sustaining treatment. Accordingly, we urge it to pass legislation in this area.[96]

The bill, S. 3320, described in the next section would do much to provide the guidance the court seeks. In addition to giving increased legal force to the right to refuse treatment, it would help eliminate some of the less meaningful distinctions found in the court's opinions. For those choosing to execute a living will, the right to refuse treatment could be exercised with a lessened threat of litigation.

B. *Legislative Proposal: S. 3320—The New Jersey Advance Directives For Health Care Act*

S. 3320, sponsored by Senator Gabriel Ambrosio,[97] would allow competent adults, declarants, to execute legally binding advance directives[98] for health care, expressing an individual's preferences for medical treatment in the event they become

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both for its wisdom and for being in the vanguard of this most sensitive and complicated area of the law." *Id.* at 2.

95 *See In re* Jobes, 108 N.J. 394, 428, 529 A.2d 434, 451-52 (1987).

96 *Id.* The court also endorsed the concept of living wills as follows: "Ideally, each person should set forth his or her intentions with respect to life-supporting treatment. This insures that the patient's own resolution of this extraordinarily personal issue will be honored." *Id.*, 529 A.2d at 451.

97 S. 3320, 203d Leg., 2d Sess. (Feb. 9, 1989). Senator Ambrosio (D-36th District) is one of the four Legislators currently serving on the Bioethics Commission. MINORITY REPORT, *supra* note 94, at 8. This bill was originally formulated by the Commission. *Supra* note 14. The other legislators serving on the Commission, Senator Gerald Cardinale (R-39th District), Assemblywoman Stephanie Bush (D-27th District), and Assemblyman C. Richard Kamin (R-23rd District) all signed the Minority Report. MINORITY REPORT *supra* note 94, at 8. The fourth dissenter was Hector M. Rodriquez, then the Ombudsman for the Institutionalized Elderly. *Id.*; *see also supra* note 78.

98 S. 3320, 203d Leg., 2d Sess. § 3 (Feb. 9, 1989). Only the term advance directive will be used for the remainder of this article. The bill originally permitted advance directives to be referred to as living wills. *Id.* The Judiciary Committee deleted this provision by amendment S. 3320, 203d Leg., 2d Sess. (June 2, 1989).

incompetent, permanently unconscious, or otherwise unable to make such decisions.[99] The bill, if enacted, would alter the evidentiary function living wills currently serve by making them dispositive of the declarant's wishes.[100] S. 3320 would not apply to persons who have not executed an advance directive and the absence of a directive would not create any presumptions about an individual's health care wishes.[101] The bill would also establish procedures for the execution of advance directives,[102] define the rights and responsibilities of parties to directives,[103] set out circumstances in which certain treatments may be foregone,[104] and provide for the implementation of advance directives.[105]

The expressed goal of S. 3320 is to create a method for the making of sound decisions regarding life-sustaining treatment.[106] In pursuit of this end, the involvement of declarants, families, physicians, health care representatives, and professionals in the decision-making process is sought.[107]

Advance directives could serve two basic functions: to appoint a person to act as the declarant's health care representative, a proxy directive, and to issue specific instructions for care, an instruction directive.[108] A single directive could serve both functions simultaneously.[109] It also provides immunity from criminal prosecution, civil liability, and professional discipline to those complying in good faith with its provisions.[110]

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99 Decision making capacity for purposes of this bill means "capacity to make a particular health care decision." S. 3320, 203d Leg., 2d Sess. § 7 (June 2, 1989).

100 *See* S. 3320, 203d Leg., 2d Sess. § 12(a)-(b) (Feb. 9, 1989). In addition, the effectuation of advance directives executed according to the laws of other states or countries are permitted, provided they are in accord with public policy. *Id.* § 25. Providers of emergency care, such as paramedics, are exempted from being bound by the terms of an advance directive if inquiry into its existence is impractical. *Id.* § 19(c).

101 *Id.* § 23.

102 *Id.* §§ 4-6.

