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Revocation by Attempted Suicide

Aaron Cohen

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To: Professor Bernstein
From: Aaron Cohen
Date: 4/29/15
Re: Final Draft – Revocation by Attempted Suicide

I. Introduction

Imagine Mr. Johnson, a New Jersey resident, upon the birth of his child, properly executed an advance directive with the requisite capacity. His advance directive unequivocally states that if he enters into a vegetative state, he wants to be kept alive via any available life-sustaining medical treatment, in hope that he may recover to continue caring for his child. Johnson named his wife, Mrs. Johnson, as his health care representative. Thirty years later, assume Johnson develops a persistent and pronounced cough. His now adult child convinces Johnson to visit his doctor. The doctor examines Johnson's lungs, discovers that he has Stage IV lung cancer, and explains to him that he has only four-six months to live. Wrought with the fear of suffering, Johnson returns home and explains his prognosis to his family. He also explains that he does not want to suffer as the end of his life draws near. One week later, Johnson attempts suicide, but fails. Johnson suffers severe mental and physical damage as a result of his suicide attempt, and is now on life support. Without the life support, he will die. Further, he is only minimally aware of his surrounding environment.

Should a doctor, in cases like Johnson's, consider a terminally ill patient's attempted suicide to be "an act evidencing an intent to revoke" his instructive directive,¹ thereby allowing a health care representative to decide to withhold or withdraw life-sustaining medical treatment.

This paper argues that a terminally ill patient's attempted suicide may constitute an "act evidencing an intent to revoke"² an instructive directive if the attending physician³, or a court,

¹ N.J.S.A. 26:2H-57(b)(1).

² *Id.*

concludes by clear and convincing evidence,⁴ that the declarant had the necessary mental capacity to achieve revocation. If the attending physician finds that the terminally ill patient was competent at the moment of revocation, his decision to revoke his instructive directive by attempted suicide was protected by his fundamental right to make health care decisions.⁵

Physicians are bound by specific ethical criteria that may conflict with a patient's fundamental right to make health care decisions.⁶ Given the extreme nature of revoking an instructive directive by attempted suicide, one can expect a physician or hospital to not recognize the revocation. However, honoring a terminally ill patient's advance directive requesting life-sustaining medical treatment after a suicide attempt fails to respect the patient's fundamental right to make health care decisions. Such a conflict would likely be resolved through the judiciary. Thus, this paper details the framework Courts should employ to resolve this conflict, and offers suggestions to the Legislature on how to keep this conflict from judicial review.

Part II defines advance directives and summarizes the relevant provision of the New Jersey Advance Directives for Health Care Act ("the Act"). Part III discusses suicide's or an attempted suicide's potential rationality. Part IV analyzes whether suicide or an attempted suicide can evidence intent. Part V evaluates whether a declarant can be considered competent

³ N.J.S.A. 26:2H-60(a).

⁴ See *Matter of M.R.*, 135 N.J. 155, 169 (1994) (holding that the challenger of incapacity bears "the burden of proving incapacity by clear and convincing evidence.").

⁵ See *Matter of Farrell* 108 N.J. 335, 347-8 (1987) ("While we held that a patient's right to refuse medical treatment even at the risk of personal injury or death is primarily protected by the common law, we recognized that it is also protected by the federal and state constitutional right of privacy."); *Matter of Conroy*, 98 N.J. 321, 346-8 (1985) (holding that the right to make decision regarding one's body is protected at common law and by the federal constitutional right of privacy); N.J.S.A. 26:2H-54(a) ("Adults have the fundamental right, in collaboration with their health care providers, to control decisions about their own health care unless they lack the mental capacity to do so.").

⁶ *Farrell*, 108 N.J. at 351 ("Even as patient's enjoy control over their medical treatment, health care professionals remain bound to act in consonance with specific ethical criteria. We realize that these criteria may conflict with some concepts of self-determination.").

after revoking an advance directive by attempted suicide. Part VI discusses whether a court should allow a patient to achieve revocation of his advance directive via a suicide attempt. Part VII offers recommendations to the Legislature to avoid having the Judiciary address this issue. Part VIII concludes this paper.

II. Advance Directives: Generally and in New Jersey

In the New Jersey Advance Directives for Health Care Act, the New Jersey Legislature declared that “adults have the fundamental right . . .to control decisions about their own health care unless they lack the mental capacity to do so.”⁷ Furthermore, the Legislature “recognizes the inherent dignity and value of human life and within this context recognizes the fundamental right of individuals to make health care decisions to have life-prolonging medical or surgical means or procedures provided, withheld, or withdrawn.”⁸ The Legislature also “recognizes the right of adults, who have the mental capacity, to plan ahead for health care decisions through the execution of an advance directive . . .and to have wishes expressed therein respected, subject to limitations.”⁹

An advance directive is “a document that takes effect upon one’s incompetency and designates a surrogate decision-maker for healthcare matters. . .The agent must make decisions in accordance with the principal’s relevant instructions, if there are any, in in the principal’s best interest.”¹⁰ A declarant is “an adult who has the mental capacity to execute an advance directive and does so.”¹¹ “An advance directive may include a proxy directive or an instructive directive,

⁷ N.J.S.A. 26:2H-54(a).

⁸ N.J.S.A. 26:2H-54(b).

⁹ N.J.S.A. 26:2H-54(c).

¹⁰ BLACK LAW DICTIONARY 60 (9th ed. 2009).

¹¹ N.J.S.A. 26:2H-55.

or both.”¹² A proxy directive is “a writing which designates a health care representative in the event the declarant subsequently lacks decision making capacity.”¹³ A health care representative is an “individual designated to make health care decisions on the principal’s behalf in the event of the principal’s incapacitation.”¹⁴ An instructive directive is “a writing which provides instructions and direction regarding the declarant’s wishes for health care in the event that the declarant subsequently lacks decision making capacity.”¹⁵

Pursuant to the Act and any applicable advance directive, “[l]ife sustaining treatment may be withheld or withdrawn from a patient. . .when a patient is in a terminal condition, as determined by the attending physician and confirmed by a second qualified physician.”¹⁶ A terminal condition is defined as

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.¹⁷

Notably, the Act allows a declarant to revoke or modify his advance directive, “including a proxy directive, or an instructive directive, or both.”¹⁸ Thus, an advance directive is a flexible document capable of changing should an unexpected circumstance arise.¹⁹ In New Jersey, a declarant can revoke an advance directive by: (1) an oral or written notification to a health care

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ N.J.S.A. 26:2H-67(a)(3).

¹⁷ N.J.S.A. 26:2H-55.

¹⁸ N.J.S.A. 26:2H-57(b).

¹⁹ Peter C. Harman, Note, ‘Locked-In’ to Their Decisions: Investigating How the States Govern Revocation of Advance Directives and How Three States Make Revocation Impossible for People with Locked-In Syndrome, 3 HASTINGS SCI. & TECH. L.J. 193, 194 (2011).

representative, physician, nurse, health care professional, or other reliable witness; (2) execution of a subsequent advance directive; or (3) “any other act evidencing an intent to revoke the document.”²⁰ “[R]evocation . . . of an advance directive is effective upon communication to any person capable of transmitting the information including the health care representative, the attending physician, nurse, or other health care professional responsible for the patient’s care.”²¹

“The attending physician shall determine whether the patient lacks capacity to make a particular health care decision,”²² such as a revocation of an instructive directive.

