SPECIAL LEGISLATIVE SURVEYS

Innovative Legislative Initiatives: The New Jersey Declaration of Death and Advance Directives for Health Care Acts

*Paul W. Armstrong & Robert S. Olick**

Advances in medical science and technology in recent years have raised complex issues at the intersection of law, medicine and ethics, presenting fundamental societal questions potentially and profoundly affecting New Jersey's citizens and its health care community. New Jersey's national leadership role in addressing bioethical issues has been established by a series of decisions of the New Jersey Supreme Court, beginning with *In re Quinlan,*[1] which first addressed the collaborative rights and responsibilities of patients, families and physicians concerning decisions about life-sustaining treatment. While the judiciary has thrust New Jersey into the national spotlight, contemporary issues in bioethics also demonstrate the interrelated roles and responsibilities of the legislature, the executive branch, state agencies and the courts in formulating public policy responses to the many dilemmas which regularly confront patients, families and health care institutions and which present new challenges for our health care system. Recognizing these interrelated responsibilities, and sensitive to the increasing public prominence and social significance of questions of death and dying, as well as the judiciary's call for comprehensive examination of these complex and multidisciplinary issues in the legislative forum, the legislature created the New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care (informally known as the New Jersey Bioethics Commission). The Commission is charged with continuing New Jersey's leadership responsibility.

The statutes examined here, the New Jersey Declaration of

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[1] 335 A.2d 647, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976).

Death and Advance Directives for Health Care Acts, were signed into law by Governor James J. Florio on 8 April and 11 July of 1991, respectively.[2] Both laws were originally drafted and proposed by the Bioethics Commission in 1988.[3] Against New Jersey's rich background of juridical activity, and the work of the Bioethics Commission, the passage of these laws reflect a high level of cooperation between the legislative and executive branches of our state's government.

I. Developing Policy in a Public Forum

The New Jersey Bioethics Commission was established in November of 1985 as a permanent legislative commission.[4] The Commission is mandated to "provide a comprehensive and scholarly examination of the impact of advancing technology on health care decisions [in order to] enable government, professionals in the fields of medicine, allied health care, law, and science, and the citizens of New Jersey and other states to better understand the issues presented, their responsibilities, and the options available to them," and is directed to make recommendations for health policy to the legislature, the Governor, and the citizens of New Jersey.

The Commission's membership comprises a diverse and multidisciplinary body of 27 appointed members, who bring to the public policy process a broad spectrum of expertise, opinions and perspectives, including medicine, nursing, health care administration, law, ethics, theology, natural science, social science, the humanities, and public affairs. The Commission's membership includes representatives of the executive and legislative

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[2] WALL ST. J., Apr. 10, 1991, at B8; *Vindicated: Quinlan, Jobes Families Hail Living Will Law*, NEWARK STAR LEDGER, July 12, 1991, at A1.

[3] The Commission's proposed New Jersey Declaration of Death Act was approved in final form on June 8, 1988, and formally transmitted to the Governor and legislature on June 15, 1988. The proposed Advance Directives for Health Care Act was given final approval by the Commission on December 29, 1988, and was first introduced in the New Jersey Senate on February 9, 1989 (S-3320). The Commission's deliberations and recommendations on these and related issues in death and dying are discussed at length in the Commission's first comprehensive report, *Problems and Approaches in Health Care Decisionmaking: The New Jersey Experience* (Princeton, May 1990).

[4] Commission on Legal and Ethical Problems in Delivery of Health Care, ch. 363 (1985) (codified at N.J. STAT. ANN. § 52:94-1 (West 1985)).

branches of state government, of major statewide professional and health care associations, and of New Jersey's professional and public communities. Thus, the composition of the Commission has assured that a wide range of serious and competing points of view are ably and openly articulated, with vigorous representation of the many streams of opinion that characterize New Jersey's pluralistic traditions.

The Commission decided early in its history to focus its initial efforts on two areas—the declaration of death and advance directives for health care. In these two areas progress and legislative action was considered both important in its own right and provides a needed foundation for confronting still more difficult questions of law, ethics and public policy posed by decisionmaking for incompetent patients who have not clearly expressed their treatment preferences. The Commission determined from the outset to recognize its role in the political process and its responsibility to be responsive to the pluralistic society it serves by conducting its deliberations and exploring the issues in full view of the public, holding all meetings open to the public with opportunity for public comment. Over the course of approximately two years the Commission held more than twenty open meetings as well as six public hearings, and received extensive testimony on a wide range of issues, reflecting a broad spectrum of professional, institutional, religious and moral perspectives. Thus, the Commission's work and recommendations—in particular the New Jersey Declaration of Death and Advance Directives for Health Care Acts—are the product of extensive and open public deliberations seeking to craft balanced approaches to complex and difficult problems in a manner respectful of the diverse moral and religious views of a wide range of New Jersey's citizenry.