103 *Id.* §§ 9-10, 13, 19.

104 *Id.* §§ 15-18.

105 *Id.* §§ 7-9, 11-12, 14.

106 *Id.* § 2(f). The right of competent adults to control their health care is explicitly recognized. *Id.* § 2(a). Limitation of this right by the four judicially recognized state interests is also incorporated into the bill. *Id.* § 2(d). The bill also rejects active euthanasia on both moral and legal grounds. *Id.* 2(e).

107 *Id.* § 2(f).

108 *See id.* §§ 3, 6.

109 *Id.* § 6(b).

110 *Id.* § 22.

Only competent adults could make advance directives,[111] which would be executed in writing with two subscribing adult witnesses.[112] Written directives could be supplemented by audio or video tapes.[113] Designated health care representatives would not be permitted to serve as witnesses to the execution of the directive appointing them.[114] Directives would not become operative until it is transmitted to the attending physician[115] and the declarant is determined to lack decision-making capacity.[116]

As stated above, one of the possible functions of an advance directive would be the appointment of a health care representative.[117] Certain limits, however, are placed on who could serve in this capacity.[118] Most significantly, employees of a health care institution in which the declarant is a patient are not eligible unless they are "related to the declarant by blood, marriage or adoption."[119] The single exception to this rule pertains to doctors employed by the facility, provided they do not serve as the declarant's attending physician.[120] The declarant would be able to limit the authority of the representative and name alternate designees.[121] If the primary designee is unable or unwilling to serve, the bill's priority scheme would govern.[122]

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111 *Id.* § 2(a).

112 *Id.* § 4.

113 *Id.*

114 *Id.*

115 Attending physician is defined as "the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient." *Id.* § 3.

116 *Id.* § 7. For an explanation of decision making capacity as used in the bill, see *supra* note 99.

117 S. 3320, 203d Leg., 2d Sess. § 6(a) (Feb. 9, 1989). Health care representative is defined as

> [t]he individual designated by a declarant pursuant to the proxy directive part of an advance directive for the purpose of making health care decisions on the declarant's behalf, and includes an individual designated as an alternate health care representative who is acting as the declarant's health care representative in accordance with the terms and order of priority stated in an advance directive.

Id. § 3.

118 *Id.*

119 *Id.* § 6(a)(2).

120 *Id.*

121 *Id.* § 6(a)(4)-(5).

122 *Id.* § 6(a)(3). If the primary designee is unable or unwilling to serve, the next designated representative is used. *Id.* If the primary designee later becomes able to serve, he may do so if practicable. *Id.*

A properly executed proxy directive would give the appointed health care representatives the legal authority to make health care decisions for the declarant.[123] This authority would be subject to the limits stated in the directive, and would not vest until the declarant is determined to lack decision-making capacity.[124] This determination would be made in accordance with the bill. Health care representatives are held to a general duty of good faith and their authority is limited to the duties granted in the directive.[125]

Representatives are generally charged with making the decision the declarant would be likely to make if competent.[126] In the alternative, the representative should make a decision in the best interest of the declarant.[127] A health care representative would retain power despite the appointment of a legal guardian for the declarant, provided that the guardian is not vested with similar authority by a court order.[128]

The bill allows for changes in the authority of the health care representative if the declarant's condition improves.[129] The decisions of a formerly incompetent declarant would control upon the return of their decision-making capacity.[130] If the declarant does not object, the representative would continue to participate in an advisory role.[131] The declarant could still alter the representative's authority by clearly expressing wishes, contrary to the representative's judgment, in an instruction directive.[132] Controlling weight would be given to the declarant's latter instructions, regardless of the declarant's mental capacity at the time.[133]

As previously stated, a properly executed advance directive would not take effect until transmitted to the attending physician

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123 *Id.* § 9(a).

124 *Id.* § 7(a)(2).

125 *Id.* § 9(a).

126 *Id.* § 11(c).