A determination that a patient lacks decision making capacity shall be based upon, but need not be limited to evaluation of the patient’s ability to understand and appreciate the nature and consequences of a particular health care decision, including the benefits and risks of, and alternatives to, the proposed health care, and to reach an informed decision.²³

This capacity test shall hereinafter be referred to as the Act’s capacity test. “The attending physician’s determination of a lack of decision making capacity shall be confirmed by one or more physician . . . [unless] the patient’s lack of decision making capacity is clearly apparent.”²⁴ “If the attending physician has determined that a terminally ill individual has capacity to make informed major medical decisions on his or her own behalf, the individual shall make decisions regarding . . . the withholding or withdrawing of LSMT”²⁵ (life-sustaining medical treatment). Logically, if the attending physician concludes that a terminally ill patient has capacity, the patient may also make the decision to revoke his instructive directive by any “act

²⁰ N.J.S.A. 26-2H-57(b)(1)-(2).

²¹ N.J.S.A. 26-2H-57(e).

²² N.J.S.A. 26:2H-60(a).

²³ N.J.S.A. 26:2H-60(g).

²⁴ N.J.S.A. 26:2H-60(b).

²⁵ N.J.A.C. 10:48B-51.

evidencing an intent to revoke,"²⁶ consistent with the Act and his fundamental right to make health care decisions.²⁷

In the above hypothetical, Johnson's decision to revoke his instructive directive by attempted suicide is tantamount to a decision to withhold or withdraw life sustaining medical treatment. Both decisions constitute a health care decision that ultimately results in the declarant's death.

Furthermore, a decision to withhold or withdraw life sustaining medical treatment is frequently made by a health care representative on the declarant's behalf due to the declarant's incapacitation. Here, although Johnson's decision to revoke his instructive directive was made while Johnson was competent, his decision left him incapacitated. His failed suicide attempt caused mental and physical damage and necessitates life sustaining medical treatment. Mrs. Johnson, as Johnson's health care representative, could withhold or withdraw his life sustaining medical treatment, but only if his instructive directive is considered revoked. Life sustaining medical treatment could be withheld or withdrawn because Johnson's Stage IV lung cancer constitutes a terminal condition under the Act.²⁸ Johnson's physician projected his life expectancy to be limited to four-six months as a result of his Stage IV lung cancer. Assuming a second physician would give the same diagnosis,²⁹ Johnson's cancer constitutes a terminal condition. Therefore, Mrs. Johnson could withhold or withdraw his life sustaining medical treatment, so long as his instructive directive is revoked.

Below is an analysis of the New Jersey doctrine regarding whether a terminally ill patient may revoke his advance directive by attempted suicide.

²⁶ N.J.S.A. 26-2H-57(b)(1).

²⁷ See *Farrell* 108 N.J. at 347-8; *Conroy*, 98 N.J. at 346-81 N.J.S.A. 26:2H-54(a).

²⁸ N.J.S.A. 26:2H-55.

²⁹ N.J.S.A. 26:2H-67(a)(3).

III. Can suicide or a suicide attempt be considered a rational and well-reasoned act?

Courts have recognized suicide, or a suicide attempt, to be a rational and well-reasoned act.³⁰ Suicide's potential rationality has been primarily discussed within the context of determining testamentary capacity. In *In re Rein's Will*, the testator was found unconscious due to gas inhalation, and subsequently revived seven and half months before drafting his will.³¹ The will's objectors claimed the gas incident was a suicide attempt, and demonstrated that the testator lacked testamentary capacity.³² The Prerogative Court of New Jersey held that there was no evidence that the gas incident was a suicide attempt and thus it did not prove testamentary incapacity.³³ However, the Court also noted "suicide or attempted suicide is not in and of itself proof of mental incapacity to make a will or proof of general insanity."³⁴ Furthermore, the Court stated that suicide can often be a rational recourse for an individual who carefully considers his "particular problem" and determines that a life of suffering – caused by that problem – is not worth living.³⁵ Moreover the Court noted that there are countless examples in literature and reality "where persons of superior intellectual force and reasoning power have deliberately chosen self-destruction as the solution to what appears to them to be an insufferable difficulty."³⁶

Similarly, in *In re Laurenson's Estate*, the Prerogative Court of New Jersey held that the testator's suicide attempt actually evidenced her testamentary capacity.³⁷ There, the testator

³⁰ *In re Rein's Will*, 50 A.2d 380, 384 (N.J. Prerog Ct. 1946), *In re Laurenson's Estate*, 165 A. 584, 584-5 (N.J. Prerog. Ct. 1933).

³¹ *Rein's Will*, 50 A.2d at 384.

³² *Id.* at 383.

³³ *Id.* at 384.

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Id.* at 384-5.

³⁷ *Laurenson's Estate*, 165 A. at 584-5.

“suffered from a kidney disorder and hardening of the arteries.”³⁸ Her condition deteriorated over the course of several years.³⁹ At one point, the testator committed a failed suicide attempt after executing a will.⁴⁰ The Court held that her suicide attempt took “grit.”⁴¹ Further, the Court held that her suicide attempt constituted powerful, albeit misdirected, evidence of mental stamina and testamentary capacity.⁴²

Likewise, the Court of Appeals of New York considered the potential rationality behind an act of suicide. In *Roche v Nason*, the testator committed suicide two days after executing a codicil to his will.⁴³ Objectors to the will claimed that if the will and codicil were executed with the intent to commit suicide thereafter, the instruments should be void as against public policy.⁴⁴ Although the Court held that there was no evidence indicating that either the will or codicil were executed with the intent to commit suicide, the Court stated that a testamentary instrument would not be void even if it was executed in contemplation of suicide.⁴⁵ Additionally, the Court held a suicidal act does not evidence testamentary incapacity, and noted “human experience has often shown that sane men have taken their own lives.”⁴⁶ Furthermore, the Court stated, “insanity is not inferable from the mere act of suicide.”⁴⁷

Although these principles stem from nearly century-old cases, their persuasive value is not diminished by their age. In actuality, the courts have long ago settled suicide’s potential rationality. The rule may be summarized as follows: A suicide or suicide attempt can be

³⁸ *Id.* at 584.

³⁹ *Id.*

⁴⁰ *Id.* at 585.

⁴¹ *Id.*

⁴² *Id.*

⁴³ *Roche v. Nason*, 77 N.E. 1007, 1007-8 (N.Y. 1906).

⁴⁴ *Id.* at 1008.

⁴⁵ *Id.* at 1009.

⁴⁶ *Id.*

⁴⁷ *Id.*

considered rational and sane when the individual chooses suicide as a solution to a particular problem, after carefully considering a life dominated by the suffering caused by that problem.

