NJ
10
H434
1989p

COMMITTEE MEETING

before

SENATE JUDICIARY COMMITTEE

SENATE BILL 3320
(The "New Jersey Advance Directives for Health Care Act")

SENATE BILL 2067
(Establishes the "New Jersey Health Care Directive Act")

SENATE BILL 2659
(Enacts the "New Jersey Declaration of Death Act")

June 8, 1989
Room 424
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Senator Edward T. O'Connor, Jr., Chairman
Senator Raymond J. Zane, Vice Chairman
Senator Garbiel M. Ambrosio
Senator Richard J. Codey
Senator John A. Lynch
Senator Richard Van Wagner
Senator Donald T. DiFrancesco
Senator John H. Dorsey
Senator Lee B. Laskin

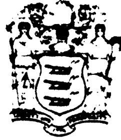
ALSO PRESENT

John J. Tumulty
Office of Legislative Services
Aide, Senate Judiciary Committee

* * * * * * * *

Meeting Recorded and Transcribed by
Office of Legislative Services
Public Information Office
Hearing Unit
State House Annex
CN 068
Trenton, New Jersey 08625

EDWARD T. O'CONNOR
CHAIRMAN
RAYMOND J. ZANE
VICE-CHAIRMAN
GABRIEL M. AMBROSIO
:HARD J. CODEY
HN A. LYNCH
CARMEN A. ORECHIO
RICHARD VAN WAGNER
DONALD T. DiFRANCESCO
JOHN H. DORSEY
WILLIAM L. GORMLEY
LEE B. LASKIN



New Jersey State Legislature
SENATE JUDICIARY COMMITTEE
STATE HOUSE ANNEX, CN-068
TRENTON, NEW JERSEY 08625
TELEPHONE: (609) 292-5526

M E M O R A N D U M

TO: MEMBERS OF THE SENATE JUDICIARY COMMITTEE

FROM: EDWARD T. O'CONNOR, CHAIRMAN

SUBJECT: COMMITTEE MEETING - JUNE 8, 1989

Please address any comments or questions to John J. Tumulty, Committee Aide at (609) 292-5526.

The Senate Judiciary Committee will meet on Thursday, June 8, 1989 at 10:00 a.m. in Room 424 in the State House Annex, Trenton, New Jersey.

The following bills will be considered:

S-3320 Ambrosio — The "New Jersey Advance Directives for Health Care Act."

S-2067 Zane — Establishes the New Jersey Health Care Directive Act.

S-2659 Ambrosio — Enacts the "New Jersey Declaration of Death Act."

Issued 5/30/89

TABLE OF CONTENTS

	Page
Jay Greenblatt, Esq. New Jersey State Bar Association	1
Ann Perone, Esq. New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care	7
Paul R. Langevin, Jr. Assistant Commissioner Health Facility Evaluation and Licensing New Jersey Department of Health	15
Walter Robokoff New Jersey Advocates for the Disabled	17
Ritamarie G. Rondum American Association of Retired Persons	22
Theresa Gleason Nurses for Ethical Care	26
Rabbi Shmuel Blech New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care	32
Pat Mahoney, R.N. President Medical Ethics Division New Jersey Right-to-Life	37
Paul W. Armstrong, Esq. Vice Chairman Bioethics Commission	39
Ed Daley American Association of Senior Citizens	42
T. Patrick Hill Director Public Information Citizens Committee on Bio-Medical Ethics	46
Richard Traynor, Esq. President New Jersey Right-to-Life	50
Marie S. Muhler Public Guardian Office of the Public Guardian New Jersey Department of Community Affairs	55
Pastor Fran Huber	57

TABLE OF CONTENTS (continued):

	Page
Ann Cardone Member Olney Foundation	58
Rose Bass Member New Jersey Eagle Forum	60
Lucille A. Link Administrator Bridgeway Convalescent Center Bridgeway, New Jersey Nursing Home Administrator	64
Stacey Herbert Buzzio Social Worker Bound Brook, New Jersey	69
Ewan C. MacQueen, Jr. Member Christian Science Committee on Publication for New Jersey	72
Mary Lertola Medical Ethics	75
Barbara Passalaqua Member Coma Recovery Association	76
Raymond Passalaqua Member Coma Recovery Association	77
Max Shachter Representative Ruth Zavatchel Kidney Foundation	79
Rita M. Martin Legislative Director New Jersey Right-to-Life and Citizens Concerned For Life	82
John Tomicki New Jersey Executive Director New Jersey Right-to-Life	86
Pat Coyle	96
Marie Neimeyer	100

TABLE OF CONTENTS (continued)

	Page
APPENDIX:	
Statement submitted by Jay Greenblatt, Esq.	1x
Statement submitted by Anne M. Perone, Esq.	6x
Statement, plus attachments, submitted by Lucille A. Link	33x
Testimony submitted by Stacey Herbert Buzzio	45x
Statement, plus attachments, submitted by Rose Bass	49x

* * * * * * * *

vf: 1-103

SENATE, No. 3320

STATE OF NEW JERSEY

INTRODUCED FEBRUARY 9, 1989

By Senators AMBROSIO, FELDMAN and CONTILLO

1 *AN ACT* concerning health care decision making.

3 BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

5 1. This act shall be known and may be cited as the "New Jersey Advance Directives for Health Care Act."

7 2. The Legislature finds and declares that:

a. Competent adults have the fundamental right, in 9 collaboration with their health care providers, to control decisions about their own health care. This State recognizes, in 11 its law and public policy, the personal right of the individual patient to make voluntary, informed choices to accept, to reject, 13 or to choose among alternative courses of medical and surgical treatment.

15 b. Modern advances in science and medicine have made possible the prolongation of the lives of many seriously ill 17 individuals, without always offering realistic prospects for improvement or cure. For some individuals the possibility of 19 extended life is experienced as meaningful and of benefit. For others, artificial prolongation of life may seem to provide nothing 21 medically necessary or beneficial, serving only to extend suffering and prolong the dying process. This State recognizes 23 that the fundamental right of individual choice extends to decisions to have life-prolonging medical or surgical means or 25 procedures provided, withheld, or withdrawn.

c. In order that the right to control decisions about one's own 27 health care should not be lost in the event a patient loses decision making capacity and is no longer able to participate actively in 29 making his own health care decisions, this State recognizes the right of competent adults to plan ahead for health care decisions 31 through the execution of advance directives, such as living wills and durable powers of attorney, and to have the wishes expressed 33 therein respected, subject to certain limitations.

d. The right of individuals to forego life-sustaining measures is

subject to certain interests of society. The most significant of these societal interests is the preservation of life, understood to embrace both an interest in preserving the life of the particular patient and a related but distinct interest in preserving the sanctity of all human life as an enduring social value. A second, closely related societal interest is the protection of individuals from direct and purposeful self-destruction, motivated by a specific intent to die. A third interest is the protection of innocent third parties who may be harmed by the patient's decision to forego therapy; this interest may be asserted to prevent the emotional and financial abandonment of the patient's minor children or to protect the paramount concerns of public health or safety. A fourth interest encompasses safeguarding the ethical integrity of the health care professions, individual professionals, and health care institutions, and maintaining public confidence and trust in the integrity and caring role of health care professionals and institutions. Finally, society has an interest in ensuring the soundness of health care decision making, including both protecting vulnerable patients from potential abuse or neglect and facilitating the exercise of informed and voluntary patient choice.

e. In accordance with these State interests, this State expressly rejects on both legal and moral grounds the practice of active euthanasia, as by deliberate lethal injection intended to cause death. No individual shall have the right to, nor shall any physician or other health care professional be authorized to engage in, the practice of active euthanasia.

f. In order to assure respect for patients' previously expressed wishes when the capacity to participate actively in decision making has been lost or impaired; to facilitate and encourage a sound decision making process in which patients, health care representatives, families, physicians, and other health care professionals are active participants; to properly consider patients' interests both in self-determination and in well-being; and to provide necessary and appropriate safeguards concerning the termination of life-sustaining treatment for incompetent patients as the law and public policy of this State, the Legislature hereby enacts the New Jersey Advance Directives for Health Care Act.

1 3. As used in this act:

"Adult" means an individual 18 years of age or older.

3 "Advance directive for health care" or "advance directive" means a writing executed in accordance with the requirements of 5 this act. An "advance directive" may include a proxy directive or an instruction directive, or both.

7 "Attending physician" means the physician selected by, or assigned to, the patient who has primary responsibility for the 9 treatment and care of the patient.

"Decision making capacity" means a patient's ability to 11 understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of each, and 13 alternatives to any proposed health care, and to reach an informed decision. A patient's decision making capacity is 15 evaluated relative to the demands of a particular health care decision.

17 "Declarant" means a competent adult who executes an advance directive.

19 "Do not resuscitate order" means a physician's written order not to attempt cardiopulmonary resuscitation in the event the 21 patient suffers a cardiac or respiratory arrest.

"Emergency care" means immediate treatment provided in 23 response to a sudden, acute and unanticipated medical crisis in order to avoid injury, impairment or death.

25 "Health care decision" means a decision to accept or to refuse any treatment, service or procedure used to diagnose, treat or 27 care for a patient's physical or mental condition, including life-sustaining treatment. "Health care decision" also means a 29 decision to accept or to refuse the services of a particular physician, nurse, other health care professional or health care 31 institution, including a decision to accept or to refuse a transfer of care.

33 "Health care institution" means all institutions, facilities, and agencies licensed, certified, or otherwise authorized by State law 35 to administer health care in the ordinary course of business, including hospitals, nursing homes, residential health care 37 facilities, home health care agencies, and hospice programs operating in this State, but does not include mental health 39 institutions, facilities or agencies, or institutions, facilities or

1 agencies for the developmentally disabled. The term "health care institution" shall not be construed to include "health care 3 professionals" as defined in this act.

"Health care professional" means an individual licensed by this 5 State to administer health care in the ordinary course of business or practice of a profession.

7 "Health care representative" means the individual designated by a declarant pursuant to the proxy directive part of an advance 9 directive for the purpose of making health care decisions on the declarant's behalf, and includes an individual designated as an 11 alternate health care representative who is acting as the declarant's health care representative in accordance with the 13 terms and order of priority stated in an advance directive.

"Instruction directive" means a writing which may be a 15 component of an advance directive and which provides instructions and direction regarding the declarant's wishes for 17 health care in the event that the declarant lacks decision making capacity. An "instruction directive" may be referred to as a 19 living will.

"Life-sustaining treatment" means the use of any medical 21 device or procedure, drugs, surgery or therapy that uses mechanical or other artificial means to sustain, restore or 23 supplant a vital bodily function, and thereby increase the expected life span of a patient.

25 "Other health care professionals" means health care professionals other than physicians and nurses.

27 "Patient" means an individual who is under the care of a physician, nurse or other health care professional.

29 "Permanently unconscious" means a medical condition that has been diagnosed in accordance with currently accepted medical 31 standards and with reasonable medical certainty as total and irreversible loss of consciousness and capacity for interaction 33 with the environment. The term "permanently unconscious" includes without limitation a persistent vegetative state or 35 irreversible coma.

"Physician" means an individual licensed to practice medicine 37 and surgery in this State.

"Proxy directive" means a writing which may be a component 39 of an advance directive and which designates a health care

1 representative in the event the declarant lacks decision making capacity. A "proxy directive" may be referred to as a medical
3 durable power of attorney.

"State" means a state, territory, or possession of the United
5 States, the District of Columbia, or the Commonwealth of Puerto Rico.

7 "Terminal condition" means the terminal stage of an irreversibly fatal illness, disease or condition. A determination
9 of a specific life expectancy is not required as a precondition for a diagnosis of a "terminal condition," but a prognosis of a life
11 expectancy of six months or less, with or without the provision of life-sustaining treatment, based upon reasonable medical
13 certainty, shall be deemed to constitute a terminal condition.

4. A declarant may execute an advance directive for health
15 care at any time. The advance directive shall be signed and dated by, or at the direction of, the declarant in the presence of
17 two subscribing adult witnesses, who shall attest that the declarant is of sound mind and free of duress and undue
19 influence. A designated health care representative shall not act as a witness to the execution of an advance directive. An
21 advance directive may be supplemented by a video or audio tape recording.

23 An advance directive may be made self-proved at the time of execution by following the formal requirements stated in
25 N.J.S.3B:3-4 for making a testamentary will self-proved.

5. a. A declarant may reaffirm or modify either a proxy
27 directive, or an instruction directive, or both. The reaffirmation or modification shall be made in accordance with the
29 requirements for execution of an advance directive pursuant to section 4 of this act.

31 b. A declarant, whether competent or incompetent, may revoke a prior proxy directive, or a prior instruction directive, or
33 both, by the following means:

(1) Notification, orally or in writing, to the health care
35 representative, attending physician, nurse or other health care professional, or other reliable witness;

37 (2) Destruction or attempted destruction of the document, or other act evidencing an intent to revoke the document; or

39 (3) Execution of a subsequent proxy directive or instruction

directive, or both, in accordance with section 4 of this act.

c. Designation of the declarant's spouse as health care representative shall be revoked upon divorce or legal separation, unless otherwise specified in the advance directive.

d. Reaffirmation, modification or revocation of an advance directive is effective upon communication to the health care representative, the attending physician, nurse or other health care professional responsible for the patient's care.

6. a. A declarant may execute a proxy directive, pursuant to the requirements of section 4 of this act, designating a competent adult to act as his health care representative.

(1) A competent adult, including, but not limited to, a declarant's spouse, adult child, parent or other family member, friend, religious or spiritual advisor, or other person of the declarant's choosing, may be designated as a health care representative.

(2) A declarant may not designate as a health care representative an operator, administrator or employee of a health care institution in which, at the time the advance directive is executed, the declarant is a patient or resident, or has applied for admission, unless the operator, administrator or employee is related to the declarant by blood, marriage or adoption.

This restriction does not apply to a physician, if the physician does not serve as the patient's attending physician and the patient's health care representative at the same time.

(3) A declarant may designate one or more alternate health care representatives, listed in order of priority. In the event the primary designee is unavailable, unable or unwilling to serve as health care representative, or is disqualified from such service pursuant to this section or any other law, the next designated alternate shall serve as health care representative. In the event the primary designee subsequently becomes available and able to serve as health care representative, the primary designee may, insofar as then practicable, serve as health care representative.

(4) A declarant may direct the health care representative to consult with specified individuals, including alternate designees, family members and friends, in the course of the decision making process.

(5) A declarant shall state the limitations, if any, to be placed

1 upon the authority of the health care representative.

b. A declarant may execute an instruction directive, pursuant
3 to the requirements of section 4 of this act, stating the
declarant's general treatment philosophy and objectives; or the
5 declarant's specific wishes regarding the provision, withholding
or withdrawal of any form of health care, including
7 life-sustaining treatment; or both. An instruction directive may,
but need not, be executed contemporaneously with, or be
9 attached to, a proxy directive.

A declarant who chooses to instruct that artificially provided
11 fluids and nutrition should be withheld or withdrawn under certain
conditions shall so indicate by an explicit statement in the
13 instruction directive.

7. a. An advance directive becomes operative when (1) it is
15 transmitted to the attending physician or to the health care
institution, and (2) it is determined pursuant to section 8 of this
17 act that the patient lacks decision making capacity.

b. Treatment decisions pursuant to an advance directive shall
19 not be made and implemented until there has been an reasonable
opportunity to establish, and where appropriate confirm, a
21 reliable diagnosis and prognosis for the patient.

8. a. The attending physician shall determine whether the
23 patient lacks decision making capacity. The determination shall
be stated in writing, shall include the attending physician's
25 opinion concerning the nature, cause, extent, and probable
duration of the patient's incapacity, and shall be made a part of
27 the patient's medical records.

b. The attending physician's determination of a lack of
29 decision making capacity shall be confirmed by one or more
physicians. The opinion of the confirming physician shall be
31 stated in writing and made a part of the patient's medical
records in the same manner as that of the attending physician.
33 Confirmation of a lack of decision making capacity is not
required when the patient's lack of decision making capacity is
35 clearly apparent, and the attending physician and the health care
representative agree that confirmation is unnecessary.