127 *Id.* § 11(e). If an instruction directive is clear and unambiguous, it would be granted priority in the decision-making process. *Id.* § 11(b). The bill also allows other evidence to be considered when appropriate and necessary. *See id.* § 11(c)-(e).

128 *Id.* § 9(b).

129 *Id.* § 11(b).

130 *Id.*

131 *Id.*

132 *Id.*

133 *Id.*

and there is a determination of incompetence.[134] This diagnosis must be made by the attending physician and confirmed by another qualified doctor.[135] Both opinions must be made in writing and attached to the declarant's medical records.[136] If the decision is based on a mental or psychological impairment and either the attending or confirming physician lacks specialized training in that area, the diagnosis must be confirmed by a doctor with appropriate expertise.[137]

Health care decisions made under advance directives would be reached through a series of steps. Health care representatives and physicians would be required to discuss all aspects of the declarant's condition, as well a the alternatives, benefits, and burdens of any potential treatments.[138] The declarant must be informed of his condition and consulted throughout the process.[139] The physician and health care representative must seek to involve the declarant in decision-making, even when his mental capacity is impaired.[140]

Instruction directives, if any, would take priority over other evidence of the declarant's wishes.[141] Evidence of oral or verbal statements made by the declarant expressing treatment preferences may also be considered.[142] Health care representatives are to exercise their judgment and act in the best interest of the declarant if adequate evidence cannot be compiled.[143] If the directive does not appoint a health care representative, an instruction directive would control if clear and unambiguous, even if it is not specific to the declarant's situation.[144] In such cases, the declarant's attending physician, in addition to a legal guardian, if any,

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134 *Id.* § 7(a).

135 *Id.* § 8(a)-(b).

136 *Id.* The attending physician's diagnosis is permitted to govern without confirmation, if the patient's incompetence is clearly apparent. *Id.* § 8(b). In such cases, health care representatives must concur in the decision. *Id.*

137 *Id.* § 8(c).

138 *Id.* § 11(a).

139 *Id.* § 11(b).

140 *Id.* This section requires the attending physician and health care representative to involve the incompetent patient to a reasonable extent. *Id.*

141 *Id.* § 11(c). The degree to which an instruction directive will control depends on its clarity and specificity to the patient's condition. *See id.*

142 *Id.*

143 *Id.* § 11(e).

144 *Id.* § 12(a).

family members, or others, are to weigh the directive's intent, spirit, and instructions.[145] These parties, exercising reasonable judgment, would then carry out the terms of the directive.[146] Any deviation from the directive must be based on clearly articulable factors which were not foreseen when the directive was executed.[147] The bill, however, does not specify where final authority would rest in such situations and there are no penalties enumerated for deviating from the terms of a directive.[148]

If an instruction directive states or is interpreted to mean that life-sustaining treatment is not to be provided to the declarant, such treatment would be withdrawn or withheld if: 1) the treatment is experimental or likely to be futile;[149] or 2) the declarant is permanently unconscious, according to both the attending physician and another qualified doctor;[150] or 3) the declarant's condition is terminal according to both the attending physician and another qualified doctor;[151] or 4) the declarant has a serious irreversible illness, and the likely risks and burdens of the treatment can be reasonably considered to outweigh the benefits, and imposing the treatment upon the unwilling declarant would be inhumane.[152] If treatment is refused or withdrawn under the fourth criteria, the attending physician would be required to consult with an appropriate institutional or regional re-

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145 *Id.* § 12(b).

146 *Id.*

147 *Id.*

148 This is an area which may be ripe for amendment. Given the obvious importance of the right to self-determination, some legal redress for its frustration should be provided.

149 S. 3320, 203d Leg., 2d Sess. § 15(a)(1) (Feb. 9, 1989).

150 *Id.* § 15(a)(2).

151 *Id.* § 15(a)(3).