In the instant hypothetical, Johnson attempted suicide to avoid a life of suffering caused by terminal lung cancer. In fact, Johnson told his wife that he did not want suffer as the end of his life drew near. Further, Johnson's decision to commit suicide occurred after receiving a fatal prognosis of having a four-six month life expectancy from his physician, and after discussing his prognosis with his wife and child. Moreover, Johnson undoubtedly contemplated suicide and its ramifications in the week between his diagnosis and his a suicide attempt. These facts indicate that Johnson's suicide attempt was a rationally and thoughtful recourse chosen to avoid any suffering in his final months of life.

IV. Can the act of suicide or attempted suicide constitute an act evidencing an intent to revoke an advance directive?

A suicide or an attempted suicide can constitute an act evidencing an intent to revoke an advance directive. As previously stated, a declarant may revoke an advance directive by an "act evidencing an intent to revoke the document."⁴⁸ Precedent for holding that a suicidal act can evidence an intent to revoke an advance directive is found in two case: *Laurenson's Estate* and *State v. Mann*. In *Laurenson's Estate*, as mentioned above, the Prerogative Court of New Jersey held that the testator's suicide attempt actually evidenced her testamentary capacity.⁴⁹

A suicidal act's evidentiary power is more frequently considered within the context of proving a criminal defendant's guilt. In *State v. Jagers*, the Court of Errors and Appeals first established the principle in New Jersey that a criminal defendant's attempted suicide while in

⁴⁸ N.J.S.A. 26-2H-57(b)(1).

⁴⁹ *Laurenson's Estate*, 165 A. at 584-5.

custody is admissible as evidence of guilt.⁵⁰ The principle was more recently reaffirmed in *State v. Mann*.⁵¹ “In admitting such evidence, courts often have relied on the traditional view that a defendant may attempt suicide because of an inability to endure the prospect of prosecution and punishment. Alternatively, attempted suicide has been regarded as evidence of a consciousness of guilt.”⁵²

Thus there is precedent for the general principle that a suicidal act may be considered as evidence of intent. The act of suicide, or an attempted suicide, is not devoid of meaning merely because society generally considers it to be reprehensible.⁵³ In fact, suicide can quite clearly and definitively evidence a victim’s intent. Suicide can demonstrate testamentary capacity or intent, and guilt. Likewise, a suicide or an attempted suicide can constitute an act evidencing an intent to revoke an advance directive, within the meaning of the Act.

V. Can a terminally ill declarant who attempted suicide be considered competent after the event to be permitted to revoke his advance directive?

A. Determining a patient’s competency to make medical decisions.

Having determined that suicide or an attempted suicide can be both a rational act and an act evidencing an intent to revoke, one must determine whether a terminally ill declarant who attempted suicide can be considered competent after the event to be permitted to revoke his advance directive, even if that suicide attempt caused incapacitation. It is important to first consider what the New Jersey Legislature wrote about determining a patient’s competency to make medical decisions.

⁵⁰ *State v. Jagger*, 58 A. 1014, 1014 (N.J. 1904).

⁵¹ *State v. Mann*, 132 N.J. 410, 421 (1993) (“Like evidence of flight, evidence of a defendant’s suicide attempt that follows the alleged commission of an offense is generally admitted.”).

⁵² *Id.*

⁵³ See *Roche*, 77 N.E. at 1009 (holding that execution of a testamentary instrument with the intent to commit suicide –however reprehensible – cannot invalidate a testamentary disposition of property).

A determination that a patient lacks decision making capacity shall be based upon, but need not be limited to evaluation of the patient's ability to understand and appreciate the nature and consequences of a particular health care decision, including the benefits and risks of, and alternatives to, the proposed health care, and to reach an informed decision.⁵⁴

New Jersey courts have also provided guidance on the matter. In *Matter of Schiller*, the Superior Court of New Jersey, Chancery Division, first delineated a test New Jersey court should use to determine whether a patient has the mental capacity to consent to medical treatment.⁵⁵ A patient has the capacity to consent when the patient has "sufficient mind to reasonably understand the condition, the nature and effect of the proposed treatment, attendant risks in pursuing the treatment, and not pursuing the treatment."⁵⁶

The Supreme Court of New Jersey adopted this capacity-to-consent test in *Matter of Conroy*.⁵⁷ In that case, the Court considered whether a feeding tube could be removed from Ms. Conroy ("Conroy"), an incompetent and institutionalized elderly woman.⁵⁸ The Court held that life-sustaining medical treatment may be withdrawn or withheld by a healthcare representative "if there is sufficient proof to satisfy the subjective, limited-objective, or pure-objective test,"⁵⁹ hereinafter referred to collectively as the substitute decision making tests. A healthcare representative may not employ these substitute-decision making tests "unless the patient has been proven incompetent to make the particular medical treatment decision at issue."⁶⁰ In so

⁵⁴ N.J.S.A. 26:2H-60(g).

⁵⁵ *Matter of Schiller*, 148 N.J. Super. 168, 180-1 (Ch. Div. 1977).

⁵⁶ *Id.*

⁵⁷ *Conroy*, 98 N.J. at 382-3.

⁵⁸ *Id.* at 335.

⁵⁹ *Id.* at 374. *See also Id.* at 361, 365-6, 366 (explaining the subjective, limited-objective, and pure-objective tests, which are to be used by a healthcare representative or other surrogate decision maker to determine whether an incompetent patient would want life sustaining medical treatment to be withdrawn or withheld).

⁶⁰ *Conroy*, 98 N.J. at 381.

holding, the Court adopted the capacity-to-consent test enunciated in *Schiller*.⁶¹ Furthermore, the Court stated “a patient may be incompetent because he lacks the ability to understand the information conveyed, to evaluate the options, or to communicate a decision.”⁶² Additionally, the Court stated that “the inability to ‘govern’ one’s self and manage one’s other affairs does not necessarily preclude the ability to make a decision to forego further medical treatment.”⁶³ Moreover, a patient’s capacity, or incapacity, must be proven by clear and convincing evidence.⁶⁴

It is important to note that *Schiller*’s capacity-to-consent test mimics the language of the doctrine of informed consent. The *Conroy* Court noted this relationship, and used the doctrine of informed consent to expand upon the Court’s definition of a patient’s competency to refuse medical treatment. “The doctrine of informed consent presupposed that the patient has the information necessary to evaluate the risks and benefits of all available options and is competent to do so.”⁶⁵

Thus, the Court held that a patient’s right to refuse medical treatment was a logical corollary to the right to give informed consent.⁶⁶ Indeed, a “patient’s ability to control his bodily

⁶¹ *Id.* at 382-3, citing *Schiller*, 148 N.J. Super. at 180-81.

⁶² *Conroy*, 98 N.J. at 382.

⁶³ *Id.* at 383.

⁶⁴ *Id.* at 382.