The primary sponsor and legislative architect of the New Jersey Declaration of Death Act (S-1208) and of the New Jersey Advance Directives for Health Care Act (S-1211) was former Senator Gabriel M. Ambrosio, a long-standing member of the Bioethics Commission.[5] The Declaration of Death Act was sponsored in the General Assembly (A-1413) by Assemblywoman Marlene Lynch Ford, and by Assemblymen C. Richard Kamin (a

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[5] In the New Jersey Senate, the Advance Directives for Health Care Act was also sponsored by Senators Paul Contillo and Matthew Feldman.

Bioethics Commission member), David C. Schwartz, Wayne R. Bryant, David C. Kronick, and Bernard F. Kenny, Jr. In the General Assembly the Advance Directives Act was sponsored by Assemblyman Gerard S. Naples and Assemblywoman Maureen Ogden.[6]

Like the Commission, both houses of the legislature conducted extensive and open committee hearings and deliberations on the two bills. In the 1990 legislative session, both the declaration of death and advance directive bills were first passed by the New Jersey Senate on March 29, 1990.[7] The declaration of death bill was passed, as amended, by the General Assembly on February 28, 1991; the New Jersey Senate concurred in the amended version of the bill on March 7, 1991. The General Assembly approved the advance directives bill, as amended, on June 10, 1991; the Senate concurred in the amended version of the bill on June 20, 1991. As evidenced by the final votes in both houses,[8] the two bills achieved overwhelming bipartisan support, as well as the widespread support of our most prestigious organizations and institutions across the state.[9]

II. The Declaration of Death Act

Whole brain death, *i.e.*, the total and irreversible loss of all

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[6] New Jersey Assembly co-sponsors of the Advance Directives Act included an impressive list of Assembly members from both political parties: Dolores Cooper, Marlene Lynch Ford, Rodney Frelinghuysen, Louis Gill, Daniel Jacobsen, Barbara Kalik, D. Bennett Mazur, James McGreevey, Elizabeth Randall, Patrick Roma, William P. Schuber, Robert Shinn, Joann Smith, Gary Stuhltrager, and John Villipiano.

[7] The two bills had previously passed the New Jersey Senate in the 1989 legislative session, on August 14, 1989, but were not posted for a vote before the General Assembly.

[8] The Declaration of Death Act was approved by a vote of 31 yea, 4 nay, and 5 abstaining in the Senate, and 54 yea, 15 nay, and 11 abstaining in the General Assembly. The Senate approved the Advance Directives for Health Care Act by a vote of 28 yea, 7 nay, and 5 abstentions, while the General Assembly approved the bill by an impressive margin of 65 yea, 7 nay, and 8 abstaining.

[9] For example, the Advance Directives Act was officially endorsed and actively supported by 41 organizations and institutions throughout New Jersey, including the American Association of Retired Persons, the American Jewish Congress, the American College of Physicians (New Jersey Chapter), the Citizens' Committee on Biomedical Ethics, and the Episcopal Diocese of Newark; New Jersey's Medical Society, Nurses Association, Association of Non-Profit Homes for the Aging, Association of Health Care Facilities, Hospital Association, Home Health Agency Assembly and Organ and Tissue Sharing Network; and all of the state agencies involved in health care issues.

functions of the entire brain, including the brain stem, is recognized by statute or judicial decision as a legal standard for the declaration of death in all 50 states and the District of Columbia. In 1988 the New Jersey Supreme Court in *Strachan v. J.F.K. Memorial Hosp.*,[10] adopted section One of the Uniform Determination of Death Act, establishing whole brain death as a legal standard for the declaration of death in New Jersey.