152 *Id.* § 15(a)(4). One of the controversial aspects of this bill is its lack of pregnancy exception. S. 2067, a less comprehensive advance directive bill which would restrict withdrawal of treatment from pregnant women, failed to make it out of the Senate Judiciary Committee earlier this year. S. 2067, 203d Leg., 1st Sess. (1988). Sponsored by Senator Raymond Zane, (D-3rd District), S. 2067 would not allow life-sustaining treatment to be withdrawn from a woman in the third trimester of pregnancy if it is reasonably certain, according to an appropriate medical specialist, that the fetus could develop to live birth with the treatment. *Id.* § 8(b). The directive would be honored only after the live birth of the fetus or a finding that it was dead or unlikely to develop to live birth. *Id.* For a summary of S. 2067, see also Summary, *The Right to Die—The New Jersey Health Care Directive Act*, 12 SETON HALL LEGIS. J 304 (1989).

viewing body.[153]

The bill sets out standards for withholding or withdrawal of artificially provided fluids and nutrition.[154] Although structurally similar to the requirements for other types of treatments,[155] these are considerably more stringent. Fluids and nutrition would be allowed to be withheld or withdrawn only if: 1) the declarant's instruction directive explicitly states that they are not to be provided;[156] and 2) their provision would be ineffective or futile in prolonging life or is likely to merely prolong an imminent dying process;[157] or 3) the declarant is permanently unconscious, according to both the attending physician and another qualified doctor;[158] or 4) the declarant's condition is terminal according to the attending physician and another qualified doctor, and the likely risks and burdens of the least burdensome treatment which is likely to be effective outweigh its likely benefits, and imposing the treatment on the unwilling declarant would be inhumane.[159] If fluids and nutrition are to be withheld or withdrawn under the final criteria, the attending physician would be required to consult with an appropriate institutional or regional reviewing body.[160]

Attending physicians are required to make an affirmative inquiry into the existence of any advance directives and attach

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153 S. 3320, 203d Leg., 2d Sess. § 15(a)(4) (Feb. 9, 1989). The ethics committee concept has been a part of treatment removal law since *Quinlan*. *In re* Quinlan, 70 N.J. 10, 54, 355 A.2d 647, 671, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976). Under the *Quinlan* approach, the role of an ethics committee was to render an opinion on the patient's chances for recovery. *Id.* S. 3320 grants them a quite different role. *See infra* note 179.

154 S. 3320, 203d Leg., 2d Sess. § 16 (Feb. 9, 1989).

155 This is a controversial topic since some consider food and water a basic human need instead of a medical treatment. The New Jersey Supreme Court has expressly rejected this argument, determining that withdrawal of artificial nutrition and hydration would not represent a cause of death independent of the patient's medical condition. *In re* Peter, 108 N.J. 365, 382, 529 A.2d 419, 428 (1987). Accordingly, the court does not make an objective distinction between the two. *Id.* The court noted, however, that a patient's subjective wish not to have such treatment removed should be respected. *Id.* n.11. Several attempts to codify the objective distinction have been unsuccessful. *See* S. 2445, 202d Leg., 2d Sess. (1987); *see also* S. 1541, 203d Leg., 1st Sess. (1988); A. 3084, 203d Leg., 1st Sess. (1988).

156 S. 3320, 203d Leg., 2d Sess § 16(b) (Feb. 9, 1989).

157 *Id.* § 16(a)(1).

158 *Id.* § 16(a)(2).

159 *Id.* § 16(a)(3).

160 *Id.*

them to the declarant's medical records,[161] as well as any modifications, reaffirmations, or revocations.[162] Physicians, nurses, and other health care professionals could refrain from participating in the withholding or withdrawal of life-sustaining treatment, including artificially provided fluids and nutrition, based on sincerely held personal or professional beliefs.[163] The bill mandates timely transfer of care in these cases, if necessary.[164] Health care professionals, however, are never relieved of their duty to alleviate pain.[165] In addition, patients would retain their right to refuse treatment on religious grounds in all cases.[166]