⁶⁵ *Id.* at 347. quoting Wanzer, Adelstein, Crnaford, Federman, ook, Moertel, Safar, Ston, Taussig & Van Eys, *The Physician’s Responsibility Toward Hopelessly Ill Patients*, 310 NEW ENG. J. MED. 955, 957 (1984) (“There are three basic prerequisites for informed consent: the patient must have the capacity to reason and make judgments, the decision must be made voluntarily and without coercion, and the patient must have a clear understanding of the risk and benefits of the proposed treatment alternatives or nontreatment, along with full understanding of the nature of the disease and prognosis.”).

⁶⁶ *Conroy*, 98 N.J. at 347.

integrity through informed consent is significant only when one recognized that this right also encompasses a right to informed refusal.”⁶⁷

The Supreme Court of New Jersey reaffirmed the capacity-to-consent test when it reaffirmed the trial court's decision in *Matter of Farrell*. In that case, the issue presented was whether a competent, terminally ill adult patient living at home could withdraw a life-sustaining respirator.⁶⁸ Kathleen Farrell was a competent, albeit terminally ill and paralyzed patient suffering from amyotrophic lateral sclerosis (ALS).⁶⁹ She wanted to be disconnected from the respirator that sustained her breathing in order to die.⁷⁰ The trial court applied the *Schiller's* capacity-to-consent test, and held that Farrell was competent to refuse life sustaining medical treatment.⁷¹ The Supreme Court of New Jersey affirmed the trial court's decision.⁷² In so affirming, the Court restated its definition of patient competency. “A competent patient has a clear understanding of the nature of his or her illness and prognosis, and of the risks and the benefits of the proposed treatment, and has the capacity to reason and make judgments about the information.”⁷³ Moreover, the Court noted that adults are presumed to be competent.⁷⁴

The *Farrell* Court's definition of patient's competency is effectively the same as *Schiller's* capacity-to-consent test. Further, both the *Farrell* Court's definition of competency and *Schiller's* capacity-to-consent test are effectively the same as the Act's capacity test.

Thus, the doctrine of law regarding patients' competency to make medical decisions is summarized as follows:

⁶⁷ *Id.*

⁶⁸ *Farrell*, 108 N.J. at 344.

⁶⁹ *Id.* at 342, 345.

⁷⁰ *Id.* at 345.

⁷¹ *Farrell*, 212 N.J. Super. 294, 299 (Ch. Div. 1986).

⁷² *Farrell*, 108 N.J. at 359.

⁷³ *Id.* at 354 n.7, citing *Conroy*, 98 N.J. at 347,

⁷⁴ *Farrell*, 108 N.J. at 356.

A determination that a patient lacks decision making capacity shall be based upon, but need not be limited to evaluation of the patient's ability to understand and appreciate the nature and consequences of a particular health care decision, including the benefits and risks of, and alternatives to, the proposed health care, and to reach an informed decision.⁷⁵

“A patient may be incompetent because he lacks the ability to understand the information conveyed, to evaluate the options, or to communicate a decision.”⁷⁶ “[T]he inability to ‘govern’ one’s self and manage one’s other affairs does not necessarily preclude the ability to make a decision to forego further medical treatment.”⁷⁷ A patient’s capacity, or incapacity, must be proven by clear and convincing evidence.⁷⁸

The New Jersey cases analyzed in Sections B and C below are addressed pursuant to a variety of capacity tests. However, a conclusion under one capacity test can be considered to be the same conclusion that would be reached under any of the other tests.

B. Cases in which patients were held to be competent to make medical decisions.

There are cases in which courts have held a patient to be competent to make medical decisions. The most famous New Jersey case is *Matter of Farrell*. As previously stated, Kathleen Farrell was a competent, albeit terminally ill and completely paralyzed patient suffering from amyotrophic lateral sclerosis (ALS).⁷⁹ She was incapable of moving any part of her body, had difficulty swallowing and speaking, was incapable of eating solid foods, was incontinent as to bowel, and had bladder difficulties.⁸⁰ The disease did not cause any mental impairment.⁸¹

⁷⁵ N.J.S.A. 26:2H-60(g).

⁷⁶ *Conroy*, 98 N.J. at 382.

⁷⁷ *Id.* at 383.

⁷⁸ *Id.* at 382.

⁷⁹ *Farrell*, 108 N.J. at 342, 345.

⁸⁰ *Farrel*, 212 N.J. Super at 296-7, *aff'd* 108 N.J. at 359.

⁸¹ *Id.* at 344.

Farrell wanted to be disconnected from the respirator that sustained her breathing in order to die.⁸² She discussed her decision to terminate her life sustaining medical treatment with her husband Mr. Farrell, her teenage children, her physician, two psychologists, her parents, and her sister.⁸³ Subsequently, Farrell's husband commenced an action to be appointed as his wife Special Medical Guardian "with the specific authority to disconnect her respirator."⁸⁴ The trial court appointed a *guardian ad litem* for the children. ⁸⁵

The trial court first considered whether Farrell was competent to decide to withhold life sustaining medical treatment.⁸⁶ The trial court employed Schiller's capacity-to-consent test.⁸⁷ At trial, Farrell testified that her decision to end her life sustaining medical treatment was motivated by a desire to end her suffering.⁸⁸ A Board-certified psychologist, who examined Farrell at the request of the children's *guardian ad litem*, "testified that she was competent to make the decision."⁸⁹ Similarly, after evaluating Farrell, her psychologist concluded, "Farrell made an informed, voluntary, and competent decision to remove the respirator."⁹⁰

Based on the totality of the evidence, the trial court concluded that Farrell clearly understood "the nature of her condition and that death is almost certain to occur as a result of the disease if the respirator is removed."⁹¹ Further, the trial court stated that Farrell was "totally aware of her surroundings and is able to understand and communicate her will and wishes to

⁸² *Id.* at 345.

⁸³ *Id.* at 345-6.

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ *Farrell*, 212 N.J. Super at 299, *aff'd* 108 N.J. at 359.

⁸⁷ *Id.*

⁸⁸ *Farrell*, 108 N.J. at 346.

⁸⁹ *Id.*

⁹⁰ *Id.* at 345.

⁹¹ *Farrell*, 212 N.J. Super at 299, *aff'd* 108 N.J. at 359.

other people.”⁹² Thus, Farrell was held to be competent.⁹³ The Supreme Court of New Jersey affirmed the trial court’s decision, holding “that a competent patient like Kathleen Farrell can choose to have her life-supporting treatment discontinued.”⁹⁴

Likewise, *Payne v. Marion General Hospital* provides an instructive example of a court holding a patient to be competent to make medical decisions. Cloyde Payne, who was suffering from “malnutrition, uremia, hypertensive cardiovascular disease, chronic obstructive lung disease, non union of a previously fractured left humerus, and congenital levoscoliosis of the lumber spine,” was admitted to Marion General Hospital.⁹⁵ Payne’s condition worsened over several days, and his lungs began filling up with mucus.⁹⁶ Using a telephone, Payne’s doctor consulted with Payne’s attending nurses and Payne’s sister regarding his condition, and subsequently ordered a “no code.”⁹⁷ “A ‘no code’ is a designation on a patient’s chart that no cardiopulmonary resuscitation is to be given in the event the patient begins to expire.”⁹⁸ The doctor did not consult with Payne before issuing the “no code.” Payne died a few hours later.⁹⁹

“Occasionally, Payne was awake and alert, and he made eye contact with the nurses attending him. Payne was [also] conscious and capable of communicating with the nurses until moments before his death.”¹⁰⁰

Payne’s Estate sued the doctor and the Hospital, alleging that the doctor committed malpractice when he ordered the “no code.”¹⁰¹ The Court granted the doctor and hospital’s

⁹² *Id.*

⁹³ *Id.*

⁹⁴ *Farrell*, 108 N.J. at 359.