37 c. If the attending physician or the confirming physician
determines that a patient lacks decision making capacity because
39 of a mental or psychological impairment or a developmental

1 disability, and neither the attending physician or the confirming physician has specialized training or experience in diagnosing
3 mental or psychological conditions or developmental disabilities of the same or similar nature, a determination of a lack of
5 decision making capacity shall be confirmed by one or more physicians with appropriate specialized training or experience.
7 The opinion of the confirming physician shall be stated in writing and made a part of the patient's medical records in the same
9 manner as that of the attending physician.

d. A physician designated by the patient's advance directive
11 as a health care representative shall not serve as the confirming physician for the determination of a lack of decision making
13 capacity.

e. The attending physician shall inform the patient, if the
15 patient has any ability to comprehend that he has been determined to lack decision making capacity, and the health care
17 representative that: (1) the patient has been determined to lack decision making capacity to make a particular health care
19 decision; (2) each has the right to contest this determination; and (3) each may have recourse to the dispute resolution process
21 established by the health care institution pursuant to section 14 of this act.

23 Notice to the patient and the health care representative shall be documented in the patient's medical records.

25 f. A determination of lack of decision making capacity under this act is solely for the purpose of implementing an advance
27 directive in accordance with the provisions of this act, and shall not be construed as a determination of a patient's incapacity or
29 incompetence for any other purpose.

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

9. a. A health care representative shall have legal authority
37 to make health care decisions on behalf of the patient. The health care representative shall act in good faith and within the
39 bounds of the authority granted by the advance directive and by

1 this act.

b. If a different individual has been appointed as the patient's
3 legal guardian, the health care representative shall retain legal
authority to make health care decisions on the patient's behalf,
5 unless the terms of the legal guardian's court appointment or
other court decree provide otherwise.

7 c. The conferral of legal authority on the health care
representative shall not be construed to impose liability upon the
9 health care representative for any portion of the patient's health
care costs.

11 d. An individual designated as a health care representative or
as an alternate health care representative may decline to serve in
13 that capacity.

e. The health care representative shall exercise the patient's
15 right to be informed of the patient's medical condition, prognosis
and treatment options, and to give informed consent to, or
17 refusal of, health care.

10. In addition to any rights and responsibilities recognized or
19 imposed by, or pursuant to, this act, or by any other law,
physicians, nurses, and other health care professionals shall have
21 the following rights and responsibilities:

a. The attending physician shall make an affirmative inquiry of
23 the patient, his family or others, as appropriate under the
circumstances, concerning the existence of an advance directive.
25 The attending physician shall note in the patient's medical
records whether or not an advance directive exists, and the name
27 of the patient's health care representative, if any, and shall
attach a copy of the advance directive to the patient's medical
29 records. The attending physician shall document in the same
manner the reaffirmation, modification, or revocation of an
31 advance directive, if he has knowledge of such action.

b. A physician may decline to participate in the withholding or
33 withdrawing of life-sustaining treatment or artificially provided
fluids and nutrition necessary to sustain life, in accordance with
35 his sincerely held personal or professional convictions. In such
circumstances, the physician shall act in good faith to inform the
37 patient and the health care representative, and the chief of the
medical staff or other designated institutional official of this
39 decision as soon as practicable, to effect an appropriate,

1 respectful and timely transfer of care, and to assure that the patient is not abandoned or treated disrespectfully.

3 In the event of transfer of a patient's care, the attending physician shall assure the timely transfer of the patient's
5 medical records, including a copy of the patient's advance directive.

7 c. A nurse or other health care professional may decline to participate in the withholding or withdrawing of life-sustaining
9 treatment or artificially provided fluids and nutrition necessary to sustain life, in accordance with his sincerely held personal or
11 professional convictions. In these circumstances, the nurse and other health care professional shall act in good faith to inform
13 the patient and the health care representative, and the head of the nursing or other professional staff or other designated
15 institutional official, of this decision as soon as practicable, to cooperate in effecting an appropriate, respectful and timely
17 transfer of care, and to assure that the patient is not abandoned or treated disrespectfully.

19 d. Nothing in this act shall be construed to require a physician, nurse or other health care professional to begin, continue,
21 withhold, or withdraw health care in a manner contrary to law or accepted professional standards.

23 11. a. The attending physician, the health care representative and, when appropriate, any additional physician responsible for
25 the patient's care, shall discuss the nature and consequences of the patient's medical condition, and the risks, benefits and
27 burdens of the proposed health care and its alternatives. Except as provided by subsection b. of this section, the attending
29 physician shall obtain informed consent for, or refusal of, health care from the health care representative.

31 (1) Discussion of the proposed treatment and its alternatives shall include, as appropriate under the circumstances, the
33 availability, benefits and burdens of rehabilitative treatment, therapy, and services.

35 (2) The decision making process shall allow, as appropriate under the circumstances, adequate time for the health care
37 representative to understand and deliberate about all relevant information before a treatment decision is implemented.

39 b. Following a determination that a patient lacks decision

1 making capacity, the health care representative and the attending physician shall, to a reasonable extent, discuss the
3 treatment options with the patient, and seek to involve the patient as a participant in the decision making process. The
5 health care representative and the attending physician shall seek to promote the patient's capacity for effective participation and
7 shall take the patient's expressed wishes into account in the decision making process.
9 If the patient is found to possess adequate decision making capacity with respect to a particular health care decision, the
11 patient shall retain legal authority to make that decision. In such circumstances, the health care representative may continue to
13 participate in the decision making process in an advisory capacity, unless the patient objects.
15 Notwithstanding any other provision of this act to the contrary, if a patient who lacks decision making capacity clearly expresses
17 or manifests the contemporaneous wish that medically appropriate life-sustaining treatment or artificially provided
19 fluids and nutrition necessary to sustain life be provided, that wish shall take precedence over any contrary decision of the
21 health care representative and any contrary statement in the patient's instruction directive.
23 c. In acting to implement a patient's wishes pursuant to an advance directive, the health care representative shall give
25 priority to the patient's instruction directive, and may also consider, as appropriate and necessary, the following forms of
27 evidence of the patient's wishes:
(1) Reliable oral or written statements previously made by the
29 patient, including, but not limited to, statements made to family members, friends, health care professionals or religious leaders;
31 (2) Other reliable sources of information, including the health care representative's personal knowledge of the patient's values,
33 preferences and goals; and
(3) The patient's contemporaneous expressions, including
35 nonverbal expressions.
d. If the instruction directive, in conjunction with other
37 evidence of the patient's wishes, does not provide, in the exercise of reasonable judgment, clear direction as applied to the
39 patient's medical condition and the treatment alternatives, the

1 health care representative shall exercise reasonable discretion, in good faith, to effectuate the terms, intent, and spirit of the 3 instruction directive and other evidence of the patient's wishes.

e. If the patient's wishes cannot be adequately determined, 5 then the health care representative shall make a health care decision in the patient's best interests.

7 12. a. If the patient has executed an instructior directive but has not designated a health care representative, or if neither the 9 designated health care representative or any alternate designee is able or available to serve, the instruction directive shall be 11 legally operative. If the instruction directive provides clear and unambiguous guidance under the circumstances, it shall be 13 honored in accordance with its specific terms by a legally appointed guardian, if any, family members, the attending 15 physician, nurses, other health care professionals, health care institutions, and others acting on the patient's behalf.

17 b. If the instruction directive is, in the exercise of reasonable judgment, not specific to the patient's medical condition and the 19 treatment alternatives, the attending physician, in consultation with a legally appointed guardian, if any, family members, or 21 others acting on the patient's behalf, shall exercise reasonable judgment to effectuate the wishes of the patient, giving full 23 weight to the terms, intent, and spirit of the instruction directive. Departure from the specific terms and provisions of 25 the instruction directive shall be based upon clearly articulate factors not foreseen or contemplated by the instruction directive, 27 including, but not limited to, the circumstances of the patient's medical condition.

29 c. Nothing in this act shall be construed to impair the legal force and effect of an instruction directive executed prior to the 31 effective date of this act.

13. a. In addition to any rights and responsibilities recognized 33 or imposed by, or pursuant to, this act, or any other law, a health care institution shall have the following rights and responsibilities:

35 (1) A health care institution shall adopt such policies and practices as are necessary to provide for routine inquiry, at the 37 time of admission and at such other times as are appropriate under the circumstances, concerning the existence and location 39 of an advance directive.

1 (2) A health care institution shall adopt such policies and practices as are necessary to provide appropriate informational
3 materials concerning advance directives to all interested patients and their families and health care representatives, and to assist
5 patients interested in discussing and executing an advance directive.
7 (3) A health care institution shall adopt such policies and practices as are necessary to educate patients and their families
9 and health care representatives about the availability, benefits and burdens of rehabilitative treatment, therapy and services,
11 including but not limited to, family and social services, self-help and advocacy services, employment and community living, and
13 use of assistive devices. A health care institution shall, in consultation with the attending physician, assure that such
15 information is discussed with a patient and his health care representative and made a part of the decision making process
17 set forth in section 11 of this act, as appropriate under the circumstances.
19 (4) In situations in which a transfer of care is necessary, including a transfer for the purpose of effectuating a patient's
21 wishes regarding the withholding or withdrawing of life-sustaining treatment or artificially provided fluids and
23 nutrition necessary to sustain life, a health care institution shall, in consultation with the attending physician, take all reasonable
25 steps to effect the appropriate, respectful and timely transfer of the patient to the care of an alternative health care professional
27 or institution, as necessary, and shall assure that the patient is not abandoned or treated disrespectfully. In such circumstances,
29 a health care institution shall assure the timely transfer of the patient's medical records, including a copy of the patient's
31 advance directive.
(5) A health care institution shall establish procedures and
33 practices for dispute resolution, in accordance with section 14 of this act.
35 (6) A health care institution shall adopt such policies and practices as are necessary to inform physicians, nurses and other
37 health care professionals of their rights and responsibilities under this act, to assure that such rights and responsibilities are
39 understood, and to provide a forum for discussion and

1 consultation regarding the requirements of this act.
b. A private, religiously-affiliated health care institution may
3 develop institutional policies and practices defining
circumstances in which it will decline to participate in the
5 withholding or withdrawing of specified life-sustaining
treatments or artificially provided fluids and nutrition necessary
7 to sustain life. Such policies and practices shall be written, and
shall be properly communicated to patients and their families and
9 health care representatives prior to or upon the patient's
admission, or as soon after admission as is practicable.
11 If the institutional policies and practices appear to conflict
with the legal rights of a patient wishing to forego health care,
13 the health care institution shall attempt to resolve the conflict,
and if a mutually satisfactory accommodation cannot be reached,
15 shall take all reasonable steps to effect the appropriate, timely
and respectful transfer of the patient to the care of another
17 health care institution appropriate to the patient's needs, and
shall assure that the patient is not abandoned or treated
19 disrespectfully.
c. Nothing in this act shall be construed to require a health
21 care institution to participate in the beginning, continuing,
withholding or withdrawing of health care in a manner contrary
23 to law or accepted medical standards.
14. a. In the event of disagreement among the patient, health
25 care representative and attending physician concerning the
patient's decision making capacity or the appropriate
27 interpretation and application of the terms of an advance
directive to the patient's course of treatment, the parties shall
29 seek to resolve the disagreement by means of procedures and
practices established by the health care institution, including but
31 not limited to, consultation with an institutional ethics
committee, or with a person designated by the health care
33 institution for this purpose.
b. A health care professional involved in the patient's care,
35 other than the attending physician, or an administrator of a
health care institution may also invoke the dispute resolution
37 process established by the health care institution to seek to
resolve a disagreement concerning the patient's decision making
39 capacity or the appropriate interpretation and application of the

1 terms of an advance directive.

c. If disagreement cannot be reconciled through an
3 institutional dispute resolution process, the parties may seek
resolution in a court of competent jurisdiction.

5 15. a. Consistent with the terms of an advance directive and
the provisions of this act, life-sustaining treatment, other than
7 artificially provided fluids and nutrition necessary to sustain life,
may be withheld or withdrawn from a patient in the following
9 circumstances:

(1) When the life-sustaining treatment is experimental and not
11 a proven therapy, or is likely to be ineffective or futile in
prolonging life, or is likely to merely prolong an imminent dying
13 process;

(2) When the patient is permanently unconscious, as
15 determined by the attending physician and confirmed by a second
qualified physician;

17 (3) When the patient is in a terminal condition, as determined
by the attending physician and confirmed by a second qualified
19 physician; or

(4) In the event none of the above circumstances applies, when
21 the patient has a serious irreversible illness or condition, and the
likely risks and burdens associated with the medical intervention
23 to be withheld or withdrawn may reasonably be judged to
outweigh the likely benefits to the patient from such
25 intervention, and imposition of the medical intervention on an
unwilling patient would be inhumane. In such cases prior to
27 implementing a decision to withhold or withdraw life-sustaining
treatment, the attending physician shall promptly seek
29 consultation with a qualified institutional or regional reviewing
body in accordance with section 18 of this act, or shall promptly
31 seek approval of a public agency recognized by law for this
purpose.

33 b. Nothing in this section shall be construed to impair the
obligations of physicians, nurses and other health care
35 professionals to provide for the care and comfort of the patient
and to alleviate pain, in accordance with accepted medical and
37 nursing standards.

c. Nothing in this section shall be construed to abridge any
39 constitutionally-protected right to refuse treatment, based upon

1 the free exercise of religion or the right of privacy, under either
the United States Constitution or the Constitution of the State of
3 New Jersey.

16. a. Consistent with the explicit terms of an advance
5 directive and the provisions of this act, artificially provided
fluids and nutrition necessary to sustain life may be withheld or
7 withdrawn from a patient in the following circumstances:

(1) When the artificial provision of fluids and nutrition is likely
9 to be ineffective or futile in prolonging life, or is likely to merely
prolong an imminent dying process;

11 (2) When the patient is permanently unconscious, as
determined by the attending physician and confirmed by a second
13 qualified physician; or

(3) When the patient is in a terminal condition, as determined
15 by the attending physician and confirmed by a second qualified
physician, and the likely risks and burdens associated with the
17 least burdensome treatment modality likely to be effective may
reasonably be judged to outweigh the likely benefits to the
19 patient from such intervention, and imposition of the intervention
on an unwilling patient would be inhumane. In such cases, prior
21 to implementing a decision to withhold or withdraw artificially
provided fluids and nutrition, the attending physician shall seek
23 prompt consultation with a qualified institutional or regional
reviewing body in accordance with section 18 of this act, or shall
25 promptly seek approval of a public agency recognized by law for
this purpose.

27 b. Nothing in this section shall be construed to provide
authorization for the health care representative, or any other
29 individual acting pursuant to this act, to direct or implement the
withholding or withdrawal of artificially provided fluids and
31 nutrition necessary to sustain life in the absence of explicit
instructions to that effect in the patient's advance directive.

33 c. Nothing in this section shall be construed to impair the
obligations of a physician, nurse or other health care professional
35 to provide for the care and comfort of the patient and to
alleviate pain, in accordance with accepted medical and nursing
37 standards.

d. Nothing in this section shall be construed to [illegible]dge any
39 constitutionally-protected right to refuse treatment, based upon

1 the free exercise of religion or the right of privacy, under either the United States Constitution or the Constitution of the State of 3 New Jersey.

17. a. Consistent with the terms of an advance directive and 5 the provisions of this act, the attending physician may issue a do not resuscitate order.

7 b. A do not resuscitate order shall be entered in writing in the patient's medical records prior to implementation of the order.

9 c. Nothing in this act shall be construed to impair any existing legal authority to issue a do not resuscitate order when the 11 patient has not executed an advance directive.

18. a. An institutional or regional reviewing body which 13 engages in prospective case consultation pursuant to paragraph (4) of subsection a. of section 15 and paragraph (3) of subsection 15 a. of section 16 of this act shall advise the attending physician, patient and health care representative whether it believes that 17 the withholding or withdrawal of the medical intervention under consideration would be in conformity with the requirements of 19 this act, including without limitation: whether such action would be within the scope of the patient's advance directive; whether it 21 may reasonably be judged that the likely risks and burdens associated with the medical intervention to be withheld or 23 withdrawn outweigh its likely benefits; and whether it may reasonably be judged that imposition of the medical intervention 25 on an unwilling patient would be inhumane. The attending physician, patient and health care representative shall also be 27 advised of any other course of diagnosis or treatment recommended for consideration.