Health care institutions[167] would be required to adopt policies and practices related to dispute resolution, transfer of care, routine inquiry into the existence of advance directives, and the education of declarants, health care representatives, employees, and families regarding the provisions of the bill.[168] Private, religiously affiliated institutions could refrain from discontinuing life-sustaining treatment under advance directives, pursuant to a written policy communicated to patients, families, and health care representatives.[169] The institution would be required to seek a resolution if a conflict arose between such a policy and an advance directive,[170] and would have to take all reasonable steps necessary to promptly transfer the declarant to another appropriate facility if an accord could not be reached.[171] This internal dispute resolution process could be invoked by either declarant, health care representative, attending physician, or any other

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161 *Id.* § 10(a).
162 *Id.*
163 *Id.* § 10(b)-(c).
164 *Id.* § 13(a)(4).
165 *Id.* § 15(b).
166 *Id.* § 15(c).
167 Health care institutions are defined as:
all institutions, facilities and agencies licensed, certified or otherwise authorized by State law to administer health care in the ordinary course of business, including hospitals, nursing homes, residential health care facilities, home health care agencies, hospice programs operating in the State, mental health institutions, facilities or agencies, or institutions, facilities and agencies for the developmentally disabled.
Id. § 3.
168 *Id.* § 13(a).
169 *Id.* § 13(b).
170 *Id.*
171 *Id.*

health care professional treating the declarant.[172] Recourse to a court of appropriate jurisdiction is allowed if the internal dispute mechanism cannot provide an acceptable solution.[173]

S. 3320 would grant broad immunity to those acting within its provisions.[174] Health care representatives acting in good faith compliance with the bill or on the advice of an appropriate reviewing body, would receive criminal and civil immunity for removing treatment.[175] Physicians, nurses, and other health care professionals would also receive immunity from disciplinary action for unprofessional conduct,[176] provided they acted in accordance with accepted professional standards.[177]

As previously indicated, the decision to withhold or withdraw life-sustaining treatment is subject to review by an institutional or regional body under certain circumstances.[178] The role of the Committee would be to render an opinion to the declarant, attending physician, and health care representative as to whether the decision is in conformity with the law.[179] The reviewing body would also be required to advise the parties of any alternatives to the proposed decision.[180] The Committee's advice would then be documented in the declarant's medical records.[181] Although the opinion of the reviewing body is not legally binding, physicians deciding to deviate from its recommendations would lose their immunity.[182] Physicians disagreeing

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172 *Id.* § 14(a)-(b).

173 *Id.* § 14(c).

174 *Id.* § 22.

175 *Id.* § 22(a).

176 *Id.* § 22(b).

177 *Id.*

178 *Id.* § 16. *See also supra* note 160 and accompanying text. Institutional or regional reviewing bodies are required to consult in decisions to withdraw treatment or nutrition/hydration. *Id.* §§ 15(a)(4), 16(a)(3). These sections establish the benefits/burdens tests described in the previous subsection. *See id.*

179 This is a much different role than the court sanctioned in *Quinlan*. *See supra* note 153. The Minority Report criticized this approach, stating that it placed unwarranted, almost blind faith in reviewing bodies. MINORITY REPORT *supra* note 94, at 5.

180 S. 3320, 203d Leg., 2d Sess. § 18(a) (Feb. 9, 1989).

181 *Id.*

182 *Id.* § 18(b)(1); *see also id.* § 22(b)(2). The Minority Report pointed out that the potential loss of immunity may cause health care professionals to act in accordance with a reviewing body's advice, even if it conflicts with their own clinical judgment. MINORITY REPORT, *supra* note 94, at 6. The Report labeled this approach historically aberrant. *Id.* at 6.

with a reviewing body would have recourse to an appropriate court or agency.[183] If a declarant were transferred to another institution, the receiving institution would have to be informed of any recommendations made by an appropriate body.[184] Reviewing bodies would have to conform to standards established by law.[185]

A declarant would be permitted to revoke an advance directive in a number of ways, including oral or written notice to a health care representative, physician, or other reliable witness as well as by destruction or attempted destruction of the document.[186] Revocation would be effective regardless of the mental capacity of the declarant at the time of the revocation.[187] Execution of a new directive would also serve as a revocation of prior directives.[188]