The New Jersey Declaration of Death Act codifies existing New Jersey law by providing a statutory basis for declaring death on the grounds of total and irreversible loss of all functions of the entire brain, including the brain stem. In two important respects, the new law goes beyond existing New Jersey law and makes New Jersey's approach to the declaration of death unique among the laws of our sister states. First, the statute mandates the adoption by law of uniform criteria for the determination of whole brain death, by requiring the Department of Health and the Board of Medical Examiners to adopt rules and regulations setting forth currently accepted medical standards, including criteria, tests and procedures, to govern such determinations.[11] The law requires that these standards be periodically reviewed and updated to keep pace with developments in medical technology. Second, the act expresses an important commitment to respect for religious values by recognizing the legal right of an individual to claim an exemption from the application of neurological criteria for determining death if such a declaration would violate that individual's personal religious beliefs. New Jersey thus is the first state to recognize such an exemption in its statutory law.[12] (New York has taken a similar approach to respect for religious beliefs through the promulgation of regulations.)[13]

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[10] 538 A.2d 346 (N.J. 1988).

[11] Regulations proposed by the New Jersey Board of Medical Examiners follow closely the protocols recommended by the Medical Consultants on the Diagnosis of Death to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Guidelines for the Determination of Death*, J. OF THE AM. MED. ASS'N 246 (19) (1981): 2184-86. The proposed regulations will be promulgated in the New Jersey Register, pursuant to the Administrative Procedure Act.

[12] These unique features of New Jersey's Declaration of Death Act are discussed at greater length in an article by Robert S. Olick, *Brain Death, Religious Freedom, and Public Policy: New Jersey's Landmark Legislative Initiative*, KENNEDY INSTITUTE OF ETHICS JOURNAL 275-92 (1991).

[13] NEW YORK COMP. CODES R. AND REGS. tit. 10, § 400.16 (1987).

The key provisions of the New Jersey Declaration of Death Act are summarized below. The statute:

1) Recognizes the traditional criteria of irreversible cessation of cardio-respiratory functions as a legal standard for declaring death.

2) Recognizes the modern neurological criteria of irreversible cessation of all functions of the entire brain, including the brain stem, as a legal standard for declaring death, when cardio-respiratory functions are maintained solely by artificial means.

3) Mandates the Department of Health and the Board of Medical Examiners to adopt, and update, professional standards for physicians and currently accepted medical standards to govern declarations of death on the basis of neurological criteria.

    A) Assures that the physician authorized to declare death has no potential conflict of interest concerning organ transplantation.

    B) Sets the time of death at the conclusion of definitive clinical examinations and any necessary confirmation.

4) Accommodates personal religious beliefs as an exception to neurological criteria for declaring death.

    A) Places responsibility with the patient (*e.g.*, in an advance directive), family or friend to advise health care providers of the patient's religious objections to neurological criteria for determining death.

    B) Provides that in these cases time of death is to be determined solely in accordance with cardio-respiratory criteria.

5) Immunizes from civil and criminal liability health care providers acting in good faith who declare death and accommodate religious beliefs.

6) Assures insurance coverage for health care regardless of the standard used to declare death or the patient's religious beliefs.

7) Requires collection of data from health care institutions, and directs the Department of Health, Board of Medical Examiners, and Bioethics Commission to evaluate the act's effectiveness.

III. The Advance Directives for Health Care Act

With the enactment of the New Jersey Advance Directives for Health Care Act, 48 states and the District of Columbia have enacted legislation recognizing some form of advance directive. (The sole exceptions are Nebraska and Pennsylvania.) At least forty-three states recognize a proxy directive, which allows the declarant to appoint another person to make health care decisions on his or her behalf in the event of subsequent loss of decisionmaking capacity. Forty-five states have accorded statutory force to instruction directives ("living wills"), which enable the declarant to state his or her instructions and directions for health care in the event of future decisionmaking incapacity. As many as forty states recognize by statute both proxy and instruction directives.[14]

New Jersey's Advance Directives Act provides a comprehensive approach to "living wills" and "medical durable powers of attorney" which allows competent adults to specify in writing their treatment preferences and to entrust a family member or friend with legal authority to carry out their wishes and to make health care decisions on their behalf in the event of future decisionmaking incapacity. Statutory recognition of advance directives clarifies prior uncertainties regarding the legal status of such documents and the obligations of health care professionals to honor advance directives. The Commission is firmly of the view that the decisionmaking process prescribed by the law protects and enhances the ability of those responsible for the patient's care to make these difficult decisions within the shared privacy of the physician-patient-family relationship, and obviates the perceived need to seek court or other interventions, except in rare cases. Significantly, the law serves as an important vehicle for public and professional education, complementing the recently enacted federal Patient Self-Determination Act (U.S. Senate bill 1766, sponsored by Senators John Danforth (R-Mo.) and Daniel Patrick Moynihan (D-N.Y.)), and enacted on November 5,

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[14] *See* Choice in Dying, formerly the Society for the Right to Die (located at 250 West 57th St., New York, N.Y. 10107), *Refusal of Treatment Legislation: A State by State Compilation of Enacted and Model Statutes* (1991). *See also* the map of state laws prepared by the Society for the Right to Die, "State Law Governing Living Wills/Declarations and Appointment of a Health Care Agent" (1991).