29 The advice of the institutional or regional reviewing body shall be documented in the patient's medical records.

31 b. The advice of an institutional or regional reviewing body acting in accordance with subsection a. of this section is not 33 legally binding. A health care representative, attending physician, nurse, or other health care professional who believes 35 the advice should not be followed may choose to:

(1) Pursue an alternative course of treatment for the patient. 37 In this case, no immunity is conferred upon such actions by this act, and the individual is subject to civil and criminal liability and 39 may be subject to discipline by the respective State licensing

1 board for professional misconduct;
(2) Seek review by a public agency recognized by law for this
3 purpose; or
(3) Seek review by a court of competent jurisdiction.
5 c. Nothing in this section shall preclude the transfer of the patient to another appropriate health care professional or health
7 care institution. In this case the health care institution responsible for the patient's care shall assure that the health
9 care professional or health care institution to which the patient is transferred is properly informed of the advice given by the
11 institutional or regional reviewing body.
d. An institutional or regional reviewing body acting in
13 accordance with subsection a. of this section shall conform to standards established by law and shall be subject to periodic
15 accreditation and review under procedures established by law.
19. a. Nothing in this act shall be construed to alter, amend or
17 revoke the rights and responsibilities under existing law of health care institutions not governed by the provisions of this act.
19 b. Nothing in this act shall be construed to preclude mental health institutions, facilities or agencies, or institutions,
21 facilities or agencies for the developmentally disabled, from respecting an advance directive for health care executed by a
23 patient or resident pursuant to this act.
c. The provisions of this act shall not be construed to require
25 emergency personnel, including paid or volunteer fire fighters; paramedics; members of an ambulance team, rescue squad, or
27 mobile intensive care unit; or emergency room personnel of a licensed health care institution, to withhold or withdraw
29 emergency care in circumstances which do not afford reasonable opportunity for careful review and evaluation of an advance
31 directive without endangering the life of the patient.
20. In accordance with the "Administrative Procedure Act,"
33 P.L.1968, c.410 (C.52:14B-1 et seq.) the Department of Health shall establish rules and regulations necessary to carry out the
35 provisions of this act. The rules and regulations shall require a health care institution to adopt policies and practices designed to:
37 a. Make routine inquiry, at the time of admission and at such other times as are appropriate under the circumstances,
39 concerning the existence and location of an advance directive;

1 b. Provide appropriate informational materials concerning advance directives to all interested patients and their families
3 and health care representatives, and to assist patients interested in discussing and executing an advance directive;
5 c. Educate patients and their families and health care representatives about the availability, benefits and burdens of
7 rehabilitative treatment, therapy and services, as appropriate;
d. In cooperation with the respective State licensing boards,
9 inform physicians, nurses, and other health care professionals of their rights and responsibilities under this act, to assure that the
11 rights and responsibilities are understood, and to provide a forum for discussion and consultation regarding the requirements of this
13 act; and
e. Otherwise comply with the provisions of this act, including
15 procedures for reporting to the department by health care institutions, and the gathering of such additional data as is
17 reasonably necessary to oversee and evaluate the implementation of this act. The Department of Health shall seek to minimize the
19 burdens of record-keeping imposed by the rules and regulations and shall seek to assure the appropriate confidentiality of patient
21 records.
21. The Department of Health and the New Jersey Commission
23 on Legal and Ethical Problems in the Delivery of Health Care established pursuant to P.L.1985, c.363 (C.52:9Y-1 et seq.), shall
25 jointly evaluate the implementation of this act and report to the Governor and the Legislature, including recommendations for any
27 changes deemed necessary, within five years from the effective date of this act.
29 22. a. A health care representative shall not be subject to criminal or civil liability for any actions performed in good faith
31 and in accordance with the provisions of this act:
(1) To carry out the terms of an advance directive; or
33 (2) To follow and implement the advice of an institutional or regional reviewing body acting in accordance with subsection a.
35 of section 18 of this act.
b. A health care professional shall not be subject to criminal
37 or civil liability or to discipline by the health care institution or the respective State licensing board for professional misconduct
39 for any actions performed in good faith and in accordance with

1 the provisions of this act and accepted professional standards:
(1) To carry out the terms of an advance directive; or
3 (2) To follow and implement the advice of an institutional or regional reviewing body acting in accordance with subsection a.
5 of section 18 of this act.
c. A health care institution shall not be subject to criminal or
7 civil liability for any actions performed in good faith and in accordance with the provisions of this act to carry out the terms
9 of an advance directive.
23. The absence of an advance directive shall create no
11 presumption with respect to a patient's wishes regarding the provision, withholding or withdrawing of any form of health care.
13 The provisions of this act do not apply to persons who have not executed an advance directive.
15 24. The execution of an advance directive pursuant to this act shall not in any manner affect, impair or modify the terms of, or
17 rights or obligations created under, any existing policy of health insurance, life insurance or annuity, or governmental benefits
19 program. No health care practitioner or other health care provider, and no health service plan, insurer, or governmental
21 authority, shall deny coverage or exclude from the benefits of service any individual because that individual has executed or has
23 not executed an advance directive. The execution, or non-execution, of an advance directive shall not be made a
25 condition of coverage under any policy of health insurance, life insurance or annuity, or governmental benefits program.
27 25. An advance directive executed in another state in compliance with the laws of that state or the State of New
29 Jersey is validly executed for purposes of this act. An advance directive executed in a foreign country in compliance with the
31 laws of that country or the State of New Jersey, and not contrary to the public policy of this State, is validly executed for purposes
33 of this act.
26. a. The withholding or withdrawing of life-sustaining
35 treatment pursuant to section 15 of this act or of artificially provided fluids and nutrition necessary to sustain life pursuant to
37 section 16 of this act, when performed in good faith, and in accordance with the terms of an advance directive and the
39 provisions of this act, shall not constitute homicide, suicide,

1 assisted suicide, or active euthanasia.

b. To the extent any of the provisions of this act are
3 inconsistent with P.L.1971, c.373 (C.46:2B-8 et seq.) concerning
the designation of a health care representative, the provisions of
5 this act shall supersede those of P.L.1971, c.373 (C.46:2B-8 et
seq.).

7 Durable powers of attorney for health care executed pursuant
to P.L.1971, c.373 (C.46:2B-8 et seq.) prior to the effective date
9 of this act shall have the same legal force and effect as if they
had been executed in accordance with the provisions of this act.

11 c. Nothing in this act shall be construed to impair the rights of
emancipated minors under existing law.

13 27. The Office of the Ombudsman for the Institutionalized
Elderly shall adopt policies and practices necessary to comply
15 with the requirements of P.L......, c....... (C........)(now pending
before the Legislature as this bill), and shall make a written
17 statement of its obligations under that act available to the public.

28. The Office of the Public Guardian for Elderly Adults shall
19 adopt policies and practices necessary to comply with the
requirements of P.L........, c........ (C...........)(now pending before
21 the Legislature as this bill), and shall make a written statement
of its obligations under that act available to the public.

23 29. a. A health care professional who willfully fails to act in
accordance with practices and procedures established by this act
25 is subject to discipline for professional misconduct pursuant to
P.L.1978, c.73 (C.45:1-21).

27 b. A health care institution that willfully fails to act in
accordance with practices and procedures established by this act
29 shall be subject to a fine of not more than $1,000 for each
offense. For the purposes of this subsection, each violation shall
31 constitute a separate offense. Penalties for violations of this act
shall be recovered in a summary civil proceeding, brought in the
33 name of the State in a court of competent jurisdiction pursuant
to "the penalty enforcement law," N.J.S.2A:58-1 et seq.

35 c. The following acts constitute crimes:

(1) To willfully conceal, cancel, deface, obliterate or withhold
37 personal knowledge of an advance directive or a modification or
revocation thereof, without the declarant's consent, is a crime of
39 the fourth degree.

1 (2) To falsify or forge an advance directive or a modification or revocation thereof of another individual is a crime of the
3 fourth degree.
(3) To coerce or fraudulently induce the execution of an
5 advance directive or a modification or revocation thereof is a crime of the fourth degree.
7 (4) To require or prohibit the execution of an advance directive or a modification or revocation thereof as a condition
9 of coverage under any policy of health insurance, life insurance or annuity, or governmental benefits program, or as a condition
11 of the provision of health care is a crime of the fourth degree.
d. The sanctions provided in this section shall not be construed
13 to repeal any sanctions applicable under other law.
30. This act shall take effect 180 days after the date of
15 enactment.

17 STATEMENT

19 This bill establishes procedures for the execution of advance directives for health care. According to the bill, advance
21 directives for health care may encompass both the designation of a health care representative, known as a proxy directive, and a
23 statement of personal wishes regarding health care in the event of loss of decision making capacity, known as an instruction
25 directive.
The purpose of this bill is to assure the respect for patients'
27 previously expressed wishes when the capacity to participate actively in health care decision making has been lost or
29 impaired. The bill establishes a procedure that facilitates and encourages a sound decision making process in which patients,
31 their families and health care representatives, physicians, and other health care professionals are active participants. In
33 addition, the bill provides the necessary and appropriate safeguards concerning the termination of life-sustaining
35 treatment for incompetent patients.
The bill provides that:
37 (1) An advance directive becomes operative when it is transmitted to the attending physician or to the health care
39 institution, and when the person is determined to lack decision

1 making capacity.

(2) Once operative, the advance directive designating a health
3 care representative confers upon that person the legal authority
to participate in the decision making process and to make health
5 care decisions on the patient's behalf.

(3) In the absence of a designated health care representative
7 an instruction directive, once operative, shall be respected and
implemented.

9 (4) Life-sustaining treatment or artificially provided fluids and
nutrition necessary to sustain life may be withheld or withdrawn
11 from a patient pursuant to an advance directive only in certain
specified circumstances.

13 (5) An impaired patient's contemporaneously expressed wish
that medically appropriate life sustaining treatment or
15 artificially provided fluids and nutrition necessary to sustain life
be provided shall take precedence over any contrary decision of
17 the health care representative and any contrary statement in the
patient's instruction directive.

19 (6) A declarant's directive to withhold or withdraw artificially
provided fluids and nutrition must be explicitly stated in an
21 advance directive.

(7) Health care professionals may decline to participate in the
23 withholding or withdrawing of life-sustaining treatment or
artificially provided fluids and nutrition necessary to sustain life
25 on the basis of sincerely held personal or professional
convictions. In such cases the health care professional shall
27 facilitate the appropriate, respectful and timely transfer of the
patient's care.

29 (8) Private, religiously-affiliated health care institutions may
adopt institutional policies and practices defining circumstances
31 in which they will decline to participate in the withholding or
withdrawing of life-sustaining treatment or artificially provided
33 fluids and nutrition necessary to sustain life.

(9) Individuals and institutions acting in good faith and in
35 accordance with the provisions of this act to carry out the terms
of an advance directive shall be immune from legal liability and
37 from discipline for unprofessional conduct.

This bill is the result of the work of the New Jersey
39 Commission on Legal and Ethical Problems in the Delivery of

1 Health Care, established pursuant to P.L.1985, c.363 (C.52:9Y-1 et seq.). This commission was established by the Legislature in
3 1985 to provide a comprehensive and scholarly examination of the legal and ethical dilemmas in the delivery of health care posed by
5 modern advances in science and medicine.

7 JUDICIARY

Health Care Facilities and Providers

9

Designated the "New Jersey Advance Directives for Health Care
11 Act."

SENATE, No. 2067

STATE OF NEW JERSEY

INTRODUCED FEBRUARY 22, 1988

By Senator ZANE

1 *AN ACT* concerning health treatment decisions and supplementing Title 26 of the Revised Statutes.

3

BE IT ENACTED *by the Senate and General Assembly of the*
5 *State of New Jersey:*

1. This act shall be known and may be cited as the "New
7 Jersey Health Care Directive Act."

2. The legislature finds and declares that individuals have the
9 fundamental right to determine whether to receive health care, and that the right to have specific treatment or procedures
11 initiated, withheld or withdrawn, including life-sustaining procedures, is in accord with the public policy of this State.

13 3. As used in this act:

a. "Declarant" means the person who executes a Treatment
15 Directive or Medical Decision Power of Attorney.

b. "Health care" means medical, surgical, hospital,
17 psychiatric, nursing, nursing home, hospice, custodial and other similar care provided to a declarant which affects his or her
19 physical or mental condition and well-being.

c. "Health care provider" means any person or entity providing
21 health care to a declarant.

d. "Life-sustaining procedure" means any health care which is
23 or may be essential for the prolongation of the declarant's life.

e. "Medical Decision Power of Attorney" means a written
25 document executed in accordance with the requirements of section 5 of this act, which appoints another individual or
27 individuals as attorneys-in-fact to make health care decisions for the declarant.

29 f. "Treatment Directive" means a written document, executed in accordance with the requirements of section 4 of this act,
31 which provides guidelines or directives with respect to a declarant's health care, including but not limited to, provisions
33 for initiating, continuing, withholding or withdrawing any or all life sustaining procedures.

1 4. Any competent adult may execute a Treatment Directive. The directive shall either:

3 a. Be signed by the declarant, or another at the declarant's direction, in the presence of two witnesses, who shall sign as such

5 in the presence of the declarant; or

b. Be signed by the declarant, or another at the declarant's

7 direction, and be acknowledged before a notary public, attorney-at-law or other person authorized to administer oaths.

9 5. Any competent adult may execute a Medical Decision Power of Attorney. This power of attorney shall be signed by the

11 declarant, or another at the declarant's direction, and be acknowledged before a notary public, attorney-at-law or other

13 person authorized to administer oaths. The Medical Decision Power of Attorney may include treatment directives or may refer

15 to or incorporate by reference a separate Treatment Directive. The power of attorney shall appoint an individual as

17 attorney-in-fact, and may also appoint another individual as substituted attorney-in-fact if the individual first appointed is

19 for any reason unavailable to act. In the event a declarant executes both a Treatment Directive and a Medical Decision

21 Power of Attorney, or a Medical Decision Power of Attorney which includes a Treatment Directive, the attorney-in-fact shall

23 make health care decisions which are not inconsistent with the Treatment Directive. Any attorney-in-fact may resign at any

25 time and for any reason. The decisions and directions of the attorney-in-fact shall have the same force and effect as if made

27 personally by the declarant.

6. If a declarant wishes to confer upon his or her

29 attorney-in-fact the authority to make health care decisions which include the decision to withhold or withdraw life-sustaining

31 procedures, the Medical Decision Power of Attorney shall include the phrase "including the power to authorize the withholding or

33 withdrawal of life-sustaining procedures," or words of similar meaning. This phrase need not be included if the Medical

35 Decision Power of Attorney refers to or includes a Treatment Directive and the directive itself authorizes the withholding or

37 withdrawal of life-sustaining procedures.

7. The following limitations apply to a Treatment Directive or a Medical Decision Power of Attorney:

a. A Treatment Directive or a Medical Decision Power of Attorney shall only be effective during the period when a declarant is clearly incompetent to make or is incapable of expressing health care decisions.

b. Nothing in this act is intended to give to the attorney-in-fact any greater authority with respect to the declarant's health care than the declarant would have if competent to personally make health care decisions.

c. Nothing in this act is intended to compel a health care provider to violate generally accepted professional standards.

8. a. If the Treatment Directive or the Medical Decision Power of Attorney contains a provision specifically recognizing the contingency of pregnancy and directs that notwithstanding pregnancy the withholding or withdrawal of life-sustaining procedures are directed or authorized, the Treatment Directive or Medical Decision Power of Attorney shall remain valid for these purposes. This provision shall not apply where the pregnancy has reached the third trimester.

b. Where the pregnancy has reached the third trimester or where the Treatment Directive or Medical Decision Power of Attorney does not contain a specific provision relating to the contingency of pregnancy as provided for in subsection a. of this section, a consultation by an appropriate medical specialist shall be obtained to determine whether, to a reasonable medical certainty, the fetus could develop to the point of live birth with continued application of life-sustaining treatment. If the medical consultation concludes that the fetus would so develop, then the Treatment Directive or Medical Decision Power of Attorney shall not be effective to withhold or withdraw life-sustaining treatment and the decision whether to withhold or withdraw life-sustaining treatment shall not be controlled by the provisions of this act. The Treatment Directive or Medical Decision Power of Attorney shall become effective upon birth or a finding to a reasonable medical certainty that the fetus has expired or is unable to develop to the point of live birth with the continued application of life-sustaining treatment.

1 9. A Treatment Directive or Medical Decision Power of Attorney may be revoked at any time by the declarant, or by 3 another at the declarant's direction, by written instrument executed with the formalities provided by sections 4 or 5 of this 5 act, or by destruction of the document by the declarant or at the declarant's direction.