S. 3320 provides for the implementation of its provisions by appropriate state agencies. The State Department of Health would be required to establish rules and regulations necessary to monitor and assure compliance with the bill.[189] Such rules may require health care institutions to adopt policies and practices dealing with routine inquiry, informational services, and the education of patients, families, and health care representatives about the law.[190] The Department would also be partly responsible for monitoring the implementation of the bill.[191] The Department and the Bioethics Commission would be required to jointly evaluate the bill's implementation and report their findings to the legislature not more than five years after enactment.[192] The Ombudsman for the Institutionalized Elderly and the Public Guardian for the Institutionalized Elderly[193] would both be re-

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183 S. 3320, 203d Leg., 2d Sess. § 18(b)(3) (Feb. 9, 1989). Health care professionals would be allowed to "[s]eek review by a public agency recognized by law for this purpose. . . ." *Id.* § 18(b)(2).

184 *Id.* § 18(c).

185 *Id.* § 18(d). Since the source of this law is not stated, it will presumably be the subject of additional legislation.

186 *Id.* § 5(b)(1)-(2).

187 *Id.* § 5(b).

188 *Id.* § 5(b)(3).

189 *Id.* § 20.

190 *Id.* § 20(a)-(e).

191 *Id.* § 21.

192 *Id.*

193 *See supra* note 14.

quired to adopt policies necessary for their compliance with the law.[194] Written statements of these policies would be required to be made available to the public.[195]

The bill prevents the existence of an advance directive to effect an individual's insurance coverage or their ability to obtain insurance.[196] It also provides that withdrawal or withholding of any life-sustaining treatment would not constitute homicide, suicide, assisted suicide, or active euthanasia.[197] In addition, the provisions dealing with the appointment of health care representatives are to take priority over inconsistent provisions in the law regarding powers of attorney.[198] Durable powers of attorney, which survive the incapacity of the declarant, would remain valid if executed prior to the effective date of the bill.[199]

Penalties for violation of the bill's provisions would be that health care professionals willfully violating the act would be guilty of professional misconduct[200] and health care institutions in willful non-compliance would be fined up to $1,000 for each violation, pursuant to the Penalty Enforcement Law.[201] The bill also makes falsification of, or fraudulent behavior regarding advance directives, among other things,[202] crimes of the fourth degree.[203]

III. The Determination of When Death Occurs

A. *Current Law*

The concept of brain death has been a consideration in treatment removal cases as far back as *Quinlan* in 1976.[204] Although

194 S. 3320, 203d Leg., 2d Sess. §§ 27, 28 (Feb. 9, 1989).

195 *Id.*

196 *Id.* § 24.

197 *Id.* § 26(a). Withdrawal or withholding treatment must be done in good faith compliance with the bill. *Id.*

198 *Id.* § 26(b).

199 *Id.*

200 *Id.* § 29(a).

201 *Id.* § 29(b). The Penalty Enforcement Law is codified at N.J. STAT. ANN. §§ 2A:58-1 to -9 (West 1982).

202 S. 3320, 203d Leg., 2d Sess. § 29(c) (Feb. 9, 1989).

203 *Id.* Crimes of the fourth degree are punishable by a fine of up to $7,500 and up to 18 months in prison. N.J. STAT. ANN. §§ 2C:43-3(b), -6(4) (West 1982).