1990.[15] The central mandates of the new federal law, which takes effect on December 1, 1991, are that all Medicare and Medicaid providers are required to 1) give to patients upon "admission" (or upon coming under the care of a covered provider) a written description, state-approved, of their rights under state law to make health care decisions and to formulate advance directives; 2) ask patients whether they have executed an advance directive and document this information in the medical record; 3) ensure compliance with state law regarding advance directives; 4) provide for staff and community education; and 5) maintain written policies and procedures with respect to advance directives and their obligations under federal and state law.

The advance directives legislation is complemented by an advance directives brochure developed by the Commission and its Task Force on Public and Professional Education and published in the Spring of 1991. The brochure, entitled *Advance Directives for Health Care: Planning Ahead for Important Health Care Decisions*, contains three detachable advance directive forms conforming to the new state law (a proxy directive, instruction directive, and combined advance directive), as well as accompanying educational materials designed to assist individuals to make informed choices and decisions in the writing of an advance directive. The Commission recommends the use of a combined advance directive as the preferred approach to appointing a health care representative and assuring respect for patient wishes by informing the health care representative in writing of the patient's own values and treatment choices. However, consistent with the intent and spirit of the advance directives law, it is intended that individuals be able to choose from among these three approaches the one best suited to their personal needs. (It is important to note that the law does not require use of the Commission's forms, and other types of forms in compliance with the technical execution requirements of the statute are to be recognized and respected.) Like the act, the forms and materials have been endorsed by a wide spectrum of health care organizations, professionals and citizens of New Jersey.[16]

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[15] Omnibus Budget Reconciliation Act of 1990, "Patient Self Determination Act," § 104 Stat. 1388-115, 115-17 (1990).

[16] The Commission's work on development of the advance directive forms, and in particular the underlying rationale and approach of the combined advance direc-

The following summarizes the basic principles and key operative provisions of the New Jersey Advance Directives Act:

1) The State of New Jersey recognizes in its law and public policy the fundamental constitutional right of competent adults, in collaboration with their health care providers, to control decisions about their own health care. This right should not be lost in the event a patient loses decisionmaking capacity and is no longer able to actively participate in making his or her own health care decisions.
2) The act recognizes the fundamental constitutional right of competent adults to plan ahead for health care decisions through the execution of advance directives.
    - The act provides that a competent adult has the right to designate another person (a "health care representative") to make health care decisions on his or her behalf in the event of future decisionmaking incapacity (a durable power of attorney for health care); to state in writing his or her instructions and directions for health care in the event of future decisionmaking incapacity (an instruction directive/"living will"); or both. The act is designed to encourage execution of a "combined" advance directive, *i.e.*, one which designates a health care representative and provides that person with written instructions and direction.
    - The act prescribes formalities for the execution of advance directives, as well as for the re-affirmation, modification, suspension, or revocation of advance directives.
    - Health care institutions are required to provide appropriate informational materials concerning advance directives to all interested patients, families and health care representatives, and to assist patients interested in discussing and executing an advance directive.
3) The act adopts the view that the ethical norm of informed consent as shared decisionmaking best promotes the twin values of respect for patient self-determination and promotion of patient well-being in health care decisionmaking. The shared decisionmaking model views competent patients

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tive, is discussed in depth in Robert S. Olick, *Approximating Informed Consent and Fostering Communication: The Anatomy of An Advance Directive*, THE J. OF CLINICAL ETHICS 186-87 1991. (Note: pagination may change for final publication of this issue).

and health care professionals, and where appropriate, family members and health care representatives, as collaborative moral agents with complementary and interactive roles in the decisionmaking process, working together to establish greater mutual understanding and an effective basis for active patient participation in the decisionmaking process.

- When the patient's decisionmaking capacity is lost or impaired, the goals and process of shared decisionmaking are best approximated through the designation of a health care representative, charged with the responsibility to stand in the place of the patient and to implement the patient's expressed wishes and best interests.

4) An advance directive becomes operative when (a) it is transmitted to the attending physician or the health care institution; and (b) it is determined that the patient lacks decisionmaking capacity.
   - Health care institutions are required to adopt policies providing for routine inquiry of patients and families designed to determine whether a patient has executed an advance directive.