7 10. A health care provider who is unwilling to comply with a Treatment Directive or the directions of an attorney-in-fact 9 pursuant to a Medical Decision Power of Attorney shall, as promptly as practicable, take all reasonable steps to transfer 11 care of the declarant to another health care provider who is willing to comply.

13 11. a. Unless otherwise provided by law, in the absence of knowledge of revocation, a person or health care provider is not 15 subject to civil or criminal liability or discipline for unprofessional conduct for complying with a Treatment 17 Directive, or complying with the instructions of the attorney-in-fact acting pursuant to a Medical Decision Power of 19 Attorney.

b. A physician or other health care provider whose actions 21 under this act are in accord with reasonable medical standards is not subject to criminal or civil liability or discipline for 23 unprofessional conduct.

12. A person is guilty of a crime of the fourth degree if he:

25 a. Willfully conceals, cancels, defaces, or obliterates a Treatment Directive or Medical Decision Power of Attorney, or a 27 revocation thereof, without the declarant's consent.

b. Falsifies or forges a Treatment Directive or Medical 29 Decision Power of Attorney, or a revocation thereof, or conceals or withholds personal knowledge of a revocation.

31 c. Coerces or fraudulently induces a declarant to execute or revoke a Treatment Directive or Medical Decision Power of 33 Attorney.

13. a. The withholding or withdrawal of life-sustaining 35 treatment pursuant to a Treatment Directive or a Medical Decision Power of Attorney and, in accordance with this act and 37 other applicable law, shall not constitute for any purpose a suicide or homicide, or the crime of aiding suicide as prohibited 39 by N.J.S. 2C:11-6.

1 b. The execution of a Treatment Directive or a Medical Decision Power of Attorney pursuant to sections 4 or 5 of this act
3 shall not affect in any manner the sale, procurement, or issuance of any policy of life insurance or annuity, nor shall it affect,
5 impair or modify the terms of an existing policy of life insurance or annuity.
7 A policy of life insurance or annuity shall not be legally impaired or invalidated in any manner by the withholding or
9 withdrawal of life-sustaining treatment from an insured declarant pursuant to this act, notwithstanding any insurance
11 term to the contrary.
c. A person shall not prohibit or require the execution of a
13 Treatment Directive or a Medical Decision Power of Attorney as a condition for being insured for, or receiving, health care
15 services. A person who violates this subsection shall be guilty of a crime of the fourth degree.
17 d. This act creates no presumption concerning the intention of an individual who has not executed or who has revoked a
19 Treatment Directive or a Medical Decision Power of Attorney pursuant to this act.
21 e. This act shall not affect the right of a declarant to make decisions regarding the use of life-sustaining procedures so long
23 as the declarant is able to do so.
f. Nothing in this act shall require any physician or other
25 health care provider to take any action contrary to reasonable medical standards.
27 14. A health care provider may presume, in the absence of knowledge to the contrary, that a Treatment Directive or a
29 Medical Decision Power of Attorney complies with this act and is valid.
31 15. A Treatment Directive or a Medical Decision Power of Attorney executed in another state in compliance with the law of
33 that state or this state is valid for purposes of this act.
16. a. An instrument executed before the effective date of
35 this act which substantially complies with sections 4, 5, or 6 of this act shall be treated as executed pursuant to this act.
37 b. This act is not intended to affect the validity or evidential weight which may otherwise be given to any written or oral
39 expression of intent concerning health care decisions made before or after the effective date of the act which does not conform to
41 the requirements of this act.

17. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this act which can be given effect without the invalid provision or application, and to that end the provisions of this act are severable.

18. This act shall take effect immediately.

STATEMENT

This bill is intended to provide two mechanisms by which an individual can exercise the fundamental right to determine whether or not to receive health care, and the right to have specific treatment or procedures initiated, withheld or withdrawn, in the event the individual becomes unable to make his own health care decisions. This bill is not intended to create new rights or expand or limit existing or future substantive legal limitations on a declarant's right to receive or refuse to receive health care.

The first, a Treatment Directive, has commonly come to be known as a "living will." The second, a Medical Decision Power of Attorney, is a power of attorney authorizing another to make health care treatment decisions.

Some indivuals may wish to specify their treatment decisions in a Treatment Directive and have those desicions followed in the event they become unable to act. However, it is often impossible for an individual, in advance of an illness or in advance of commencing a course of health care treatment, to anticipate all of the circumstances which may influence treatment care decision, and it may be difficult to execute a Treatment Directive covering all treatment decisions. Instead, many individuals may wish to entrust some or all treatment decisions to a trusted person acting under a Medical Decision Power of Attorney.

Under the provisions of the bill any competent individual may execute a Treatment Directive or a Medical Decision Power of Attorney, or both. If the declarant wishes to have life-sustaining treatment withheld or withdrawn, the document must specifically state so. A Treatment Directive or a Medical Decision Power of

1 Attorney may be revoked at any time. In the event a health care provider is unwilling to comply with a Treatment Directive or
3 Medical Decision Power of Attorney, the provider shall take all reasonable steps to transfer the declarant to another health care
5 provider. The bill also makes provision for a pregnant declarant and provides immunity from all civil or criminal liability for
7 complying with the Treatment Directive or Medical Power of Attorney.

9

11 HEALTH
Civil Rights

13

Establishes the New Jersey Health Care Directive Act.

SENATE, No. 2659

STATE OF NEW JERSEY

INTRODUCED JUNE 16, 1988

By Senator AMBROSIO

1 *AN ACT* concerning the determination of death, enacting the New Jersey Declaration of Death Act and supplementing Title
3 26 of the Revised Statutes.

5 BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*
7 1. a. This act shall be known and may be cited as the "New Jersey Declaration of Death Act."
9 b. The death of an individual shall be declared in accordance with the provisions of this act.
11 2. An individual who has sustained irreversible cessation of all circulatory and respiratory functions, as determined in
13 accordance with currently accepted medical standards, shall be declared dead.
15 3. Subject to the standards, procedures and exemptions established in accordance with sections 4, 5, and 6 of this act, an
17 individual whose circulatory and respiratory functions can be maintained solely by artificial means, and who has sustained
19 irreversible cessation of all functions of the entire brain, including the brain stem, shall be declared dead.
21 4. a. A declaration of death upon the basis of neurological criteria pursuant to section 3 of this act shall be made by a
23 licensed physician professionally qualified by specialty or expertise, in accordance with currently accepted medical
25 standards and additional requirements, including appropriate confirmatory tests, as are provided pursuant to this act.
27 b. Subject to the provisions of this act, the Department of Health, jointly with the Board of Medical Examiners, shall adopt,
29 and from time to time revise, regulations or interpretive guidelines setting forth (1) requirements, by specialty or
31 expertise, for physicians authorized to declare death upon the basis of neurological criteria; and (2) currently accepted medical
33 standards, including criteria, tests and procedures, to govern declarations of death upon the basis of neurological criteria. The

initial regulations and interpretive guidelines shall be issued within 120 days of the enactment of this act.

c. If the individual to be declared dead upon the basis of neurological criteria is or may be an organ donor, the physician who makes the declaration that death has occurred shall not be the organ transplant surgeon, the attending physician of the organ recipient, nor otherwise an individual subject to a potentially significant conflict of interest relating to procedures for organ procurement.

d. If death is to be declared upon the basis of neurological criteria, the time of death shall be upon the conclusion of definitive clinical examinations and any confirmation necessary to determine the irreversible cessation of all functions of the entire brain, including the brain stem.

5. The death of an individual shall not be declared upon the basis of neurological criteria pursuant to sections 3 and 4 of this act when such a declaration would violate the personal religious beliefs or moral convictions of that individual and when that fact has been communicated to, or should, pursuant to the provisions of section 6, reasonably be known by, the licensed physician authorized to declare death. In these cases, death shall be declared, and the time of death fixed, solely upon the basis of traditional cardio-respiratory criteria pursuant to section 2 of this act.

6. a. Prior to declaring an individual dead upon the basis of neurological criteria pursuant to sections 3 and 4 of this act, the licensed physician authorized to declare death, or another responsible person designated for that purpose, shall make reasonable efforts, in good faith, to determine whether this declaration would violate the personal religious beliefs or moral convictions of that individual. These efforts shall include, as is appropriate under the circumstances, review of available medical records, including advance directives for health care, and reasonable efforts to contact a person or persons, such as a family member, personal physician, religious leader, or friend, who maintained a close association with the individual sufficient to render that person knowledgeable concerning the nature and content of the individual's personal religious beliefs or moral convictions.

1 b. If a claim of exemption is reasonably advanced on the
individual's behalf under this act, a physician or other health
3 care provider responsible for the treatment and care of that
individual shall:

5 (1) refrain from declaring the individual dead upon the basis of
neurological criteria; and

7 (2) refrain from discontinuing, solely upon the basis of the
individual's neurological status, mechanical or other artificial
9 means employed to maintain the individual's circulatory or
respiratory functions.

11 7. A licensed health care practitioner, hospital, or the health
care provider who acts in good faith and in accordance with
13 currently accepted medical standards to execute the provisions of
this act and any rules, regulations or guidelines issued by the
15 Department of Health or the Board of Medical Examiners
pursuant to this act, shall not be subject to criminal or civil
17 liability or to discipline for unprofessional conduct with respect
to those actions. These immunities shall extend to conduct in
19 conformity with the provisions of this act following enactment of
this act but prior to its effective date.

21 8. Changes in pre-existing criteria for the declaration of death
effectuated by the legal recognition of modern neurological
23 criteria shall not in any manner affect, impair or modify the
terms of, or rights or obligations created under, any existing
25 policy of health insurance, life insurance or annuity, or
governmental benefits program. No health care practitioner or
27 other health care provider, and no health service plan, insurer, or
governmental authority, shall deny coverage or exclude from the
29 benefits of service any individual solely because of that
individual's personal religious beliefs or moral convictions
31 regarding the application of neurological criteria for declaring
death.

33 9. a. Pursuant to the "Administrative Procedure Act", P.L.
1968, c. 410 (C. 52:14B-1 et seq.) the Department of Health shall
35 establish rules, regulations, policies and practices as may be
necessary to collect annual reports from health care institutions,
37 to gather additional data as is reasonably necessary, to oversee
and evaluate the implementation of this act, including provisions
39 relating to the exemption procedure established pursuant to

1 sections 5 and 6 of this act. The department shall seek to minimize the burdens of record-keeping imposed by these rules,
3 regulations, policies and practices, and shall seek to assure the appropriate confidentiality of patient records.
5 b. The Department of Health, the Board of Medical Examiners, and the New Jersey Commission on Legal and Ethical Problems in
7 the Delivery of Health Care shall jointly evaluate the implementation of this act and report to the Legislature,
9 including recommendations for any changes deemed necessary, within five years from the effective date of this act.
11 10. If any provision of this act or its application to any individual or circumstance is held invalid, the invalidity shall not
13 affect other provisions or applications of this act which can be given effect without the invalid provision or application, and to
15 this end the provisions of this act are severable.
11. This act shall take effect on the 180th day following the
17 date of its enactment.

19

STATEMENT

21

This bill, "The New Jersey Declaration of Death Act", sets
23 forth the provisions for declaring an individual dead. This bill contains the recommendations of the Commission on Legal and
25 Ethical Problems in the Delivery of Health Care, the New Jersey Bioethics Commission. An individual who has sustained
27 irreversible cessation of all circulatory and respiratory functions shall be declared dead. An individual whose circulatory and
29 respiratory functions can only be maintained by artificial means, and who has sustained irreversible cessation of all functions of
31 the entire brain shall only be declared dead upon the basis of neurological criteria by a qualified licensed physician.
33 The Department of Health with the Board of Medical Examiners shall adopt regulations or guidelines setting forth the
35 professional requirements of physicians authorized to make a declaration of death upon the basis of neurological criteria and
37 set forth the medical standards, tests and procedures by which to declare someone dead.
39 Where an individual is a potential organ donor, the physician

1 making the determination of death may not be the surgeon for the organ transplant or the attending physician of the organ
3 recipient or otherwise be in a conflict of interest.

The bill sets forth an exemption to accommodate the personal
5 religious beliefs or moral convictions of the individual. An individual shall not be declared dead based on neurological
7 criteria if the determination would violate his beliefs or convictions and that fact has been communicated to the physician
9 or should be known by the physician authorized to make the determination of death. The physician shall make reasonable
11 efforts to determine if the individual's beliefs or convictions would be violated by reviewing the medical records and
13 contacting another person who maintained a close association with the individual so as to know the individual's religious beliefs
15 or moral convictions.

The bill sets forth immunity from criminal or civil liability for
17 any health care provider who acts in good faith in accordance with this bill.

19 The bill is not intended to impair or modify any health or life insurance policy or governmental benefits program. Nor shall
21 coverage be denied solely on the basis of an individual's beliefs regarding the neurological criteria for determining death.

23 The Department of Health, State Board of Medical Examiners and the New Jersey Commission on Legal and Ethical Problems in
25 the Delivery of Health Care shall monitor and evaluate the bill and report to the Legislature within five years.

27

29 HEALTH

Civil Rights

31

Enacts the "New Jersey Declaration of Death Act."

SENATOR EDWARD T. O'CONNOR (Chairman): Ladies and gentlemen, if you'll take your seats, you'll see that members will be arriving throughout the morning and the afternoon. We have a sign-up list which we are following from the first meeting, this being the adjourned date of that meeting.

The first speaker, Mr. Jay Greenblatt from the New Jersey State Bar Association.

J A Y G R E E N B L A T T, E S Q.: Good morning, Mr. Chairman, Senators. I am here representing the New Jersey State Bar Association.

Let me preface this by saying that the New Jersey State Bar Association is not in the business of preparing proposed legislation for submission. As a matter of fact, I think it is unprecedented. About four or five years ago, I attended the first conference of the AHA and the Canadian Hospital Association of Bio-Medical Ethics. They kept turning to those of us from New Jersey and wondering what the position in New Jersey was, and it was somewhat embarrassing, since we didn't have any legislation. That embarrassment grew until several years ago, at which time several pieces of legislation came to the attention of the Board of Trustees. We had negative reports from our sections or our Committees on them, and could have very easily taken a position against or taken a position of no position whatsoever.

But because of the pressing need that we felt in the State of New Jersey, we decided to form a Committee and write a piece of legislation. And that's what we did. Now, I have provided to you in written form, testimony. I do not intend to read it; I do not intend to even paraphrase it. I would only wish to highlight several points for you. I don't come here to oppose any other

bill; the other proposed bill, 3320 is a good bill. It represents a great deal of work that went into it. When we first met, we decided not to take that particular tact. Our vantage point was totally different. Our vantage point was not to anticipate all of the problems that might arise and attempt to solve all those problems in advance. Our attempt was only to do what might be termed a state's rights approach, and that is, to preserve to the people all the rights that the people now have; provide to the people the formal means by which they can incorporate those rights in some written document, give it the stamp of approval, and grant to caregivers the immunity that caregivers require and deserve. We did that, and nothing more.

To highlight some of the positions that we have taken in our bill, I would point to the fact that in our first draft-- There were several drafts, and we didn't know whether we could come from the position of what has gone through the courts, since we were attempting to codify the existing law, as we understand existing law to be, and then we came to the conclusion that, to sit back as a Committee and determine what people shall, and shall not be able to do under certain circumstances, first of all, raises some very definite constitutional issues, and, secondly, was a lost cause from the beginning, in our opinion since, no matter how many members of the Committee we would add, we would have that many more points of view on ethical and moral positions. So, trying to codify existing law, as the law was at the time, we concluded that we would not look to the cases and adopt the fact situations of those cases, such as a terminally ill person, or a permanently unconscious person, because to do that would be to restrict the rights of individuals to only those situations.

If, given a situation where someone were unconscious in a hospital and had to undergo a surgical

procedure which was thought to be appropriate from a medical point of view and that person could somehow miraculously awake, that person would have certain rights, and one right would be to refuse that procedure. So, to take the position that we are going to sit there as a Committee and propose to you legislation to be adopted which would restrict those rights, which is the position taken by and under the Bill 3320, we felt to be the inappropriate point of view.