⁹⁵ *Payne v. Marion General Hosp.*, 549 N.E.2d 1043, 1044 (Ind. Ct. App. 1990).

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ *Id.* at 1050.

¹⁰⁰ *Id.* at 1044.

motion for summary judgment and Payne’s Estate appealed.¹⁰² On appeal, the Estate argued that Payne was competent at the time the “no code” was ordered.¹⁰³ Thus, the doctor should have obtained his informed consent before issuing the “no code.”¹⁰⁴ The Court of Appeals of Indiana, Second Circuit ultimately reversed the trial court’s grant of summary judgment.¹⁰⁵

In evaluating the Estate’s claim, the Court examined the depositions of Payne’s attending nurses.¹⁰⁶ The depositions revealed that Payne was “conscious, alert and able to communicate when the ‘no code’ was entered.”¹⁰⁷ At first, Payne was capable of verbal responses.¹⁰⁸ Further, his communication was responsive and the nurses were able care for him based upon his responses.¹⁰⁹ Even when Payne lost the ability to communicate verbally, the nurses testified that he never lost his ability to communicate entirely.¹¹⁰ One nurse also testified that Payne was conscious and aware of his surroundings.¹¹¹ That nurses also stated that Payne had the capacity to hear and understand what was being said to him.¹¹² Therefore, the Court held that “Payne was competent when [the doctor] issued the ‘no code.’”¹¹³

C. Cases where patients were held to be incompetent to make medical decisions.

¹⁰¹ *Id.*

¹⁰² *Id.* at 1045.

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ *Id.* at 1046-9.

¹⁰⁷ *Id.* at 1046.

¹⁰⁸ *Id.* at 1047.

¹⁰⁹ *Id.*

¹¹⁰ *Id.* at 1048.

¹¹¹ *Id.*

¹¹² *Id.* at 1049.

¹¹³ *Id.*

Conversely, courts have held patients to be incompetent to make medical decisions. In *In Re A.A.*, A.A. was involuntarily committed to a psychiatric hospital.¹¹⁴ She suffered from severe depression and hallucinations.¹¹⁵ A.A. named her daughter as her health care representative in her advance directive.¹¹⁶ The psychiatric hospital commenced the action, seeking to administer electro-convulsive therapy (“ECT”) to treat A.A., using the consent of her daughter.¹¹⁷

The issue considered was “whether the living will executed by A.A., constituted sufficient authorization for the administration of ECT.”¹¹⁸ The Superior Court of New Jersey, Chancery Division, stated that a determination of A.A.’s incapacity must be made pursuant to the Act before A.A.’s advance directive can become operative.¹¹⁹ The Court considered A.A.’s capacity pursuant to the Act’s capacity test.¹²⁰ As per the Act’s requirements, two psychiatrists submitted certifications stating that A.A. lacked capacity to make medical decisions.¹²¹ They stated that A.A. was severely depressed and suffered from psychotic symptoms.¹²² Additionally, one psychiatrist stated that A.A. did not believe any treatment would be a benefit.¹²³ Moreover, both doctors stated that A.A.’s condition rendered her incapable of making medical decisions.¹²⁴ Finally, they both doctors stated that ECT was necessary treatment.¹²⁵ The Court held this evidence sufficient to establish that A.A. lacked decision-making capacity, and that two

¹¹⁴ *In re A.A.*, 381 N.J. Super 334, 335 (Ch. Div. 2005).

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ *Id.*

¹¹⁸ *Id.* at 336.

¹¹⁹ *Id.* at 341.

¹²⁰ *Id.*

¹²¹ *Id.* at 341-2.

¹²² *Id.*

¹²³ *Id.* at 342.

¹²⁴ *Id.*

¹²⁵ *Id.*

psychiatrists opinion's satisfied the Act's procedural requirement.¹²⁶ Thus, the Court found A.A.'s advance directive to be operative, thereby allowing A.A.'s daughter to consent to ECT.¹²⁷

Similarly, the Superior Court of New Jersey, Chancery Division, found a patient to lack decision-making capacity in *Matter of Schiller*. In that case, a hospital sought appointment of a special guardian for William's Schiller's to consent to the amputation of Schiller's gangrenous leg.¹²⁸ The hospital submitted affidavits from a surgeon stating that Schiller's condition was life threatening, and from a psychiatrist stating that Schiller was mentally incapable of giving consent to the operation.¹²⁹

The Court determined Schiller's decision-making capacity pursuant to the capacity-to-consent test.¹³⁰ Schiller testified that he "had no real problems before he came to hospital."¹³¹ However, the surgeon who was on duty the day Schiller was admitted stated that Schiller, upon admission to the hospital, was covered in his own excrement, disheveled, and had gangrenous foot.¹³² He opined that Schiller's condition developed over months.¹³³ Additionally, the surgeon stated that he talked to Schiller about his condition and explained the need to amputate his leg to prevent further infection, but Schiller was never able to decide to consent to the surgery.¹³⁴

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ *Schiller*, 148 N.J. Super. at 171.

¹²⁹ *Id.*

¹³⁰ *Id.* at 180-1.

¹³¹ *Id.* at 181-2.

¹³² *Id.* at 182.

¹³³ *Id.*

¹³⁴ *Id.*

The psychiatrist stated that Schiller had organic brain damage and “that Schiller did not comprehend the amputation as a life-saving technique.”¹³⁵ Moreover, the psychiatrist opined, “Schiller did not have the mental capacity to knowingly consent or refuse to consent.”¹³⁶

Finally Schiller testified, “he did not want the operation; he just wanted to be left alone and die; he wanted to continue to receive care, and if there were a place he could go and be taken care of, he was interested in living.”¹³⁷ An attorney was eventually appointed.¹³⁸ The attorney filed an Answer to the hospital’s Complaint, stating, “Schiller did not want the operation and did not consent.”¹³⁹

At trial, two psychiatrists “testified that Schiller was incapable of understanding his present condition, understanding the amputation as a life-saving technique, and either consenting to or refusing to consent to the amputation.”¹⁴⁰ An independent psychiatrist also testified that Schiller suffered from brain damage, was disoriented as to time and place, did not understand who was talking to him, was unable to manage himself or his affairs, and could not do simple addition or subtraction.¹⁴¹

Therefore, the Court found Schiller to lack decision-making capacity.¹⁴² The Court granted the hospital’s petition and appointed Schiller’s cousin as special guardian with the power to consent to the amputation.¹⁴³

D. Johnson was competent when revoking his instructive directive by attempted suicide.

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ *Id.* at 182-3.