5) The act adopts a decision-specific approach to the question of decisionmaking capacity. A determination that a patient lacks decisionmaking capacity should be based upon an evaluation of the patient's ability to understand and appreciate information regarding the nature and consequences of a particular health care decision, including the benefits and risks of the proposed health care and its alternatives, and to reach an informed decision.
   - Patients should not be assumed to lack capacity on grounds of age or disability, nor should it be assumed that lack of capacity to make one health care decision means the patient lacks capacity to make other health care decisions.
   - The act prescribes an informal (non-judicial) process for assessing a patient's decisionmaking capacity which places primary responsibility for such determinations with physicians.

6) Once operative, an advance directive designating a health care representative confers upon that person the legal authority to make health care decisions on the patient's behalf,

in accordance with the terms of the advance directive. This authority should be respected by physicians, health care professionals and health care institutions.

- The health care representative should exercise the patient's right to give informed consent to or refusal of health care.
- In the exercise of this authority, the health care representative's primary responsibility is to implement the patient's expressed wishes. The health care representative also has the authority to exercise informed discretion and judgment, and to make health care decisions in the patient's best interests.

7) The health care representative and attending physician (and where appropriate, family and other members of the health care team) are obligated to seek to enhance patient capacity and to actively involve the patient with impaired capacity in the decisionmaking process, to the extent it is reasonable to do so. The patient's expressed wishes should be taken into account in the decisionmaking process.
    - A patient's contemporaneously expressed wish that medically appropriate life-sustaining treatment be provided should be respected, even if contrary to the decision of the health care representative or the terms of the patient's instruction directive.
8) In the absence of a designated health care representative, an instruction directive, once operative, should be respected by those responsible for the patient's care, and should be followed in accordance with its specific terms.
9) Health care institutions are required to establish an institutional mechanism for dispute resolution, such as an ethics committee. In case of disagreement concerning the patient's decisionmaking capacity, the appropriate implementation of an advance directive, or other matters, recourse to this local process should preferably be sought in the first instance, prior to seeking court review.
10) The fundamental constitutional right to control decisions about one's own health care includes the right to forego life-sustaining treatment ("any medical device or procedure, artificially provided fluids and nutrition, drugs, surgery or therapy that uses mechanical or other artificial means to sus-

tain, restore or supplant a vital bodily function, and thereby increase the expected life span of a patient"). This right is not absolute, and is subject to certain interests of society, including the preservation of life, the prevention of suicide, the protection of innocent third parties, and safeguarding the integrity of the health care professions. Society also has an interest in ensuring the soundness of health care decisionmaking, including both protecting vulnerable patients from potential abuse or neglect and facilitating the exercise of informed and voluntary patient choice.

- The act takes a situation-specific approach to decisions to forego life-sustaining treatment, in accordance with the patient's advance directive, which identifies the circumstances in which such decisions would be authorized.
- The act rejects on both legal and moral grounds the practice of active euthanasia, as by deliberate lethal injection.

11) Honoring a patient's wishes, as expressed in an advance directive, that life-sustaining treatment be withheld or withdrawn is authorized in the following circumstances:
    - When the treatment is experimental, likely to be ineffective or futile in prolonging life, or likely merely to prolong an imminent dying process.
    - When the patient is permanently unconscious.
    - When the patient is in a terminal condition. (" 'Terminal condition' means the terminal stage of an irreversibly fatal illness, disease or condition. A determination of a specific life expectancy is not required as a precondition for a diagnosis of a "terminal condition," but a prognosis of a life expectancy of six months or less, with or without the provision of life-sustaining treatment, based upon reasonable medical certainty, shall be deemed to constitute a terminal condition.")
    - When the above circumstances are not present, but the patient has a serious and irreversible illness or condition, and the likely risks and burdens of the treatment may reasonably be judged to outweigh the likely benefits, or imposition of the treatment on an unwilling patient would be inhumane. In this latter circumstance a local or regional reviewing body (such as an ethics committee), or a

public agency (such as the Ombudsman), may, but need not, be consulted prior to implementing the decision.