That does not mean that we oppose that bill or we urge you to adopt some bill to provide to the people of the State, and especially to the caregivers of those people some means by which they can express their wishes. We urge, however, that if you do this, do it by a simple bill which can be easily read and understood by a hospital administrator or any care-giver or vice president for nursing in a hospital, codify the existing law of the State of New Jersey as it presently exists, not run the risk of violating any constitutional safeguards which have been afforded, and afford to the people all of the rights which they now have and provide to them a formal means by which to express those rights; an immunity to those people who would follow the dictates of the given patient. You would be providing almost everything to the people of the State of New Jersey that has been a crying need to the State of New Jersey for so many years.

I'm not saying that that would be the end of it. I'm not saying that some of the problems and some of the troubles that are foreseen by the other Bill, 3320, would not, and could not, arise. But, I would say that in order to overcome all of the pitfalls that one must encounter, when one attempts to do everything for everyone, one would spend several more years in an attempt to do that. We simply don't have that.

I speak to you as an attorney and Trustee of the New Jersey State Bar Association, as a chairman of the

board of the hospital, and as a person in the last week who has had to answer two telephone calls of this very type of problem existing within a hospital.

There are people sitting in the halls of hospitals now who are friends, relatives, parents, and children of patients, and we have no further time with which to attempt to answer the needs of all. As lawyers and as legislators, it is necessary for you to adopt something now, and I am suggesting that the better of the two bills is the bill suggested by the New Jersey State Bar. However, if this Committee sees the matter philosophically from the point of view of the Task Force, then, by all means, adopt that bill. Thank you, Mr. Chairman. Any questions?

SENATOR AMBROSIO: As I understand it, the main difference that you have between the Bar Association bill and the ethics -- Bioethics bill, is it is too complicated, or much more complicated than you would like it to be.

MR. GREENBLATT: I don't think that's the main difference. I think the main difference is that a medical directive, or whatever you wish to call that piece of paper, would never take effect under the Bioethics Commission bill, unless and until there was a certain factual situation; that is to say, terminal condition or permanent lack of consciousness, and our bill does not provide for that, not at all.

As pointed out, I believe in the comments -- and I read the comments of Dr. Erde -- there are many situations where that bill would not fit the needs of the patient, and it would be simply inhumane to continue with treatment. And it doesn't answer the question.

SENATOR AMBROSIO: Your bill does not make any different distinction between medical treatment, and fluids and nutrition as another form of medical treatment.

MR. GREENBLATT: That is correct.

SENATOR AMBROSIO: You treat them as the same, right?

MR. GREENBLATT: We treated them as the same, leaving to the individual the ability to define between the two. As was pointed out in something that I recently read by Dr. Erde, it was suggested by him that in section 3b of our bill, the words "technologically supplied nutrition" be added, so that there be no question, but that that is included as medical care.

SENATOR AMBROSIO: And your bill also deals with pregnancy issues by, in effect, adopting the current case law, and allows an advanced directive to take effect regardless of pregnancy.

MR. GREENBLATT: Under certain conditions at certain points in time. That took up quite a bit of time of our Committee. At first we decided that it would be best to leave it out, and then we thought better of it, and thought that it is something that is a matter that could be supported perhaps not as simply as we supported it by established law, and that being so, we felt it had to be met.

I might say, Senator, that both the hydration and nutrition issue, and the pregnancy issue, are not the most important points of the thrust of the bill. But you are correct, the proposed bill includes it. It's a menu that we submit, but it's not fixed price. It's "a la carte," if you wish.

SENATOR AMBROSIO: Is there a companion bill in the Assembly?

UNIDENTIFIED SPEAKER FROM AUDIENCE: Yes, there is.

SENATOR AMBROSIO: Do you know the status?

UNIDENTIFIED SPEAKER FROM AUDIENCE: It hasn't been heard by the Judiciary--

SENATOR AMBROSIO: Do you know the status of that? (no response)

SENATOR O'CONNOR: Any other questions?

SENATOR LASKIN: I want you to know that I have had a great deal of trouble with some of the portions of this bill, as every member up here has had trouble with the bill's philosophy. The problem-- I happen to agree, though, that Dr. Erde made some very good points. I would like to see the bill revised to include some of his suggestions.

But I also recognize that there are some very tactical problems in getting a bill passed, in view of the long history in New Jersey of strong opposition to this kind of will legislation.

Is it your position that if these changes are not made, you are against the bill?

MR. GREENBLATT: Would you define, Senator, the changes to which you make reference?

SENATOR LASKIN: Any changes that you've suggested in your testimony today.

MR. GREENBLATT: Oh, no, no, I would welcome any changes that do not defeat--

SENATOR LASKIN: What I'm saying is, if the bill that we have before us were not to be changed, even though some of us would like to see some changes in it, but if it were not changed, would you be against the existing legislative proposal that we have?

MR. GREENBLATT: Which bill? I'm speaking now to two different bills.

SENATOR LASKIN: Both of them; both of the Ambrosio bills.

MR. GREENBLATT: I'm speaking with regard to the Zane and Ambrosio bills.

SENATOR LASKIN: Let's talk Ambrosio. Are you for that bill as it is, even if we don't amend it?

MR. GREENBLATT: As compared to nothing at all?

SENATOR LASKIN: That's the problem.

MR. GREENBLATT: The New Jersey State Bar Association is for that bill as compared to nothing at all, although--

SENATOR LASKIN: I understand, believe me.

MR. GREENBLATT: May I comment on that? As with many issues that we have in the country today, some of which are included in these bills, we have personal feelings both ethical, moral, and on religious grounds, whatever they may be. But we felt that if we're going to attempt to propose legislation on those criteria, it is improper, inappropriate, and impracticable, and, therefore, we issued those considerations and attempted to codify, to allow to the people everything that they already have, and do nothing more than that.

SENATOR LASKIN: Okay.

SENATOR O'CONNOR: Any other questions? Anyone else? Senator DiFrancesco?

SENATOR DiFRANCESCO: No questions. Thank you.

SENATOR O'CONNOR: Ann Perone, of the New Jersey Bioethics Commission.

A N N P E R O N E, E S Q.: My name is Ann Perone. I'm an attorney in the State of New Jersey, former Dean of Administration at Seton Hall Law School, and a newly appointed member of the Bioethics Commission.

I did not participate in any of the meetings that formulated the bills that are before you today. As a matter of fact, I've only attended my first meeting of the Commission. I'm not testifying on behalf of the Commission, although I am a newly appointed Commissioner.

SENATOR O'CONNOR: I invite you to have a seat and please speak into the microphone.

MS. PERONE: Somerset County-- I'm here, and I'm former corporate counsel for New Jersey Right-to-Life. I'm here today to testify against S-3320 and the

New Jersey Health Care Directive Act S-2067, and my reasons for testifying against them are many.

First of all, the Bioethics Commission, which formulated basically this legislation, and then it was kind of worked over by Senator Ambrosio, was mandated by the Legislature to do certain things before they produced any of these reports. From the enabling statute, P.L. 1985, Chapter 363, paragraph 3b says that the Commission was supposed to gather data about how New Jersey and other jurisdictions handled decision making regarding the termination and refusal of care and treatment.

This was supposed to be in an initial report to the Legislature, and this data and these reports have not been forthcoming. Paragraph 3c states that the Commission should assess the need for additional programs and services relating to medical decision making. Again, this data and these reports have not been forthcoming.

Finally, the enabling statute in paragraph 6 says, "The Commission shall make its report to the Governor, the Legislature, and the public. The initial report shall include a report on the current status of the law in New Jersey, and other jurisdictions, regarding the termination of treatment, surrogate decision making, and related issues." Where is this data, and where are the reports? The Commission has provided no such report of current practices and procedures, or has New Jersey -- or how New Jersey and other jurisdictions handle medical decision making, or any assessment of the need for change, and there are no reports regarding how well current practices work.

We've had a few cases in New Jersey, but we've had no reports, other than a report that was provided by the Ombudsman to the Commission. Other than that, there's been no data as to what is going on in hospitals and

nursing homes for people who are not covered by the Ombudsman's Office. We actually don't know what's going on, and this legislation is being put forth in a vacuum. S-3320 even says, on its last page, "This Commission was established to provide a comprehensive and scholarly examination of the legal and ethical dilemmas in the delivery of health care posed by modern advances in science and medicine." There is no scholarly and comprehensive examination or report that has been provided to this Legislature.

The only thing that's been provided is legislation that would change the status quo in New Jersey without knowing how well the status quo is working. All we've had are a few cases, and even the cases that we've had have provided protections for patients. And I'll get into that shortly.

Paragraph 6f of the enabling statute says, "Accompanying the reports, the Commission shall submit proposed legislation," but there are no reports accompanying this legislation. That is what they were mandated to do first, and that's what we failed to do, and there's been quite a bit of money spent by this Commission. I'm a member of it, and I can see that the money that was allotted to them has not been spent for that which they were organized to do.

One of the reasons I'm against this legislation -- one of the main reasons -- is because it's dangerous. The major protection that is granted by a living will is not to the patient, but to the doctors, the professionals, and the institutions. Complete immunity is granted to doctors and institutions from civil, criminal, and professional liability. No profession, including that of a lawyer, or a plumber, or a carpenter, is granted such sweeping and complete immunity.

Recently, I finished a building project myself on a commercial building, and if the carpenter doesn't do what he's supposed to do, he shall be liable. If the plumber doesn't do what he's supposed to do, he'll be liable. However, this legislation gives certain professions complete immunity, and all they have to do is follow good-faith efforts, which to me sounds like a healthy "check list." I wouldn't want a plumber or carpenter who used good-faith efforts who did what they had to do on my building. They also have to abide by the best medical standards, which are accepted medical standards. They also, in this legislation, talk about powers of attorney as to override the existing power of attorney law, and to incorporate the law that is being proposed here.

The present power of attorney law grants rights to people to appoint someone to handle their financial matters when they are no longer capable of doing it. And in one of the leading cases, the Hilda Peter case, she used the power of attorney, and so did her friend at the time use the power of attorney statute that is presently on the books, to allow the other person to make medical decisions. The difference between that right and that which was upheld by Justice Garibaldi in the Hilda Peter case was they said that they did respect the power of attorney to make medical decisions. The only reason that went to court is because the woman, Hilda Peter, did not grant the power to remove food and water, and that's the only reason it went to court.

But the court did respect the existing law that we have on the books for the power of attorney law. So, what is the need for this particular legislation? It's merely not to protect the patient and give them rights to make decisions, but to give complete immunity to medical professionals. I don't see why they need it, if they are doing everything right. There is no reason to have sweeping, complete immunity for any profession. There are

good and bad in every profession, and the public and the people paying for their medical treatment should have the benefits of knowing that that professional is working to their highest capacity. Even people who are given power of immunity in financial matters are not giving away all their rights. There was a case where a woman who was 92 years old gave power of attorney to a gentleman who absconded with all of her life's savings. That man was criminally prosecuted, and charged with fraud and embezzlement, and we should do no less than that for people who are in charge of medical decisions.

However, how can we protect people after they are dead? It's one thing to lose all your life savings. It's another thing to lose your life.

The current power of attorney law that we have does not give sweeping immunities and, therefore, it's not necessary to have the legislation we have. We have something on the books already. Another reason why this legislation is dangerous, is because we have to consider the source of the legislation, and I don't mean Senator Ambrosio, and I don't mean all of the Commission. There are many, many fine people on the Commission. However, the Commission is also made up of 14 seats for the public. And various people in government, the Governor, Senators, the head Senator, Speaker of the Assembly, had certain people to appoint, and I'm sure in good faith they appointed people they thought were knowledgeable. However, out of the first 14 seats on this Commission, nine of those 14 people were also members of the New Jersey Citizens Committee. The New Jersey Citizens Committee has been heavily funded by the Prudential Foundation, the very insurance company that should be paying for the medical treatment of people in nursing homes.

SENATOR O'CONNOR: I did not watch the clock closely. You've now passed your 10 minutes. Can you sum up for us, please?

MS. PERONE: Basically, certainly these people, even before they were on the Commission, have traversed the country, preaching pro death mentality. This mentality is not to protect patients' rights to make medical decisions. We have common law rights now for families to make decisions with doctors. We have existing power of attorney where people can make decisions. There is no reason why we have to put something on the books. It's not protecting the patients. It's protecting the professionals and the institutions, and also it's going to give a great benefit to the insurance people who are backing this movement, not only in New Jersey, but across the country. The Prudential Foundation has put in hundreds of thousands of dollars through the AARP, through the Hastings Institute in Oregon and Arizona.

The other final point, all the states that have living wills, the concern for dying people, Hemlock people, are now pushing aid in dying or lethal will injections, pills on demand. They have funded conferences in Boston and come out with statements by doctors that they've chosen -- they've made for the conferences. And these doctors, nine out of the ten, are the same ones that met five years ago who said food and water were medical treatment.

Now, it's ethical for doctors to provide aid in dying for people that are terminally ill. My concern is, most of the cases on the books, including one in New Jersey and New York, are patients that are not dying and not terminally ill. They are being diagnosed as being in a persistent vegetative state or irreversible coma. I have an article in which a woman whose daughters went to New York-- The court gave permission to have all the tubes removed. The woman, after four-and-a-half months of this coma, woke up before they could remove the food and water. There are mistakes being made, and there will be many more

mistakes. I'm afraid we're going to have a holocaust in our State, if we do not keep this legislation out.

We've done well for hundreds of years without it. We don't need it now. I have my testimony at length in written form, which I'll provide you, in addition to the article from The New York Times about Carey Kunz, who was defined as being in an irreversible vegetative state, who is now talking and doing well enough for a woman of her age.

SENATOR O'CONNOR: Thank you very much. Questions?

SENATOR AMBROSIO: I suspect we're going to hear similar testimony on the question of the Bioethics Commission. I want to make it clear, this bill is my bill. We're not here to review the work of the Bioethics Commission, and whether it followed the-- It is not before this Committee.

What's before this Committee is the bill that I introduced. Secondly, I want to ask you two questions: You oppose living wills as a matter of principle, do you not?

MS. PERONE: I oppose them because the Euthanasia Society-- I oppose them because of the source, and the source is the Euthanasia Society. We've had them coming into New Jersey trying to educate the people. There are people on the Board of the Euthanasia Society, John Hannis, who sat at a conference table with you and bashed various governmental leaders. These are board members of the Euthanasia Council for 15 years. They are trying to come into New Jersey and force down the public's throat, and the throats of our legislators, who are elected to represent the people, their bill of goods. And we don't need their bill of goods. We need to have the common law rights, the constitutional rights to life of our people in New Jersey protected, and not wiped away by people who have a different philosophical--

SENATOR AMBROSIO: I assume that is a yes?

MS. PERONE: Yes, you may assume that means yes.

SENATOR AMBROSIO: My next question is: If you had to have one of these two bills, S-3320 or S-2067, which one, in your judgment, is less objectionable to your principle?

MS. PERONE: One of the things I object to in both bills-- If I wanted to protect myself and said I wanted full treatment, if I signed anything under these bills, and if they were passed, then I'd be signing a statement saying I want full treatment. I want food and water and antibiotics; I want insulin. If I say that, then I'm giving complete immunity to doctors, nurses, and professional institutions to do whatever they want -- if I sign a living will.

SENATOR AMBROSIO: Which bill is less objectionable to you?

MS. PERONE: I cannot sign a living will. However, your bill puts there will be no presumption that a person who doesn't want-- I'm in a Catch-22. Your bill will take care of me if I don't sign one, and your bill will take care of me if I do. If I do not, I lose my rights. If I do, I'm giving immunity to doctors, nurses, and professional institutions, which I don't want to do. I'm in a Catch-22. I find your bill replete with areas that would take away tremendous protection from the citizens of New Jersey.

Now, Senator Ambrosio's bill is less objectionable. Yours is more objectionable. The other bill is looser in language, because the euthanasians have now promoted amendments to all living wills. They've gone in seven states for lethal will injections, and terms for people. Both of them are dangerous.

SENATOR O'CONNOR: Any other questions? (no response)

Mr. Paul Langevin, Health Facilities and Evaluation Licensing from the New Jersey Department of Health. Good morning.

ASST. COMM. P A U L R. L A N G E V I N, JR.: Good morning, Mr. Chairman. I'd like to thank you for the opportunity to appear before the Committee today, and address Senate Bill 3320, and I'd also like to address S-2659. I believe you have already gotten copies of my testimony, which, hopefully will be very brief.