¹³⁸ *Id.* at 184.

¹³⁹ *Id.* at 185.

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² *Id.* at 186.

¹⁴³ *Id.*

Johnson was competent when revoking his instructive directive by attempted suicide. First, as an adult, Johnson is presumed to have been competent.¹⁴⁴ Furthermore, suicide is nothing if not final. It is purposeful self-destruction. It is the ending of one's life. Johnson's cancer prognosis was terminal. He understood that he was going to die as a result of the cancer within four-six months of his diagnosis. Similarly, one can assume that Johnson understood and appreciated that his decision to commit suicide would also result in self-destruction. Thus, Johnson understood the nature and repercussions of his decision to revoke his instructive directive by attempted suicide.

Moreover, Johnson's decision to revoke his instructive directive by attempted suicide is akin to Farrell's decision to terminate life-sustaining medical treatment. Farrell understood that disconnecting from her respirator would result in her death, and that her death would achieve her goal of ending her suffering.¹⁴⁵ Likewise, Johnson understood the benefits of suicide. As previously stated, courts have recognized that a sane man can rationally chose to commit suicide in order to escape or avoid an "insufferable difficulty."¹⁴⁶ Johnson considered a life dominated by the pain and suffering of cancer to be an insufferable difficulty. In fact, he told his family that he did not want to suffer as the end of his life drew near. Furthermore, Johnson's doctor properly informed him about his Stage IV lung cancer. Johnson was aware that he had no other life-saving treatment alternatives. Johnson knew that his cancer was terminal. Therefore, using his "superior intellectual force and reasoning power,"¹⁴⁷ Johnson determined suicide to be best solution to avoid any suffering.

¹⁴⁴ *Farrell* 108 N.J. at 356.

¹⁴⁵ *Farrell*, 212 N.J. Super at 299, *aff'd* 108 N.J. at 359; *Farrell*, 108 N.J. at 346.

¹⁴⁶ *Rein's Will*, 50 A.2d at 384-5.

¹⁴⁷ *Id.* at 384-5.

Additionally, Johnson never lacked the ability to understand his diagnosis and prognosis. Johnson never suffered from a mental illness or mental impairment. One can assume that he evaluated his options post diagnosis while discussing his illness with his family and during the week between his diagnosis and his attempted suicide. Further, as previously established, Johnson can communicate his decision to revoke his instructive directive via attempted suicide.¹⁴⁸ Also, there is no evidence to indicate that Johnsons was unable to manage himself or his affairs prior to and the time of his cancer diagnosis. Thus, Johnson was competent when revoking his instructive directive by attempted suicide.

VI. Should a court allow a declarant to achieve revocation of his advance directive via a suicide attempt?

In *Farrell*, the Supreme Court of New Jersey established a procedure to be used when competent patients decide to withdraw with withhold life-sustaining medical treatment.¹⁴⁹ First, the patient must be “competent and properly informed about his or her prognosis, the alternative treatments available, and the risk involved in the withdrawal of the life sustaining treatment.”¹⁵⁰ Second, the patient’s choice must be made voluntarily and without coercion.¹⁵¹ Third, the patient’s decision to forgo life-sustaining medical treatment “must be balance against the four potentially countervailing state interests.”¹⁵² “Generally a competent informed patient’s ‘interest in freedom from nonconsensual invasion of her bodily integrity would outweigh any state interest.’”¹⁵³ Furthermore, the Court required that two non attending physicians examine a

¹⁴⁸ *Mann*, 132 N.J. 410, 421 (1993) (“Like evidence of flight, evidence of a defendant’s suicide attempt that follows the alleged commission of an offense is generally admitted.”). *Laurenson’s Estate*, 165 A. at 584-5 (testator’s suicide attempt actually evidenced her testamentary capacity).

¹⁴⁹ *Farrell* 108 N.J. at 353.

¹⁵⁰ *Id.* at 354.

¹⁵¹ *Id.* at 354.

¹⁵² *Id.*

¹⁵³ *Id.*, citing *Conroy*, 98 N.J. at 355.

patient “to confirm that he or she is competent and is fully informed about his or her prognosis, the medical alternatives available, the risks involved, and the likely outcome.”¹⁵⁴

In *Matter of Conroy*, the Supreme Court of New Jersey described the four State interests that limit a competent patient’s right to decline life-sustaining medical treatment. The State interests are as follows: (1) preserving life; (2) preventing suicide; (3) safeguarding the integrity of the medical profession; and (4) protecting innocent third parties.¹⁵⁵

The State’s interest in preserving life was deemed to be the most significant, and encompassed the interest of preserving the patient’s life and the sanctity of all life.¹⁵⁶ Moreover, the State’s interest in preventing suicide was subsumed in the States interest in preserving life.¹⁵⁷ However, the State’s interest in preserving life does not outweigh a competent patient’s right to self-determination when the decision to refuse medical treatment only affects the decision maker’s own life.¹⁵⁸ This type of decision does not involve the actual or potential life of another.¹⁵⁹ Thus, a competent patient has a “stronger personal interest in directing the course of his own life.”¹⁶⁰ Indeed, “the value of life may be lessened rather than increased by the failure to allow a competent human being the right of choice.”¹⁶¹

Similarly, a competent person’s choice to refuse life sustaining medical treatment does not constitute a suicide attempt, because the patient’s death would be the result of the underlying

¹⁵⁴ *Farrell*, 108 N.J. at 356.

¹⁵⁵ *Id.* at 348-9.

¹⁵⁶ *Id.* at 349.

¹⁵⁷ *Id.* at 350.

¹⁵⁸ *Id.* at 349.

¹⁵⁹ *Id.* at 349-50.

¹⁶⁰ *Id.* at 350.

¹⁶¹ *Id.* (quotations omitted); *but cf* N.J.S.A. 26:2H-60(a)-(b) (only requiring one attending physician to determine that a patient has capacity, but requiring two non-attending physicians to confirm that the patient lacks capacity).

disease rather than a self-inflicted injury.¹⁶² “Recognizing the right of a terminally ill person to reject medical treatment respects that person’s intent, not to die,” but to self-determination.¹⁶³

Furthermore, the State’s interest in safeguarding the integrity of the medical profession is not implicated by a competent patient’s refusal of life-sustaining medical treatment.¹⁶⁴ When treating a competent patient, a doctor’s responsibility does not extend beyond advising the patient of the risks and urging the patient to accept treatment.¹⁶⁵ After fully advising the competent patient, the patient is entitled to accept or reject treatment.¹⁶⁶ “Indeed, if the patient’s right to informed consent is to have any meaning at all, it must be accorded respect even when it conflicts with the advice of the doctor or the values of the medical profession as a whole.”¹⁶⁷

Finally, the Court stated that a competent patient’s right to self-determination must give way if innocent third parties, such as the patient’s minor children, are directly and adversely affected by the patient decision to forgo life sustaining medical treatment.¹⁶⁸ The Supreme Court of New Jersey reaffirmed these four State interests in *Farrell*.¹⁶⁹

The New Jersey Legislature later codified five State interests used to limit a competent patient’s fundamental right to make health care decisions, including: (1) preserving the patient’s life and the sanctity of all life; (2) preventing “purposeful self-destruction, motivated by a specific intent to die;” (3) protecting innocent third parties from harm; (4) safeguarding the

¹⁶² *Id.* at 350-1.