12) Public policy should honor the personal and professional integrity of health care professionals while at the same time assuring that neither the rights of patients nor standards of professional care are compromised.
    - The act provides that physicians, nurses, and other health care professionals have the right to decline to participate in the withholding or withdrawal of life-sustaining treatment on the basis of sincerely held personal or professional convictions. In the exercise of this right, health care professionals are obligated to facilitate appropriate, respectful and timely transfers of care, and to assure that the patient is not abandoned.
13) The act also provides that private religiously-affiliated health care institutions have the right to adopt institutional policies and practices defining circumstances in which they will decline to participate in the withholding or withdrawal of life-sustaining treatment.
    - Such policies are to be stated in writing and communicated to patients, families and health care representatives in a timely fashion. When the patient's wishes cannot be accommodated, the health care institution is obligated to effect an appropriate, respectful and timely transfer of care to another health care institution appropriate to the patient's needs, and to assure that the patient is not abandoned.
14) Physicians, nurses and other health care professionals, and health care institutions, acting in good faith and in accordance with the requirements of the act, and any rules and regulations established pursuant to the act, to carry out the terms of an advance directive, would be immune from legal liability and from discipline for unprofessional conduct. Health care representatives acting in good faith and in accordance with the requirements of the act to carry out the terms of an advance directive would be immune from legal liability.

In summary, the Advance Directives Act assures respect for patients' previously expressed wishes when the capacity to participate actively in decisionmaking has been lost or impaired; facilitates and encourages a sound decisionmaking process in which patients, health care representatives, families, physicians, and other health care professionals are active participants; properly considers patients' interests both in self-determination and in well-being; respects the individual conscience of health care professionals; and provides necessary and appropriate safeguards concerning the termination of life-sustaining treatment for incompetent patients.

IV. Conclusion

The New Jersey Declaration of Death and Advance Directive for Health Care Acts attest to the value of the shared role of the Commission and lawmakers in devising legal responses to the difficult dilemmas borne of advances in medical science and technology. New Jersey's courts, the Bioethics Commission, community organizations, legislature and Governor have contributed to our rich body of law by defining the fundamental rights, duties and obligations of patients, families and caregivers, and by setting forth a comprehensive process and procedure recognizing and vindicating individual medical decisionmaking. It is fair to say that the New Jersey legislature in the Declaration of Death and Advance Directives for Health Care Acts and the United States Congress in the Patient Self-Determination Act have joined in affirming the landmark decisions of the New Jersey and United States Supreme Courts. It is apt as well to affirm that by striving to publicly examine, deliberate and craft legislation on the declaration of death and advance directives the New Jersey Bioethics Commission now shares in the larger reputation of New Jersey as a national leader in law, medicine and bioethics.

APPENDIX A

PROXY DIRECTIVE—(Durable Power of Attorney for Health Care)
Designation of Health Care Representative

I understand that as a competent adult, I have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction and they will turn to someone who knows my values and health care wishes. By writing this durable power of attorney for health care I appoint a health care representative with the legal authority to make health care decisions on my behalf and to consult with my physician and others. I direct that this document become part of my permanent medical records.

A) CHOOSING A HEALTH CARE REPRESENTATIVE:

I, ______________________________, hereby designate ______________________________,

of ____

____.

(home address and telephone number of health care representative)

as my health care representative to make any and all health care decisions for me, including decisions to accept or to refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition and decisions to provide, withhold or withdraw life-sustaining measures. I direct my representative to make decisions on my behalf in accordance with my wishes as stated in this document, or as otherwise known to him or her. In the event my wishes are not clear, my representative is authorized to make decisions in my best interests, based on what is known of my wishes.

This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care, and any necessary confirming determinations.

B) ALTERNATE REPRESENTATIVES: If the person I have designated above is unable, unwilling or unavailable to act as my health care representative, I hereby designate the following person(s) to act as my health care representative, in the order of priority stated:

1. *name* ______________________________	2. *name* ______________________________
address ______________________________	*address* ______________________________
city ____________________ *state* ________	*city* ____________________ *state* ________
telephone ______________________________	*telephone* ______________________________

C) SPECIFIC DIRECTIONS: Please initial the statement below which best expresses your wishes.

______ My health care representative is authorized to direct that artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion, be withheld or withdrawn.

______ My health care representative does not have this authority, and I direct that artificially provided fluids and nutrition be provided to preserve my life, to the extent medically appropriate.

APPENDIX A (Continued)

(If you have any additional specific instructions concerning your care you may use the space below or attach an additional statement.)