I'm here to express the Department of Health's support of S-3320 and the principles upon which it is based. The Department has always held the position that competent adults have the right to make their own decisions regarding the course of their health care, and I know someone looking at the bill might argue with that.

Historically, the decision-making process has taken place at the patient's bedside and decisions have been arrived at after careful deliberation by the patient, the family, and the patient care team. Advances in modern medicine have presented new alternatives to patients when they consider the course of their treatment. Unfortunately, medicine's ability to prolong life through new technological developments has raised questions concerning the appropriateness of this treatment for all patients. We at the Department of Health believe that the patient should continue to retain control over the decision-making process, and that any policy which furthers that end is laudable.

The bill under consideration today outlines a reasonable and well-developed procedure which any person can employ to ensure that their wishes concerning their health care are known and accessible. For the first time, all of the elements which should be considered when making a treatment decision are contained in a single document which clearly delineates the responsibilities of the patient, their family, the health professionals caring for

the patient, and the health care institution in which the patient is receiving care. The extent to which the bill addresses the role of each party in the decision-making process speaks to the exhaustive deliberation which went into drafting the document.

The procedures established by the bill are notable for the following reasons: They establish a clear record of the patient's wishes regarding medical treatment and require health professionals and institutions to make affirmative efforts to ascertain the patient's wishes before decision making takes place.

The procedures are simple enough that any person can execute an advanced directive with relative ease, and at little or no expense.

They identify the circumstances under which life-sustaining procedures may be withdrawn or withheld, and they always protect the patient when there is uncertainty about the patient's wishes by requiring treatment in the absence of clear directions.

They encourage health care professionals to seek to determine the patient's wishes and, once determined, to carry out those wishes. The offer of immunity to persons acting in good faith to carry out the terms of an advanced directive will encourage providers to help patient's achieve their wishes.

They require health care facilities to consider these complex issues in advance, to develop institutional policies regarding the withholding or withdrawing of treatment, and to make those policies known to patients prior to admission.

They establish institutional and/or regional review bodies to assist health care providers and health care representatives in reaching a decision which is commensurate with the patient's wishes.

They ensure access to health care institutions where a patient's wishes regarding withholding and withdrawing of life-sustaining treatment will be honored by requiring all institutions with the exception of private, religiously affiliated entities to honor a patient's wishes.

They require that the entire decision-making process be well-documented and available for review by those concerned with, and responsible for, the patient. This approach is the best safeguard against inappropriate care, or lack of care, as a result of a secretive, ill-defined decision-making process.

For the reasons which I have listed above and because I believe that this bill represents an excellent foundation for health care decision making, one that is sorely needed, I would again offer the full support of the Department of Health for this bill.

And briefly, I would also like to say that the Department is in support of S-2659. We have worked with the Bioethics Commission during the discussion of the issue of declaration of death, and we recognize that this bill does contain some compromises. But we believe it represents a process which can be effected expeditiously and will serve the citizens of the State. I'm available for questions.

SENATOR O'CONNOR: Are there any question? (no response) No questions. Thank you very much.

Dr. Ira Kusoff? (no response) Mr. James N. Perry, New Jersey Advocates for the Disabled.

W A L T E R R O B O K O F F: My name is Walter Robokoff. I've been asked to stand in on their behalf -- the New Jersey Advocates for the Disabled.

I am with the Fort Lee Gospel Church in Fort Lee, New Jersey. As a member of the New Jersey Advocates for the Disabled, I would like to express the deep concern of the members of our organization about the Bill, S-2659.

We believe that the bill, if it were to become law, could result in people being declared dead-- There are many dangerous aspects to this bill. However, I will confine my remarks to the part which requires doctors to use "currently accepted medical standards." The word, "currently," is particularly dangerous. It is a fact that in the last 20 years, the 20 years in which doctors have been declaring death based on the patient's brain condition, the doctors have grown more and more lax. Twenty years ago when the Harvard criteria were first announced, a 24-hour waiting period was required before pronouncing irreversible coma.

The most important study of brain death was done by the National Institute of Health. It determined that at least seven hours were needed to do the required testing. The collaborative study, as it was called, requested six hours or twelve hours, or when drugs were involved, at least 48 hours. Some doctors have currently become increasingly lax about extremely important confirming EEG and blood flow tests, or if they do them, they often are done in a sloppy manner. They risk the patient's life by discussing shorter and shorter time periods.

In Ohio, a 33-year-old welfare mother was declared brain dead 18 minutes after arriving in the emergency room. She tested positive for drugs. In New Jersey, a 20-year-old man was declared brain dead 25 minutes after arrival in the hospital. In South Carolina, a 16-year-old girl was declared brain dead in less than two hours. Yet, in the case of the Ohio woman who was declared dead in 18 minutes, drugs were found and doctors simply disregarded it; drugs, of course, which could give the appearance of brain death.

The neurologist said -- Dr. Mollinari, who was director of the study done by the National Institute of Health -- even one sleeping pill in conjunction with head

trauma can cause symptoms that are similar to brain death. Even before the test results came back from the laboratory, the transplant team arrived and they were giving the woman large amounts of water. Too much water to the brain causes trauma. It can cause great damage. However, water is very helpful in preserving kidneys for transplantation. Apparently, the testing done on this woman was just a pretense, because they were treating her as a donor, and not as a patient whom they were trying to save. They also flashed a light into her eyes to see if her pupils would contract. With trauma close to the eyes, the patient often does not react to light.

An Ohio lawyer commented about this case, saying, "If the woman had been the Mayor of Toledo, and not a welfare mother, I don't think she would have been declared brain dead in 18 minutes." There were other deficiencies in this Ohio case. However, I'd like to point out another example which occurred in California. An unidentified Hispanic young man was found unconscious in the street. He was taken to a medical center in Newport Beach. The following day, his beating heart was removed and given to a 58-year-old doctor who had formerly been a staff member of the hospital. The transplant was done six hours after the young man was pronounced brain dead, and he was pronounced brain dead despite the fact that drugs and alcohol were found in the system.

The day after the transplant, his family came to the hospital, after going to the police department. They identified his body as Elano Julio Ramirez, a 19-year-old immigrant busboy. It requires accepted medical standards. Apparently, these are not good enough to declare death, because some patients who are being declared dead are miraculously-- Just a comment here: I remember on a recent program that I was just watching, somebody had commented about a police officer in Minnesota who had been declared brain dead, recovered from the coma, and later

said he was able to hear and remember everything that was said near him in the room.

In such a serious matter involving the life and death of a patient, doctors should not be permitted to use accepted medical standards, because they are too often low and vague. Doctors should be using scientifically valid standards. If the doctors can't come up with truly valid standards, they shouldn't be pronouncing people dead because of the brain's apparent condition. This serious matter of the doctors' standards for death should not be shunted over to the Department of Health or the Board of Medical Examiners. The State of New Jersey has spent millions of dollars on the State Bioethics Commission, which was instrumental in producing Bill S-2659. After hearing all the expert testimony, the Commission was not able to devise the safeguards in this bill which will protect living people from being declared dead; truly, a self-fulfilling pronouncement. The deficiencies in this bill should not be glossed over. The safeguards to New Jersey's public should be written into the bill. If the Commission could not come up with adequate protections in the many months that they studied this issue, how can we expect the Department of Health and Board of Medical Examiners to do that? That concludes their comments.

I want to make a comment or two of my own. Let me know when my 10 minutes are up. I am very concerned with the definition of brain death that is being used currently in society, because brain death is not death. There are 30 criteria that are used, and none of them have to do with the actual decomposition of the brain itself. They have to do with, in fact, the cessation of the brain's functions. Sometimes, as in the case of the police officer I just referred to, people are brain dead because their brain does not appear to be functioning. They appear to be in a coma or vegetative state. They are in a coma, but they have other functions that are operative.

As much of the testimony has brought forth, people by the hundreds have come out of these cases, and said, "Yes, they, in fact, had heard what was going on." Just recently in upstate New York, one family had asked for the right to allow, I believe it was a mother, to be withheld food and water so she might pass from her coma into death. Shortly after they had stopped her food and water, the woman recovered, and the judge had to order the family to begin feeding her again.

I want to give you a little story of something that happened in California to a man who was declared brain dead because he had been shot in an apparent robbery attempt. And I will read it to you: "Michael Odette captured national attention during week after week" -- that's the wrong section.

Well, I will tell you what it is, so I don't waste any more time. The case which I'm referring to, and I do have it documented, is a case in which a man who was arrested for trying to break into a home was later shot. He was shot in the head. He was brought to a hospital, and though he was breathing and his heart was beating, he was declared brain dead. They were later able to transplant his heart into another patient who went on to live as a result of this very gracious donation. Some people saw irony. Well, he was a robber. He broke into a house. The important fact to remember, however, is that this man was never convicted of the crime. He didn't have a chance to go to trial, based on the fact that he was considered more of a lowlife of society. A judgment was rapidly passed because his brain had ceased measurable function in the exterior realms. It could not evaluate all the other functions of the brain that were going on. Only the person is aware of that. That's why we need a state of decomposition to identify brain death, and not cessation of function. Thank you. I appreciate it.

SENATOR O'CONNOR: Any questions? (no response) Thank you very much.

New Jersey Medical Society (no response)

Ritamarie Rondum, American Association of Retired Citizens.

RITAMARIE G. RONDUM: Good morning, gentlemen. I wish I could add, "and gentlewomen," but I cannot.

I'm going to read the testimony from AARP, and I hope that you'll be gracious and understanding that I prefer to read it. My name is Ritamarie Rondum, and as a member of the American Association of Retired Persons, I'm pleased to have this opportunity to testify on behalf of our New Jersey membership, I wish to thank you for this chance to state the Association's views on the New Jersey Advanced Directives for the Health Care Act.

Let me say at the outset that the Association commends the New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care for their work towards the enactment of legislation that would assure adults the right to control their medical treatment, in the event that they lack the capacity to make health care decisions. The Association recognizes the need to clarify the rights and protections of patients and providers, when faced with medical treatment decisions regarding life-sustaining procedures.

AARP is especially concerned about this issue because it is frequently the elderly who lose their decision-making capacity. The Association cites three major reasons for states to confront this difficult issue:

First, patients, families, and health care providers are increasingly confronted with treatment dilemmas as a result of modern advances in science and medicine. People are living longer thanks to highly technical life support systems. As a result, we are often forced to make quality-of-life decisions. It's critical

that this State offer some guidance in the area to its residents and to its health care providers.

Second, as we all know, the threat of malpractice is of major concern to both health care professionals and administration. If we expect providers to honor patients' previously expressed wishes when their decision-making capacity has been lost, then we must offer providers that act in good faith protection from both civil and criminal liability. Finally, decisions regarding life-sustaining treatment are often made in reference to the elderly.

By the year 2000, it's estimated that the elderly will comprise 13% of our population. As our elderly population grows, health care providers will increasingly be confronted with critical decisions regarding life-sustaining therapies. It's critical that elderly citizens maintain the right to make voluntary, informed choices about their health care, and that appropriate safeguards exist concerning the termination of life-sustaining treatment for those older persons who are unable to actively participate in their medical treatment choices.

The Association believes that the recommendations proposed by the Commission would be beneficial to New Jersey residents. Some of the recommendations that we see as being especially important include the following: Competent adults could provide instructions and directions regarding their wishes for health care -- a living will or instructive directive, designated health care representative -- in the event that they lack the proxy directive, or designate a proxy and write a living will.

Many people, primarily older persons, do not have anyone to appoint as a health care representative. This legislation would help ensure that those persons are

accorded the same right to have their medical treatment decisions honored. The attending physicians would determine whether a patient lacked decision-making capacity. This determination, however, would have to be confirmed by one or more physicians, unless the lack of decision-making capacity was clearly apparent to both the attending physician and the health care representative.

In addition, if the patient lacks the ability to make informed health care choices due to mental impairment or developmental disability, this determination would have to be confirmed by a physician who has specialized training in diagnosing psychological conditions or developmental disabilities. We believe that these significant provisions will provide patients greater protection from abuse. We applaud the Commission for including them in the legislation.

Finally, competent adults could choose to have artificially provided fluids and nutrition withheld or withdrawn under certain conditions, providing it is explicitly stated in the advanced directive. This provision is significant. In a March 1986 statement, the American Medical Association stated that it is not unethical to halt feeding for patients in irreversible coma. In 1988, the American Academy of Neurology said consistently, "Comatose means lacking the capacity to feel pain and suffering, and artificial feeding provides no benefit." By including these provisions in its legislation, New Jersey recognizes the right of its citizens to control decisions about their own health care.

In general, AARP supports the New Jersey Advance Directives for Health Care Act. We do, however, offer the following recommendations to increase the protection of New Jersey residents: We recommend imposing tighter restrictions on persons who witness the patient's signature on the proxy. We recommend that witnesses not be

a relative, be entitled to a portion of the patient's estate, be the attending physician, or be financially responsible for the patient. These restrictions would reduce the potential for patient abuse.

Also, this bill would require health care professionals in institutions to inform and educate interested patients and their families about advance directives. Although this is a laudable goal, patients and their families would be learning about these crucial documents upon admission to a hospital or nursing facility. This is a time when patients may be quite ill, and particularly vulnerable; patients' families may be emotionally exhausted, as well, and unable to comprehend the significance of these directives.

We would recommend instead that the Department of Health conduct a large-scale educational campaign throughout the State to inform residents about advance directives. Proxy forms and instructive directives should be largely distributed throughout New Jersey. This would give people the opportunity to inquire about, and possibly execute, an advance directive before they are admitted to a health care facility.

In conclusion, we commend the Commission on Legal and Ethical Problems on the Delivery of Health Care for its efforts to ensure that competent adults control decisions about their medical treatment. The provisions in this legislation would facilitate and encourage a sound decision-making process in which patients' health care representatives, families, and health care professionals are active participants.

This legislation, along with our recommendations for improvement, would go a long way in protecting the residents of New Jersey. Thank you.

SENATOR O'CONNOR: Thank you. Would you care to submit your written testimony to us?

MS. RONDUM: Yes, I will.

SENATOR O'CONNOR: Next witness is Theresa Gleason of the Nurses for Ethical Care.

T H E R E S A G L E A S O N: Good morning. Before I read the statement, I would like to ask your indulgence, if I may read to you the Florence Nightingale pledge, and I would like to submit the question to you, which line would you delete from this pledge which many nurses have taken at the time of their studies: "I solemnly pledge myself before God and in the presence of this assembly to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievousand will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping, and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavor to aid the physician in his work, and devote myself to the welfare of those committed to my care."

The statement I would like to read is: As a nurse interested in the ethical tradition of my profession, I have come to oppose bill S-2659. Before giving my reasons for opposing the bill, I need to provide you with certain information. What does a patient look like who has been declared dead, based on the condition of his brain? The patient's heart is still beating. His blood pressure is recordable. He sweats. He urinates. He defecates. He perspires. His knee will jerk if it is tapped. To prevent bed sores, he is turned. To prevent pneumonia, the patient is turned or suctioned as needed. His color is normal. If pressure is applied to his skin, it blanches. His color returns when the pressure is removed. A normal color indicates the cir. 'atory and the respiratory systems are working. There is life. Despite all these signs of life, the patient has been declared, "dead."

What methods were used by the doctor to reach that conclusion? And are the doctor's methods reliable? Most people believe that advanced medical technology is used when the patients are declared brain dead. That is not true. In the United States, the vast majority of doctors use clinical tests. These are bedside tests.

Death of the patient can be based solely on the following tests: Ice water in the patient's ear to see if his eyes flutter; cotton touched to the eye, the cornea, to see if there's a blinking reflex; light shone in his eyes to see if the pupils will contract and accommodate, indicating central nervous system; twisting the patient's head to observe eye movements; placing a tube down his throat to produce gagging; disconnecting the ventilator to see if the patient breathes on her own, perhaps 10 to 15 minutes. Sometimes doctors may add an EEG -- electroencephalogram; non-invasive blood flow tests -- tests for blood flow; or other confirmatory tests. What has to be remembered about all these tests, however, is that they are not scientifically valid.