204 *In re* Quinlan, 70 N.J. 10, 26-29, 355 A.2d 647, 655-57, *cert. denied sub. nom.* Garger v. New Jersey, 429 U.S. 922 (1976).

its direct adoption was not necessary in that context, it has significant importance in other areas of bioethics law.[205] The New Jersey Supreme Court, recognizing the effect modern technology has had on traditional notions of death,[206] accepted the modern definition in *Strachan v. John F. Kennedy Memorial Hospital*.[207] As a result, New Jersey currently recognizes two grounds for a declaration of death: the irreversible cessation of cardiopulmonary functions and the irreversible cessation of all brain functions.[208]

The legislature is presently considering a bill which would codify these terms.[209] The bill also seeks to accommodate various religious and moral beliefs regarding the nature of death.[210]

B. *Legislative Proposal: S. 2659—The New Jersey Declaration of Death Act*

Bill, S. 2659, also sponsored by Senator Ambrosio, would establish legal criteria for declaring death in New Jersey.[211] As stated above, it would codify the definitions of death currently applied by the courts.[212] As with S. 3320, the implementation of this bill would not be permitted to alter an individual's status for insurance purposes.[213]

Individuals suffering an irreversible cessation of circulatory and respiratory functions would be declared dead under this bill.[214] Declarations of death under this criteria are required to be made in accordance with currently accepted medical

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205 One of the more notable areas is organ removal. This situation is addressed in S. 2659. *See infra* notes 227-28 and accompanying text.

206 *Quinlan*, 70 N.J. at 27, 35 A.2d at 656; *In re* Farrell, 108 N.J. 335, 340-41, 529 A.2d 404, 406 (1987).

207 109 N.J. 523, 538 A.2d 346 (1988). *Strachan* involved a tort action brought by the parents of a suicide victim for inappropriate handling of their son's body. *Id.* at 526-27, 538 A.2d at 347-48.

208 *Id.* at 533-34, 538 A.2d at 350-51. The definition adopted by the court is identical to that contained in § 1 of the Uniform Determination of Death Act. *Id.* The court also pointed out that New Jersey currently recognizes brain death in the criminal context. *Id.* at 533, 538 A.2d at 351 (citing State v. Watson, 191 N.J. Super. 464, 467 A.2d 590, *cert. denied*, 95 N.J. 230, 470 A.2d 443 (1983) (holding that murder conviction was proper when defendant caused brain death of victim)).

209 S. 2659, 203d Leg., 1st Sess. (June 16, 1988).

210 *See id.*

211 *Id.* §§ 1-4.

212 *Id.* §§ 5-6.

213 *Id.* § 8; *see also* S. 3320, 203d Leg., 2d Sess. § 24 (Feb. 9, 1989).

214 S. 2659, 203d Leg., 1st Sess. § 2 (June 16, 1988).

standards.[215]

Cessation of brain death is also recognized as a definition of death.[216] In order to be declared dead under the modern neurological criteria, an individual must have suffered an irreversible cessation of all brain functions, including those of the brain stem,[217] and require artificial means to sustain their circulatory and respiratory functions.[218]

The Department of Health and the Board of Medical Examiners would be authorized to adopt regulations setting forth the medical standards to govern declarations of death in New Jersey.[219] Declarations of death under this standard could be made only by doctors "professionally qualified by specialty or expertise. . . ."[220] Adherence to generally accepted medical standards would also be required.[221]

S. 2659 would allow an individual to choose to be declared dead solely under the traditional cardio-respiratory criteria based on religious or moral beliefs,[222] by requiring physicians to conduct a good faith inquiry into the individual's wishes.[223] This requirement would include review of any medical records, including advance directives, and consultation with family and others close to the person before declaring brain death.[224] Physicians would be precluded from using this criteria only if the individual's wishes have been enunciated to the doctor, or the doctor is in a position to reasonably know them.[225] Doctors would also be required to refrain from declaring an individual brain dead whenever a claim for exemption is reasonably advanced on their

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215 *Id.*
216 *Id.* § 3.
217 *Id.*
218 *Id.*
219 *Id.* § 4(b).
220 *Id.* § 4(a).
221 *Id.* This bill was originally formulated by the Bioethics Commission. *Supra* note 14. Senator Cardinale introduced a declaration of death bill, S. 2631, which is nearly identical to S. 2659. *See* S.2631, 203d Leg., 1st Sess. (June 13, 1988). One major difference between the two proposals is that S. 2631 would require declarations of death under the modern neurological criteria to be made in accordance with universally accepted medical standards. *Id.* § 2(b)(1).
222 S. 2659, 203d Leg., 1st Sess. § 5 (June 16, 1988).
223 *Id.* § 6(a).
224 *Id.*
225 *Id.* § 5.