¹⁶³ *Id.* at 351; *see also* N.J.S.A. 26:2H-77(a) (“The withholding or withdrawing of life-sustaining treatment. . .shall not constituted homicide, suicide, assisted suicide, or active euthanasia.”).

¹⁶⁴ *Conroy*, 98 N.J. at 352.

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

¹⁶⁷ *Id.* at 352-3.

¹⁶⁸ *Id.* at 353.

¹⁶⁹ *Farrell*, 108 N.J. at 353.

ethical integrity of the medical profession; and (5) protecting vulnerable patient's from potential abuse and "facilitating the exercise of informed and voluntary patient choice."¹⁷⁰

As previously stated, Johnson's decision to revoke his advance directive by attempted suicide is tantamount to a decision to forgo life-sustaining medical treatment. Thus, Johnson's decision should be analyzed pursuant to the *Farrell* framework. Under said framework, Johnson should be allowed to revoke his instructive directive via his attempted suicide. Johnson's competency to revoke his instructive directive by attempted suicide was previously established *supra* page 20-22. Moreover, his act of revocation was voluntary and without coercion. Johnson voiced to Mrs. Johnson his desire to avoid any suffering as he neared his death. No one coerced, or even suggested, how he might avoid suffering in his final months. Furthermore, there is no evidence that Johnson was under the influence of drugs or alcohol when revoking his instructive directive. Although his act of revocation was extreme, it was consistent with desire to avoid any suffering. It was a rational decision. Thus, Johnson's method of revocation was voluntary and implemented without coercion.

Furthermore, the State's interests do not outweigh Johnson's right to chose to revoke his instructive directive by attempted suicide. First, the State's interest in preserving life is not implicated. Johnson's choice and method of revocation did not involve the actual or potential life of another. Rather, he was the only person affected by his decision. When the decision maker is the only person affected by the choice, "the state's indirect and abstract interest in preserving the life of the competent patient. . .gives way to the patient's much stronger personal interest in

¹⁷⁰ N.J.S.A. 26:2H-54(d).

directing the course of his own life.”¹⁷¹ Thus, the State’s interest in preserving life does not apply.

Additionally, the state’s interest in preventing suicide creates no tension in this hypothetical. The Legislature explicitly phrased this interest as preventing “purposeful self-destruction, motivated by a specific intent to die.”¹⁷² The language the Legislature used is telling. The State is concerned with preventing people from choosing to commit suicide if they are motivated by a specific intent to die. Here, Johnson was not motivated by a specific intent to die when he attempted suicide. He was motivated by a desire to avoid pain and suffering. True, Johnson’s method of revocation was extreme. However, his choice to revoke his instructive directive in an extreme or dangerous manner was protected by his fundamental right to make health care decisions.¹⁷³

Similarly, the State’s interest in safeguarding the integrity of the medical profession is not implicated. Johnson’s doctor explained his prognosis and life expectancy to him when he was diagnosed with Stage IV lung cancer. Given that Johnson was competent at the time he was diagnosed, his doctor’s responsibilities did not extend beyond advising Johnson about his prognosis.¹⁷⁴ After being fully advised, Johnson was free to make any personal health care decision, no matter how extreme.

Moreover, innocent third parties were not affected by Johnson’s decision to revoke his instructive directive by attempted suicide. Mrs. Johnsons and their child are adults and capable of taking care of themselves.

¹⁷¹ *Farrell* 108 N.J. at 349.

¹⁷² N.J.S.A. 26:2H-54(d).

¹⁷³ *M.R.*, 135 N.J. at 167.

¹⁷⁴ *Conroy*, 98 N.J. at 352.

Finally, Johnson is not in any of danger of abuse by allowing him to achieve revocation by attempted suicide. Johnson's condition is terminal. His life expectancy is four-six months. Further, his suicide attempted caused incapacitation. But for Johnson's instructive directive, Mrs. Johnson – as his health care representative – would be allowed to withhold his life-sustaining medical treatment because Johnson's cancer constitutes a terminal condition.¹⁷⁵ Allowing Mrs. Johnson to withhold life-sustaining medical treatment would be consistent with Johnson's rational choice to attempt suicide, motivated by an intent to avoid suffering. It would not constitute abuse.¹⁷⁶ Thus, Johnson is not in any danger of abuse by allowing him to revoke his instructive directive by attempted suicide.

However, in the instant hypothetical, it would be impossible for two non-attending physicians to confirm whether Johnson was competent when revoking his instructive directive by attempted suicide because his revocatory act left him incompetent. Johnson's suicide attempt caused severe mental and physical damage, resulting in the need for life-sustaining medical treatment.

When a competent declarant's method of revocation causes incompetency, a court should employ one of the three substitute decision-making tests established in *Conroy* to determine if revocation of the declarant's advance directive is consistent with his wishes or best interests. Thus, depending on the types of evidence available, a court should first apply the substitute judgment test.¹⁷⁷ If not enough trustworthy evidence exists to satisfy the substitute judgment test,

¹⁷⁵ N.J.S.A. 26:2H-67(a)(3).

¹⁷⁶ N.J.S.A. 26:2H-77(a).

¹⁷⁷ *Conroy*, 98 N.J. at 360-1.

a court should apply the limited-objective test.¹⁷⁸ If no evidence exists as to the declarant's intent, a court should apply the pure-objective test.¹⁷⁹

The substitute judgment test requires the health care representative to determine what the particular incompetent declarant would have done under the same circumstances if he were competent.¹⁸⁰ The limited-objective test requires the healthcare representative to balance the burdens of the patient's continued life with treatment against the benefits of that life.¹⁸¹ The pure-objective test requires the healthcare representative to weigh the net burdens of the patient's life with treatment against the benefits.¹⁸²

Replacing the "two non-attending physicians" requirement with an analysis pursuant to one of the applicable substitute decision-making tests is appropriate because it maintains the *Farrell* Court's goal of protecting patients and their right to self-determination.¹⁸³ In fact, the *Farrell* Court adopted the "two non-attending physicians" requirement "to preclude the need for court action to establish competency of the patient."¹⁸⁴ Here, given that the patient's incompetency may necessitate judicial review, an analysis of their subjective wishes or best interests would properly protect an incompetent declarant who, while competent, revoked an instructive directive by extreme measures.¹⁸⁵

Johnson's intent to revoke is most aptly corroborated under the substitute judgment test. Johnson sought to avoid any pain and suffer through death. His choice entirely contradicts the

¹⁷⁸ *Matter of Roche*, 296 N.J. Super. 583, 588 (Ch. Div. 1996), *citing Conroy*, 98 N.J. at 365-6.