Dr. Alan Schumann who has written brilliantly on this subject, makes that clear in his article, "Caution in the Definition and Diagnosis of Infant Brain Death." Besides the tests just mentioned, there are two other methods which doctors use in declaring brain death: three vessel angiography. It is rarely done in the United States. It is dangerous, and can cause brain death. An x-ray is taken of the brain after injections of opaque material, in order to show blood circulation. The second method in the rostral-caudal of symptoms. This is rarely a cause of brain death. It happens when the brain swells and crushes itself in a downward direction. The conclusion of all this is: Brain death is being declared by doctors by using scientifically non-valid methods. Perhaps the inadequacy of the methods used by the doctors can best be

shown by considering some recent studies. In 1985, a study was done of organ donors who were in the operating room having their organs removed. It was found that as soon as the scalpel cut into the body, in 85% of the cases, the blood pressure and the heart beat rose dramatically. Theoretically, this should not have happened. The patient supposedly of brain stem deaths-- Brain stems control blood pressure and rate of the heart beat, not the heart beat itself. If the brain stems were dead, how could the pressure and the heartbeat rise so quickly, or at all?

In a 1980 study, five patients who were supposedly brain dead had normal blood pressure without the help of drugs. These two studies, and other recent studies, indicate that patients declared brain dead may not be quite as dead as they are supposed to be. Our concern about bill S-2659, is that since it provides doctors -- excuse me, it will provide that doctors will be free of all liability. And since it does not require scientifically valid methods, it will result in the killing of some comatose patients. Please do not release bill 2659 from Committee. Thank you very much.

SENATOR O'CONNOR: Senator Zane.

SENATOR ZANE: If I just might-- You outlined some tests that are done. You mentioned the ice water, the cotton, and attempting to induce gagging. Are there other tests that are done more scientific than that?

MS. GLEASON: I'm not really equipped to answer questions, because I'm very intimidated by this scene. There are studies-- I have had a personal experience of one case where I did see the doctor-- I was present at the bedside of a patient whose feeding tube was requested to be removed by the family. I saw the doctor do tests at the bedside, and one particular test that he did do was a pain reflex test. And that could be considered in this case an answer to your question. However, the way that it was

administered, Mr. Zane, was that he was testing pain on the side on which he was paralyzed. And he not only did that, but he also -- it would seem to me-- I don't want to accuse this doctor of not thinking clearly in the situation, because I believe he was under a lot of tension and pressure, but he did the test about five times; each time, even though she was paralyzed, putting pressure with his thumb upon her, above her eyebrow, around that area. She responded each time with a deep moan, which, to me could signify pain response, and once wasn't enough. But he had to do it two times, three times, four times, and fifth time. This lady had been under my care for approximately five years. And there's an emotional trauma just seeing that happen to another person, let alone seeing the individual response of that woman who, in the course of this particular situation made no sounds while she was lying there in the bed in a coma. The end result: There were mixed motives for the request of this withdrawal of the feeding tube.

SENATOR ZANE: What I'm asking, are there advanced technological pieces of equipment that are used to make this determination as to whether or not a person is brain dead or not?

MS. GLEASON: There are a couple of other tests, but I don't have the names of them. I will -- did read about them. There are risks. The risks involve using dyes which could cause renal failure. There are other tests that are out there.

SENATOR ZANE: Thank you.

SENATOR AMBROSIO: Senator Zane, I might submit that Dr. Belsh has given us some testimony on rather extensive review of the methods and tests that are used and are available, and they are applicable. If you haven't gotten a copy of his testimony on that, I'll make sure you get it.

SENATOR O'CONNOR: Senator Laskin?

SENATOR LASKIN: You say this woman-- I'm going to ask you about your specific case. I recognize you're a little bit nervous. This woman who was under your care for five years, was she in the hospital for five years?

MS. GLEASON: It was about 1982. This was a nursing home situation. She had been in a hospital and transferred to us after--

SENATOR LASKIN: In the five years, what was wrong with her?

MS. GLEASON: She was in a coma, and she still lives today.

SENATOR LASKIN: The problem I have, and I say this to all the witnesses, and I don't mean this to make anybody intimidated, because I recognize it's difficult to be a witness-- Just like in a courtroom, it's difficult for somebody to be out there. But, see, when somebody says to me that this woman, or man, whatever it was, is in a coma for five years, but is alive-- See, I have a difficult time with understanding the definition of "alive," to be very honest with you.

That's why, when the AARP testified I was so thrilled because it was the best testimony I've heard thus far, because it was the first witness who testified from the heart, not from some technical medical definition of what brain dead means and test means.

The woman said, "quality of life," to me. Five years in a coma to me is not alive, even though technically the person's brain functions, and they breathe. I just want everybody to understand that at least as far as I am concerned, as just one person on this Committee, I've been listening to these technical arguments ever since we had this bill. I'm concerned. My personal feeling is, I get dozens and dozens and doz... of telephone calls and letters

from elderly people, and they visit me, and they cry, and they say, "I don't want to be alive in that manner."

So, quality of life is a very important issue to me. I want you all to understand that. Five years in that coma-- They may be technically alive, but I don't think they are alive. I want you to understand that.

MS. GLEASON: May I respond to your statement, sir?

SENATOR LASKIN: Yes.

MS. GLEASON: Quality of life varies in so many ways from person to person. Each person, if you ask in here, would have a different definition. I would grant you, or I would imagine, quality of life. Sanctity of life, as you probably have heard, has a different definition--

SENATOR LASKIN: I understand that.

MS. GLEASON: --that would be equal for all. And I'm speaking from the heart. At the bedside of any patient, but in particular this one lady, who is one of many people I am taking care of while they are in a non-verbally responsive state.

SENATOR LASKIN: I understand your position, and I respect it. And I respect all of those who are concerned about sanctity of life, just as well as quality of life. It's a tough issue. I'm a little more concerned, I think, with the quality definition.

MS. GLEASON: If I may finish my response to you, sir. If the personality of the person does not end until the person stops breathing, let's say, or in the culmination of circulatory processes-- The personality of the person, your personality, my personality every day deepens because of experience, whether it's subjective or objective. Therefore, because a person is not verbally responding to you, does not mean there's no life there.

The person-- I don't think you believe me, but I think you're "yesing" me.

SENATOR LASKIN: I do believe you, and I say I respect all these positions. I do not argue with your conscience and your philosophy. I don't. And I respect your position as well as everybody else's who testifies. It's a tough issue. The only point I made was, when you tell me somebody is in a coma for five years, that, to me, is a quality of life issue, not a sanctity of life issue. I respect what you're saying.

MS. GLEASON: Then may I put this question to you: Would you pull her feeding tube, sir?

SENATOR LASKIN: I don't know what I would do.

MS. GLEASON: That's the implication of your "quality of life."

SENATOR LASKIN: I don't know what I would do, but the bill doesn't give me that right. The bill gives us safeguards as to who can do that, family members in consultation with doctors, and everybody else. No, no, I don't know if I would do that.

MS. GLEASON: It isn't, sir, when I'm faced with the problem.

SENATOR O'CONNOR: Excuse me, I thank you for focusing our attention on that issue. We are going to have to move on. Thank you very much.

Rabbi Blech.

RABBI SHMUEL BLECH: Mr. Chairman and members of the Committee: My name is Rabbi Shmuel Blech. I am a clergyman from the central section of our State, and serve as a chaplain in a 240-bed nursing facility. I'm also a Professor of Biblical Law and Bioethics, a Governor appointee, of which I am a member of the Executive Committee, and Chair the Task Force on Protecting.

Thank you for the opportunity to testify before you on behalf of the legislative initiatives being studied today. S-2639, the New Jersey Declaration of Death Act, as you know, is the result of well over two years of intensive

deliberation and debate. It has been, no doubt, pondered as any other important legislation might be, but it is, nevertheless, the product of sincere effort on the part of a dedicated group of men and women, of which I am proud to be numbered. It is particularly significant in New Jersey that we in New Jersey were wise in allowing ourselves to wait, under great pressure, until the dust had settled. This allowed us to observe the many other states where similar legislation had already been enacted, and benefit from the collective experience which that engendered. The temptation to quickly follow suit, to fill a void, especially in light of the State's role as a pacesetter for the entire nation was enormous. It did allow that an extremely diverse group of people were able to carve out, and stand out as a model of sensitivity and concern, again, establishing a precedent to be emulated by others, as to substance.

The personal or religious exemption, section 5, page 14, which not only allows for the acceptance of new criteria in the pronouncement of death, but continues to recognize the traditional, is probably the element which invites the most attention. I would like to share some of my thinking on these very important issues, since your Committee is the appropriate forum for analysis.

Ideological concerns from a segment, and I'm confident it is a small segment, which continue the acceptance of traditional criteria perpetrating an archaic concept, must be best viewed as cavalier and shallow in its depth. Health care providers, as well, are, and always should be, opened to considerably more than the narrow confines of their own disciplines. They, as professionals in other fields as well, cannot claim infallibility and possess the same shortcomings common to all of us. This dictates that we must move gradually in reshaping the historical data given to us by several thousands of years of civilization. The practice of medicine has breathtaking highs, tempered, if not diminished, by dismal and often

fatal failures, much like a jagged mountain peak, and separated by deep valleys. In-between, we on the Commission were mindful of the need to recognize this truth, and seek to earn the trust and confidence of our citizens by allowing for free expression of personal preferences, rather than dictates.

The additional concerns of those involved in transplant work that maintaining traditional criteria might undermine the acceptance of neurological criteria in the definition of death is, in my opinion, also unfounded; quite the opposite. Insisting on the dramatic departure from deeply held principles which expand must, by its very form, that distrust, allowing for gradual awareness through intolerance for diversity, contributes to credibility and acceptance.

As to the further concern that our health care system cannot easily tolerate a two-track approach for the sake of uniformity, and imposes an undue stress upon the caregivers, the Bioethics Commission, which includes some of the most prestigious and knowledgeable health experts, direct medical centers, hospitals, long-term care facilities, themselves doctors and nurses, public health officials and others, unanimously agreed that this would not be a problem that would, or should, stand in the way of retaining the traditional format for the declaration of death. In addition, as disquieting as it must be, I must draw an inference, with your indulgence, from Roe v. Wade, the legal acceptance of abortion on demand, no matter which side of this. I have very strong personal and theological feelings about the question, which may present a picture in the obstetrics field of a struggle to deliver prematurely, while ironically dispatching another fetus, much in the same condition, in a second bed, and which the health care community has not viewed as inconsistent. This duality, it appears to me, is much more striking and emotionally

demanding of our health care providers, than waiting the relatively short time -- and I stress this -- seldom more than 24 to 48 hours, between neurological criteria and traditional standards, hardly unreasonable and burdensome on the system and its practitioners. I think that this has perhaps not been articulated clearly enough because of the lay confusion between brain death, which this bill addresses, and the so-called PVS -- permanent vegetative state -- which it does not.

As to S-3320, the advance directive bill being discussed today, I would like to submit the statement I included when we voted in the Commission on this bill, copies of which have been distributed to the members of the Committee, by Professor Noel Weissbard, to reflect my thinking and reservations as well. Specifically, though, I find the suggestion in earlier testimony that this proposed bill is too restrictive, distressing, and therefore, felt compelled to address this question. To insist on strict protocol and supporting evidence in life and death decisions does not speak too much to questioning the ability nor the integrity of the decision maker, as it speaks to our commitment to the value and irreversibility of human life. This would then mean that, despite its being cumbersome as a process, proper safeguards and testing must be employed. To diminish proper protocol as difficult or impractical is to be cynical about the seriousness of human life.

I must also, in good conscience, take note of what appeared to me, and particularly was accentuated in the discussion shortly before my testimony, to be the apparent fear and distrust I had noticed from groups representing senior citizens and handicapped who had testified before us. It has been assumed that the elderly and other vulnerable groups are anxiously awaiting legislation. I strongly recommend reaching out to these groups if, in fact, this truly affects their thinking, or

perhaps more accurately the thinking of younger and healthier people dreading that frailty. An amendment might impose-- What this might suggest is not abrogating a right of an individual who may have the constitutional right to refuse treatment, but at the same time not to permit the imposition of one's quality of life judgment on anyone else in the absence of the carefully crafted and updated advance directive.

The concern that many people may not take advantage of this newly legislated right, and therefore be subject to a denial of this privilege seems poorly thought out to me. Our democratic process encourages and fosters decisions. We inform, educate, create the incentives, but we do not dictate. That must ultimately be: One elects to vote, to avail themselves of social services, to take advantage of amnesty, to seek public office, and all the other rights that free and open society grants its citizenry. We do not insist, but rather invite participation, and to filter the information to the interested public. This gradual process may not pick everyone up immediately, as, in fact, no other right ever did, but rather allows for awareness which dispels distrust and ignorance.

I'm certain that there are many people who still cling to old-fashioned passbook savings plans, even though there are more glamorous savings instruments available. They still may not have the IRS credit them by substituted judgment with a better term. Gradual societal adjustment and acceptance has worked well in the past, in its many other settings, and would seem appropriate for advance directives as well.

Thank you once more for allowing me the privilege of sharing some thoughts with you. May your work

be divinely blessed, so that you may make the best decision for the citizens of the State of New Jersey.

SENATOR O'CONNOR: Thank you. The next witness is Pat Mahoney, President of the Medical Ethics Committee.

P A T M A H O N E Y: My name is Pat Mahoney. I thank you for allowing me to be here today.

I represent the Medical Ethics Division of the New Jersey Right-to-Life. I am a registered nurse, and I am here to testify against Bills 2067 and 3320. I have worked in a general hospital in northern New Jersey and have personally witnessed a 76-year-old female patient suffering from Alzheimer's disease, starve to death in September of last year. This was done because of an agreement between the patient, doctor, and her family, not to insert a feeding tube when the patient lost her ability to swallow.

The family felt the feeding tube would be painful to the patient. She had been without food and water for a period of three weeks, and she was in the final stages of starvation when I was assigned to her. She was awake, emaciated with edema of both feet and hands because of the fluids which takes place in-- It is not necessary to describe her condition here, as I'm sure you know what painful and prolonged dying is caused by starvation.

There was nothing written on the patient's chart that showed she was being starved, and the nurses on the floor did not know how to handle this, though they were very upset. On speaking to the Director of Nursing, she explained that the precedent had already been set for the withholding of food and water in our own State with the Conroy and Nancy Dobbs case. She stated that the doctor should have brought this case to the Medical Ethics Committee in the hospital where certain criteria had to be met before the Committee could decide whether it was proper to withhold food and water from that particular patient.

He had not done this. His reason: He did not expect her to take so long to die. The protections of the system that were built into withholding food and water did not work. I am sure that this is not unique to the hospital. And patients are not being protected in other hospitals and other situations.

I personally know a person who suffered an aneurysm in 1987. He was 39 years old. After surgery, he slipped into a coma in a southern New Jersey Hospital. For three months he lingered, and was transferred to Columbia Presbyterian Hospital in New York City. There his wife was told that he was brain dead and his tube feeding should be discontinued so he could, "Die with dignity." His wife refused to accept this declaration and removed him to a rehabilitation hospital in Connecticut. After five months, he came out of his coma and is now back to work, doing well. He told us that because he was young and in good condition prior to his coma, the doctor wanted to use his organs for transplants.

The system did nothing to protect him, and apparently their definition of brain dead was invalid. If it wasn't for his wife, he would not be here today, functioning at full capacity.

The living will is a horror in the beginning of active euthanasia. We had a female patient, aged 59, in July of 1988, who suffered a stroke. She had a living will. The nurses and doctors treated her differently than the other patients. They did not take her care too seriously, because their understanding of the living will was that, "She wanted to die." This was not the case. She was frightened of hospitals and afraid of the procedures. When she became ill with an upper urinary tract infection, she was very concerned and asked to be treated. She did go on to become rehabilitated.

And, finally, an 86-year-old man shot himself in the head in July of '88 and was also in a coma. Two weeks later, he was holding his own when his lawyer called and requested that I have the doctor remove the feeding tube, stating, "He shot himself. He wanted to die." We should respect his wishes and let him die. He, too, came out of his coma and went to live with his son. His problem: He didn't want to live alone any more.

As a nurse, I can say that the living will is a detriment to the nursing staff that places much stress on the nurses who were taught and have vowed to preserve life and restore the sick patient to maximum functioning. How can we now contribute to their dying? How can any patient put trust in a nurse or doctor who has no respect for life, and who will assist either in curing or in killing them, at their desire? I would not want these people taking care of me.

I urge you not to allow the passage of the living will. Thank you very much.

SENATOR O'CONNOR: Thank you. Are there questions? (no response)

Paul Armstrong.