behalf.[226]

The bill would restrict organ removal from potential donors who are declared dead under the modern neurological criteria.[227] Physicians making a declaration of brain death would not be permitted to remove organs from the patient or serve as the organ recipient's attending physician because of a "potentially significant conflict of interest. . . ."[228]

Physicians and other health care providers acting in good faith compliance with the bill would be granted immunity from civil and criminal liability, as well as professional discipline, for their judgments in declaring death.[229]

The Department of Health would be charged with gathering annual reports and other data from health care facilities concerning the operation of the bill.[230] The Department would also be required, in conjunction with the Board of Medical Examiners and the Bioethics Commissions, to evaluate the implementation of the bill.[231] These agencies would report their findings to the legislature at least once every five years.[232]

IV. Conclusion

These bills represent an opportunity for New Jersey to enhance its reputation in the area of health care law. The passage of advance directive legislation would make the protection of the rights of all competent adults easier to administer.[233] Integration of the brain death concept into our statutory law would not only

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226 *Id.* § 6(b)(1). Doctors would also be precluded from discontinuing artificial maintenance of circulatory and respiratory functions in this situation. *Id.* § 6(b)(2). This prohibition is limited to cases in which such treatment would be withdrawn solely on the basis of neurological condition. *Id.* Presumably, an advance directive or other evidence could override this provision.

227 *Id.* § 4(c).

228 *Id.* § 4(c).

229 *Id.* § 7.

230 *Id.* § 9(a).

231 *Id.* § 9(b).

232 *Id.*

233 Those opposing the bill on right to life grounds should remember that advance directives may express any treatment preference except active euthanasia. Individuals wishing to be kept alive by any possible means could have their rights honored pursuant to an advance directive as surely as someone who wants treatment removed.

facilitate organ removal and transplantation,[234] but would also serve to prevent the infliction of emotional distress on caring families.[235]

Despite the progress that would be made by passing these bills, the legislature would undoubtedly be required to continue refining the state's approach to bioethics issues. For instance, some mechanism for verifying the authenticity of advance directives should be considered. The current version of S. 3320 does not contain such a provision, and it is possible that fraud in the inducement or execution of advance directives may go undetected. The Assembly should consider amending the bill to include a procedure analogous to probate to correct this problem.[236] Great care should be exercised in formulating such an amendment, since one of the primary purposes of S. 3320 is to reduce the possibility of litigation in treatment removal cases. In addition, it should be specified that treatment withdrawal performed in violation of the bill may expose the actors to prosecution for homicide, assisted suicide, or active euthanasia.

Such a provision need not unduly discourage or restrain physicians and health care representatives from effectuating advance directives, since a threshold determination of bad faith could be established as a requirement for prosecution. The continued involvement of the Bioethics Commission, the public state agencies and interested professional and religious groups will ensure that the legislature is exposed to divergent views on these topics.

Although there is no perfect legislative solution to the difficult problems these bills address, they will at least contribute to

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234 Organ removal and transplantation would be facilitated, but subject, of course, to the conflict of interest provisions.

235 *Strachan* provides a good example of this, in which a patient meeting the modern neurological criteria was disconnected from the respirator sustaining cardiorespiratory functions. *See* Strachan v. John F. Kennedy Mem. Hosp., 109 N.J. 523, 538 A.2d 346 (1988).

236 A provision authorizing self-proved advance directives was deleted from S. 3320 by amendment. S. 3320, 203d Leg., 2d Sess. § 4 (May 8, 1989). The deleted provision would employ the procedure in N.J. STAT. ANN. § 3B:3-4 (West 1982), which governs self-proved testamentary wills. *Id.* The Judiciary Committee Statement is silent on the reasons for the change. *See id.*

the public debate on bioethics issues as they await consideration from the Assembly and Governor.

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