¹⁷⁹ *Id.* at 366.

¹⁸⁰ *Id.* at 360-1.

¹⁸¹ *Id.* at 365.

¹⁸² *Id.* at 366.

¹⁸³ *Farrel*, 108 N.J. at 356.

¹⁸⁴ *Id.*

¹⁸⁵ See generally *M.R.*, 135 N.J. at 167 ("By recourse to a 'substituted judgment' test, once-competent patients who have become incompetent also can express their right of self-determination.")

terms of his instructive directive requesting life-sustaining medical treatment. Thus, Johnson's instructive directive does not reflect his current wishes.

Furthermore, Johnson's instructive directive is outdated. It was created thirty years ago, when Johnson wanted to receive life-sustaining treatment in the event of incapacitation in hope of regaining his ability to care for his child. However, Johnson's child is now an adult and capable of caring for himself. Therefore, the purpose with which he created his instructive directive is too remote and inconsistent with his current situation to reflect his current end of life wishes.

Additionally, Johnson specifically told his wife that he did not want to suffer as his death drew near. This fear of suffering is both mature and rational. Given the fear's rationality, it is clear that Johnson would not want his outdated advance directive to serve as an obstacle in avoiding that fear.

Moreover, the medical evidence is particularly important in this case. Johnson was diagnosed with Stage IV lung cancer. He was only given four-six months to life. Johnson's suicide attempt caused severe mental and physical damage, and he now being kept alive via life sustaining medical treatment. He is experiencing the very pain and suffering he sought to avoid by attempting suicide. Therefore, pursuant to the substitute judgment standard, it is clear that Johnson intended to revoke his instructive directive requesting life-sustaining medical treatment. His instructive directive should be considered revoked, thereby allowing Mrs. Johnson to terminate life-sustaining medical treatment.

VII. Recommendations to the Legislature to avoid having the Judiciary address this issue.

Courts routinely state that issues involving a person's right to make health care decisions are more properly addressed in the Legislature.¹⁸⁶ In the Legislature, "fact finding can be less confined and the view points of all interested institutions and disciplines can be presented and synthesized."¹⁸⁷ As such, below are recommendations to the Legislature to keep this issue from judicial review.

No one can gainsay the Legislature's interest in preserving life or preventing suicide.¹⁸⁸ Moreover, few, if any, would oppose a statutory provision prohibiting a suicide attempt from constituting an act evidencing intent to revoke. Oregon adopted one such provision, which states "[i]n making a health care decision, a health care representative may not consider an attempted suicide by the principal as any indication of the principal's wishes with regard to health care."¹⁸⁹ By enacting a similar provision, the Legislature would obviate the need for courts to conduct a complicated analysis aimed at balancing the declarant's fundamental right to make health care decisions with the State's potentially countervailing interests.¹⁹⁰

Additionally, the Legislature could adopt an alternative statutory scheme for the revocation provisions of the Act. There are three major statutory frameworks that states have adopted to govern revocation of advance directives, including the Majority Approach, the Third Party Approach, and the Principal-Only Approach.¹⁹¹ The Majority Approach allows a patient to revoke an advance directive "at any time and in any manner by the declarant" or "at any time

¹⁸⁶ *Washington v. Glucksberg*, 521 U.S. 702, 786-89 (1997) (Souter, J., concurring); *Farrell*, 108 N.J. at 342-3; *Conroy*, 98 N.J. at 344-5.

¹⁸⁷ *Id.*

¹⁸⁸ *Cruzan by Cruzan v. Dir., Missouri Dept. of Health*, 497 U.S. 261, 280 (1990).

¹⁸⁹ O.R.S. § 127.750(1).

¹⁹⁰ *See Farrell* 108 N.J. at 354.

¹⁹¹ Peter C. Harman, Note, *'Locked-In' to Their Decisions: Investigating How the States Govern Revocation of Advance Directives and How Three States Make Revocation Impossible for People with Locked-In Syndrome*, 3 HASTINGS SCI. & TECH. L.J. 193, 202 (2011).

and in any manner that communicates an intent to revoke.”¹⁹² “This is the broadest type of language and allows a wide range of actions by a patient to validly revoke or modify an advance directive.”¹⁹³

The Third Party Approach and the Principal-Only Approach generally allow advance directives to be revoked “orally or in writing or by some physical act that manifests an intention to revoke the document, such as ‘being canceled, defaced, obliterated, burned, torn, or otherwise destroyed.’”¹⁹⁴ These two approaches differ in one major way. Under the Third Party Approach, a third party may effectuate the revocation of the advance directive;¹⁹⁵ whereas under the Principal-Only Approach, only the declarant can effect the revocation.¹⁹⁶ Moreover, a majority of the states that follow the Third-Party approach require the third party who is revoking the advance directive on behalf of the declarant to be in the presence of the declarant.¹⁹⁷

New Jersey follows the Majority Approach.¹⁹⁸ That is why Johnson’s attempted suicide constitutes an act evidencing an intent to revoke his instructive directive. In order to prevent the instant conflict under the Act’s revocation provision, the Legislature should adopt the Third-Party Approach. A suicide or a suicide attempt is not physical act that actually destroys the advance directive. Thus, adopting the Third-Party Approach would prevent one from ever achieving revocation of an advance directive by attempted suicide.

Moreover, the Third-Party Approach is similar to New Jersey’s provision regarding revocation of wills. “A will. . .is revoked. . .by the performance of a revocatory act on the will, if

¹⁹² *Id.* at 203 (citations omitted).

¹⁹³ *Id.*

¹⁹⁴ *Id.* at 203-4.

¹⁹⁵ *Id.* at 204.

¹⁹⁶ *Id.* at 204-5.

¹⁹⁷ *Id.* at 204.

¹⁹⁸ N.J.S.A. 26-2H-57(b)(1).

the testator performed the act with the intent and for the purpose of revoking the will.”¹⁹⁹ A “revocatory act on the will” includes burning, tearing, canceling, obliterating or destroying the will of any part of it.”²⁰⁰ If the Legislature adopted the Third-Party Approach with regard to the revocation of advance directives, it would provide congruity in the law. Wills and advance directives – which are both end-of-life documents – would only be revocable by the same physical acts. Finally, the Third-Party Approach is better than the Principal-Only Approach because the Principal-Only Approach is too restrictive.²⁰¹ Therefore, these legislative changes would help keep the instant issue from judicial review.

VIII. Conclusion.

In conclusion, a terminally ill declarant’s suicide attempt can constitute an act evidencing an intent to revoke an instructive directive requesting life-sustaining treatment.

¹⁹⁹ N.J.S.A. 3B:3-13(b).

²⁰⁰ *Id.*

²⁰¹ Peter C. Harman, Note, *‘Locked-In’ to Their Decisions: Investigating How the States Govern Revocation of Advance Directives and How Three States Make Revocation Impossible for People with Locked-In Syndrome*, 3 HASTINGS SCI. & TECH. L.J. 193, 212 (2011).