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____

D) COPIES: The original or a copy of this document has been given to my health care representative and to the following:

1. *name* ______________________

   address ______________________

   city ____________ *state* ________ *telephone* ____________

2. *name* ______________________

   address ______________________

   city ____________ *state* ________ *telephone* ____________

E) SIGNATURE: By writing this durable power of attorney for health care, I inform those who may become entrusted with my care of my health care wishes and intend to ease the burdens of decisionmaking which this responsibility may impose. I have discussed the terms of this designation with my health care representative and he or she has willingly agreed to accept the responsibility for acting on my behalf in accordance with my wishes as expressed in this document. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this ______ **day of** __________, **19** ___ .

signature ______________________

address ______________________

city ______________________ *state* ______

F) WITNESSES: I declare that the person who signed this document, or asked another to sign this document on his or her behalf, did so in my presence, that he or she is personally known to me, and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative, nor as an alternate health care representative.

1. *witness* ______________________

   address ______________________

   city ____________ *state* ______

   signature ______________________

   date ______________________

2. *witness* ______________________

   address ______________________

   city ____________ *state* ______

   signature ______________________

   date ______________________

APPENDIX B

INSTRUCTION DIRECTIVE

I understand that as a competent adult I have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction concerning my care and they will require information about my values and health care wishes. In order to provide the guidance and authority needed to make decisions on my behalf:

A) I, ______________________________, hereby declare and make known to my family, physician, and others, my instructions and wishes for my future health care. I direct that all health care decisions, including decisions to accept or refuse any treatment, service or procedure used to diagnose, treat or care for my physical or mental condition and decisions to provide, withhold or withdraw life-sustaining measures, be made in accordance with my wishes as expressed in this document. This instruction directive shall take effect in the event I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care, and any necessary confirming determinations. I direct that this document become part of my permanent medical records.

Part One: Statement of My Wishes Concerning My Future Health Care

In ***Part One,*** *you are asked to provide instructions concerning your future health care. This will require making important and perhaps difficult choices. Before completing your directive, you should discuss these matters with your doctor, family members or others who may become responsible for your care.*

In ***Sections B and C,*** *you may state the circumstances in which various forms of medical treatment, including life-sustaining measures, should be provided, withheld or discontinued. If the options and choices below do not fully express your wishes, you should use* ***Section D,*** *and/or attach a statement to this document which would provide those responsible for your care with additional information you think would help them in making decisions about your medical treatment.* **Please familiarize yourself with all sections of Part One before completing your directive.**

B) **GENERAL INSTRUCTIONS.** To inform those responsible for my care of my specific wishes, I make the following statement of personal views regarding my health care:

Initial ONE of the following two statements with which you agree:

1. _____ I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition.

2. _____ There are circumstances in which I would not want my life to be prolonged by further medical treatment. In these circumstances, life-sustaining measures should not be initiated and if they have been, they should be discontinued. I recognize that this is likely to hasten my death. In the following, I specify the circumstances in which I would choose to forego life-sustaining measures.

APPENDIX B (Continued)

If you have initialed statement 2 on page 1, please initial each of the statements (a, b, c) with which you agree:

a. ______ I realize that there may come a time when I am diagnosed as having an incurable and irreversible illness, disease, or condition. If this occurs, and my attending physician and at least one additional physician who has personally examined me determine that my condition is **terminal,** I direct that life-sustaining measures which would serve only to artificially prolong my dying be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

In the space provided, write in the bracketed phrase with which you agree:

To me, terminal condition means that my physicians have determined that:

____

[I will die within a few days] **[I will die within a few weeks]**
[I have a life expectancy of approximately **or less** *(enter 6 months, or 1 year)***]**

b. ______ If there should come a time when I become **permanently unconscious,** and it is determined by my attending physician and at least one additional physician with appropriate expertise who has personally examined me, that I have totally and irreversibly lost consciousness and my capacity for interaction with other people and my surroundings, I direct that life-sustaining measures be withheld or discontinued. I understand that I will not experience pain or discomfort in this condition, and I direct that I be given all medically appropriate care necessary to provide for my personal hygiene and dignity.

c. ______ I realize that there may come a time when I am diagnosed as having an **incurable and irreversible** illness, disease, or condition which may not be terminal. My condition may cause me to experience severe and progressive physical or mental deterioration and/or a permanent loss of capacities and faculties I value highly. If, in the course of my medical care, the burdens of continued life with treatment become greater than the benefits I experience, I direct that life-sustaining measures be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

(Paragraph **c.** *covers a wide range of possible situations in which you may have experienced partial or complete loss of certain mental and physical capacities you value highly. If you wish, in the space provided below you may specify in more detail the conditions in which you would choose to forego life-sustaining measures. You might include a description of the faculties or capacities, which, if irretrievably lost, would lead you to accept death rather than continue living. You may want to express any special concerns you have about particular medical conditions or treatments, or any other considerations which would provide further guidance to those who may become responsible for your care. If necessary, you may attach a separate statement to this document or use* ***Section D*** *to provide additional instructions.)*

Examples of conditions which I find unacceptable are:

____

____

____

____

Appendix B (Continued)

C) SPECIFIC INSTRUCTIONS: Artificially Provided Fluids and Nutrition; Cardiopulmonary Resuscitation (CPR). *On page 2 you provided general instructions regarding life-sustaining measures. Here you are asked to give specific instructions regarding two types of life-sustaining measures—artificially provided fluids and nutrition and cardiopulmonary resuscitation.*

In the space provided, write in the bracketed phrase with which you agree:

1. In the circumstances I initialled on page 2, I also direct that artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion,

____

[be withheld or withdrawn and that I be allowed to die]
[be provided to the extent medically appropriate]

2. In the circumstances I initialled on page 2, if I should suffer a cardiac arrest, I also direct that cardiopulmonary resuscitation (CPR)

____

[not be provided and that I be allowed to die]
[be provided to preserve my life, unless medically inappropriate or futile]

3. If neither of the above statements adequately expresses your wishes concerning artificially provided fluids and nutrition or CPR, please explain your wishes below.

____

____

____

D) ADDITIONAL INSTRUCTIONS: *(You should provide any additional information about your health care preferences which is important to you and which may help those concerned with your care to implement your wishes. You may wish to direct family members or your health care providers to consult with others, or you may wish to direct that your care be provided by a particular physician, hospital, nursing home, or at home. If you are or believe you may become pregnant, you may wish to state specific instructions. If you need more space than is provided here you may attach an additional statement to this directive.)*

____

____

____

E) BRAIN DEATH: *(The State of New Jersey recognizes the irreversible cessation of all functions of the entire brain, including the brain stem (also known as whole brain death), as a legal standard for the declaration of death. However, individuals who cannot accept this standard because of their personal religious beliefs may request that it not be applied in determining their death.)*

Initial the following statement only if it applies to you:

______ To declare my death on the basis of the whole brain death standard would violate my personal religious beliefs. I therefore wish my death to be declared solely on the basis of the traditional criteria of irreversible cessation of cardiopulmonary (heartbeat and breathing) function.

APPENDIX B (Continued)

F) AFTER DEATH—ANATOMICAL GIFTS: *(It is now possible to transplant human organs and tissue in order to save and improve the lives of others. Organs, tissues and other body parts are also used for therapy, medical research and education. This section allows you to indicate your desire to make an anatomical gift and if so, to provide instructions for any limitations or special uses.)*

Initial the statements which express your wishes:

1. _____ **I wish** to make the following anatomical gift to take effect upon my death:

A. _____ any needed organs or body parts

B. _____ only the following organs or parts

____

for the purposes of transplantation, therapy, medical research or education, or

C. _____ my body for anatomical study, if needed.

D. _____ special limitations, if any:

____

If you wish to provide additional instructions, such as indicating your preference that your organs be given to a specific person or institution, or be used for a specific purpose, please do so in the space provided below.

____

____

____

2. _____ **I do not wish** to make an anatomical gift upon my death.

Part Two: Signature and Witnesses

G) COPIES: The original or a copy of this document has been given to the following people *(NOTE: It is important that you provide a family member, friend or your physician with a copy of your directive.):*

1. *name* ______________________ 2. *name* ______________________

address ______________________ *address* ______________________

city ______________ *state* _____ *city* ______________ *state* _____

telephone ______________________ *telephone* ______________________

APPENDIX B (Continued)

H) SIGNATURE: By writing this instruction directive, I inform those who may become entrusted with my health care of my wishes and intend to ease the burdens of decisionmaking which this responsibility may impose. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this________**day of**_______________**, 19**_____**.**

*signature*____

*address*____

*city*________________________ *state*________________

I) WITNESSES: I declare that the person who signed this document, or asked another to sign this document on his or her behalf, did so in my presence, that he or she is personally known to me, and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative, nor as an alternate health care representative.

1. *witness*____

   *address*____

   *city*________________________ *state*________________

   *signature*____

   *date*____

2. *witness*____

   *address*____

   *city*________________________ *state*________________

   *signature*____

   *date*____