PAUL W. ARMSTRONG, ESQ.: Good morning, Mr. Chairman, members of the Senate Judiciary Committee. I want to thank you at the outset for the opportunity to briefly address you, as you deliberate these three important bills. But, before I do that, Mr. Chairman, in preface, let me take this initial opportunity, as Vice Chairman of the Bioethics Commission, to place on the record some sentiments of Senator Ambrosio's fellow Commissioners at the Bioethics Commission.

We would like to publicly thank you, Gabe, not only for your sponsorship of the legislation before you as a Committee -- that goes without my saying -- but what is of more importance, has been, and is, your contributions to

the process of serious inquiry into the profound issues of bioethical ethics. Gabe has brought not only the skills of lawyer and legislator, but a practical wisdom and keen understanding of the legislative process.

Like the Senate, we, at the Commission, have been enriched, Gabe, by your membership and commitment. Yesterday, I spent some time in my file room in preparation for this morning's testimony, and what I found, and handed to John Tumulty and asked that he provide to each of you as members of the Committee, were two December and February of 1976 bills which were introduced in this body by then Senator Anne Martindell of Princeton, and the now Senate President, John Russo. This, of course, addressed for the first time the very issues that are before you, brain death and living wills, in the aftermath of the landmark case of Karen Ann Quinlan.

I also have discovered that I have been privileged to be before that Committee some 14 times since we argued the Quinlan case, as many of you know, in this very room, which was then, of course, the Supreme Court of the State of New Jersey.

I have been wisely counseled by Senator Ambrosio and Senator Laskin. I take your remarks to heart as well, that I could probably best serve your deliberations not by functioning as historian of past legislative efforts, but by sharing with you essentially two simple perspectives, born of the privilege of representing patients, families, physicians, and institutions before the Supreme Court of New Jersey.

As members of the Judiciary Committee, I know that you are especially conversant with the holdings in the cases of Karen Ann Quinlan, Claire Connell, Nancy Ellen Jobes, Hilda Peter, and Kathleen Farrell; therefore, I will t touch upon their important principles. What I think is of importance is that invariably the courts have

underscored, and I think this is what Senator Dorsey often likes to hear -- these sentiments opined from the Supreme Court-- They have invariably indeed underscored the supremacy of the legislative process in fashioning legislative responses to bioethical issues of living wills and brain death.

While the courts have, in part, recognized these concepts as you're well aware, they have repeatedly entreated the Legislature to provide a more comprehensive approach to these questions for the 7.6 million New Jerseyans that you serve as representatives. In 1985, appreciating the interrelationship among the Legislature, the Executive, and the courts, a number of us worked closely with the President of the Senate, the Speaker of the Assembly, and the Governor in order to create the Commission of Bioethics, which was designed to serve the Legislature in its efforts to draft legislation in keeping with the demands of the people of New Jersey, a three-year process, as our Chairman had pointed out.

Through our Executive Director, in open hearings it has been pointed out that objective analysis has yielded the bills that are now pending before you. We, as the Commission, are proud of our effort and will serve in that capacity.

The last perspective I share with you is that not only of a lawyer for patients, families, physicians, nurses, and institutions, but one who well knows the anguish and ordeal of those who have had to make sacredly private family decisions at the end of life on the front pages of our nation's newspapers. The simple lesson here is that case-by-case adjudication is a bad way to make public policy on these kinds of issues. Since Karen's trial, some 80 families nationwide have gone to the court to effect treatment decisions and, as you well know, 40 states and the District of Columbia have adopted statutes providing for living wills.

Before joining you this morning, I spoke to the families of Karen Ann Quinlan and Nancy Ellen Jobes, and they asked me to share with you a simple request. They asked that no more families have to endure the ordeal of a trial, of an appeal, and an argument before the New Jersey Supreme Court. They asked that you craft a legislative scheme which will obviate the necessity for recourse to the courts.

Historically, the patient, family, and physician have been the proper cooperators in making the necessarily difficult decisions at the end of life. These bills are in keeping with that history, with the ethos of medicine, are shared Judeo-Christian heritage, as has been pointed out, and are uniquely of these families, the legacy of their daughters, Karen Ann Quinlan and Nancy Ellen Jobes.

I thank you for the efforts you have shown. We at the Commission stand ready to answer, in writing or formally, any questions that you may have concerning these important bills. Thank you.

SENATOR O'CONNOR: Thank you, Mr. Armstrong. Any questions? (no response)

Jacqueline Galli of the American Association of Senior Citizens.

E D D A L E Y: She is not here today. I would like to read this for her, if I may. Good morning, the American Association of Senior Citizens is a national network in states throughout the country from Colorado to Vermont. This year, the Association in New Jersey sponsored, along with Seton Hall, a symposium on life and death issues. In March of 1988, the Association sent questionnaires to 406 hospitals and nursing homes. Seventy-one of the health care facilities responded to the survey. The results of the survey indicate overwhelming support for the following concepts:

Incidentally, I will provide your group with the results of the survey, rather than read them. But, the results were, first, that food and water, nutrition and hydration, are basic human needs, and not medical treatment.

Secondly, that patients should not be starved to death.

And, thirdly, health care facilities should not be required by law to starve and dehydrate patients to death.

The proposal on advance directives does not incorporate these concepts. Section 6b, lines 10 through 13, page 7, legalized euthanasia by starvation and dehydration: These sections allow patients to be denied basic human needs such as food and water. Moreover, the definition of "life-sustaining treatment," section 1, lines 20 to 24, page 4, does not exclude food and water as medical treatment.

Section 13a and b, lines 2 to 7, page 14 mandate non-religious affiliated health care facilities to participate in the starvation and dehydration to death. No facility should be forced to violate its moral principles. Those who responded to our survey unanimously support the right of health care facilities to choose their own policies.

In a recently completed study at Harvard Medical School, reported in "The Journal of the American Medical Association," it was found that many nursing home patients are being over-medicated. A similar study done 10 years ago showed the same problem. Dr. Mark Bearce, chief author of the study, stated that patients might be considered less functional than they actually are and more demented than they actually are.

The definition of "permanently unconscious" is too broad and too sweeping. Since patients are being over-medicated, the dangers exist that, number one,

impaired patients may be signing living wills without proper understanding of what they are consenting to.

Second, over medicated patients may refuse treatment without proper understanding.

Third, patients may be wrongly diagnosed incompetent or permanently unconscious.

Four, the danger also exists that overly drugged patients with living wills may have their will activated wrongly. In the light of information reported in New Jersey in the last month of abuse and negligence of senior citizens, Star-Ledger, November 23, 1988, November 27, 1988, and The Bergen Record on November 23, 1988, what is needed is protection for the elderly and the assurance of quality care, proper diagnosis, and sanitary, healthy, and humane conditions. This proposed legislation takes away protection and makes patients more vulnerable. It exempts everyone from liability, because they had so-called "good intentions." That's on lines 29 and 31, page 19, and section 14.

The members of the American Association of Senior Citizens are opposed to bill S-2659. It may endanger the lives of senior citizens and other citizens of New Jersey if it is enacted into law. The cost of medical care keeps rising. At the same time, the senior citizen population is increasing, while the population of employed taxpayers is decreasing. Medical care and Medicaid are one of the great expenses for the State and Federal government. When these facts are considered altogether, it is clear that government agencies have an interest in keeping down medical costs, and that measures have been taken to increase the cost negatively, which has an important impact on senior citizens. For this reason, we find the provision of S-2359, brain dead, in the hands of the Department of Health and the Board of Medical Examiners, to be dangerous.

The State of New Jersey could gain financially if medical costs for our senior citizens and others could be reduced by premature definition of death. It's frightening. The medical standards for death should not be left to the Department of Health and Board of Medical Examiners. Death is a permanent condition, not on the decisions of bureaucracies. Why does bill S-2659 not require that any standards set up by the Department of Health and the Board of Medical Examiners be based on scientifically valid evidence?

In a matter so important as the declaration of death of a patient, anything less than scientific validity and the medical standards that are used for brain death is unthinkable. Bill S-2659's failure to take a stand on that is made a thousand times worse by the provision in the bill to free doctors of criminal or civil liability or from discipline for unprofessional conduct, if they act in good faith. Carpenters, plumbers, dentists, and other professionals, if they do a good-faith effort-- The carpenter has to build safe stairs. He can't make a good-faith effort. If the car mechanic has, in this case, to repair your brakes, he can't make a good-faith effort. Why should a doctor be free to make a good-faith effort at declaring people dead, and then be free of every type of liability, including civil and criminal?

Again, I remind you, although S-2659 is dangerous, it is especially dangerous for senior citizens, in light of cost containment. Harold Sobalski was declared to have been brain dead for 10 weeks. It was decided to disconnect his life support. His family gathered around his bed to be there for his last moments. When the ventilator was disconnected, Mr. Sobalski's 2-year-old grandson called out from the doorway, "Hey, Grandpop." Grandpop sat up, and extended his arms to his grandson.

Just recently, Mr. Sobalski bought a new car and has been driving around Totowa.

Rabbi Blech, who has previously testified, has said that a law does not require doctors to use reliable methods to pronounce death. It is an informal law. New Jersey's a State known for its concern for the weak and vulnerable. We must retain those high standards, which provide laws for adequate protection for our weakest members. They must be built into the system of law, and not be left to bureaucracies.

Bill S-2659 does not provide such protection and should be rejected. Thank you.

SENATOR O'CONNOR: Thank you, Mr. Daley. The next scheduled witness is Sister Jane Francis.

UNIDENTIFIED SPEAKER FROM AUDIENCE: She asked that her support of both bills, including the previous, be conveyed to the Committee, and she regrets that a prior commitment made it impossible for her to be with you today.

SENATOR O'CONNOR: Patrick Hill, Citizens Committee on Bio-Medical Ethics.

T. PATRICK HILL: Mr. Chairman, members of the Senate Judiciary Committee, thank you very much for permitting this testimony. My name is T. Patrick Hill. I'm the Director of Public Information for the Citizens Committee on Bio-Medical Ethics. The Citizens Committee is a nonpartisan grass-roots movement in New Jersey which provides an educational forum for the general public to discuss medical ethics. Since April of 1986, the Citizens Committee has held over 300 community and professional meetings all over the State to allow the citizens of New Jersey to discuss a wide range of medical ethical issues, including living wills and the refusal of medical treatment.

At the same time, the Citizens Committee has been conducting statewide surveys of public opinion on

a number of critical medical ethical issues. The findings were released in a final report, copies of which have been given to the Committee, in July 1988. I am here today to represent, not the interests of the lobby, but the expression of a statistically valid sample of public opinion in New Jersey, on the issues contained in Senate Bill No. 3320, the New Jersey Advance Directives for Health Care Act. Specifically, my remarks will be addressed to the designation of a health care representative, content of a living will, and decisions to forego treatment. I would like to point out that there is a distinct corroboration between these survey findings and the substance of the New Jersey Supreme Court's decisions in the cases of Kathleen Farrell, Nancy Ellen Jobes, and Hilda Peter.

Specifically, this corroboration is evident in the following points: 1) The primacy of the individual's right to make treatment decisions at the end of life and the belief that incompetence does not compromise the exercise of this right; 2) The endorsement of the living will as a means to secure the execution of these decisions; 3) Responsibility for making medical decisions rests with patient, family, and physician; 4) Life expectancy is not to be, in the case of the terminally ill, a primary consideration.

Regarding the issue of whose responsibility it is to maintain and protect life, four broad conclusions emerged in our surveys. Respondents overwhelmingly feel that adults, regardless of age or physical disability, bear the primary responsibility for protecting and maintaining their own lives. Conversely, respondents feel that the immediate family bears the responsibility for children, or for adults suffering from any mental disability. The level of adult disability which triggers family responsibility can stem from a situation as severe as a coma, to one as relatively mild as severe depression. While respondents feel that, regardless of circumstances, neither doctors nor

society bear primary responsibility, doctors are far more likely than society as a whole to be seen as having some responsibility. These conclusions hold not only for the respondents as a group, but also, when the figures are looked at, for subgroups of respondents distinguishable by religious domination, age, or other variables. Regarding issues of treatment for disabled persons, the findings show that under an assumption of physical or mental incapacity, overwhelmingly people want decisions made for them by their immediate family, and not by society as a whole.

One-fourth of all respondents, and more than one-third of those over 60, say they have given someone a written power of attorney. Although more than half of the respondents said they had thought about a "living will," only about one in eight has written one. Of these, a quarter are 60 and over. Four out of five respondents say that there should be a law making living wills legal -- one in five actually say they should be required -- with only 3% expressly rejecting the concept, and the balance being unsure.

As to the content of a living will, respondents, who, by the way, understand that the doctor and/or hospital could not be held liable for malpractice in carrying out in good faith the directives of a living will, indicated the following preferences: 1) 82% would include instructions to withdraw heroic measures if there is brain death or a severe coma; 2) 68% would include instructions to withhold food and water if there is brain death or severe coma; 3) 68% would include instructions to alleviate excessive pain, even if the drugs used, such as morphine, may be addicting; 4) 70% would include instructions to force the doctor to release the patient from a hospital to go home, even if it means he may die sooner; 5) 71% would include instructions for the distribution of organs to

transplant recipients; 6) 59% would include instructions permitting use of new medications or therapies for research purposes. Regarding the issue of refusal of care, the survey indicates the following: 25% of all respondents say they should have the right to end their life, "whenever I wish." Thirteen point three percent feel they have no right to refuse even heroic measures and thus cannot end their lives under any circumstances.

The numbers vary somewhat among respondents who are members of a religious denomination, but even among Catholics only about one in six say, "I do not have the right to end my life under any circumstances," about the same proportion of Catholics who say they should be able to end their lives whenever they wish. Most respondents say that, in effect, the legitimacy of refusal of care depends on the circumstances.

Sixty-one point seven percent of respondents say a person should have the right to refuse treatment just because it will be too costly. This increases to 75.7% if the treatment will be too painful, and to 82.6% if refusal means the person will die earlier.

In light of these findings, in particular as they pertain to living wills and their content, the designation of health care representatives and decisions to forego life-sustaining treatment, the Citizens Committee supports the substance of Senate Bill No. 3320 as in keeping with the preferences of New Jersey citizens. There is one major concern. Our data indicates that New Jersey citizens do not define "medical care" as narrowly as Senate Bill No. 3320 would, in respect to artificially provided fluids and nutrition. Forty-eight percent say that artificially provided fluids and nutrition are part of medical care. In distinguishing as it does, e.g., 15a, artificially provided fluids and nutrition from other life-sustaining treatment, the bill seems counter, in both spirit and letter, to the understanding of the public,

without any apparent justification. We would urge that the distinction be dropped.

I would, therefore, repudiate an earlier gratuitous misrepresentation of the Citizens Committee as a group that is advocating euthanasia. That is not the case, and those who are making those allegations know it is not the case.

Finally, at this time, the Citizens Committee will not offer testimony on Senate Bill No. 2659 simply because the Committee has not had the opportunity to develop a clear sense of what the public thinks on this particular issue. Thank you very much.

SENATOR O'CONNOR: Any questions? (no response) Thank you.

Next witness is Veronica P. Hyatt. (no response) Richard Traynor.

R I C H A R D T R A Y N O R, E S Q.: Good morning, Mr. Chairman, members of the Committee. I appear as an attorney from Morristown, New Jersey, having been co-counsel for the Lincoln Park Nursing Home in the Nancy Ellen Jobes case, and as President of the New Jersey Right-to-Life currently.

I speak in opposition to the proposed legislation, and I'm speaking now of Senator Ambrosio's bill, 3320, as well as Senate Bill No. 2659. The proposed legislation is both dangerous and unnecessary. The ethical practice of medicine, society's traditional interest in the preservation of human life, the exercise of humane care toward the sick and the vulnerable, as well as the duty to exercise reasonable care toward one's own body, obviate the need for this legislation. The potential for human error inherent in any health care activity, indeed, all human activity, and the potential for pain and suffering in the state of illness or the dying process, are not sufficient reason to abandon objective ethical standards and to

experiment with a style of medical care or lack thereof which can only lead to tragedy.

The genesis of this legislation is as follows: One, the desire to exercise control over human fate. Two, the agenda of euthanasia proponents, who, in seeking right-to-die legislation give little recognition to revelation and traditional medical ethical practice. And three, the desire on the part of many to avoid pain and suffering, and, as it is styled, a low quality of life, a useless existence.

These advance directives and so-called living wills implementing the directives, and their serious consideration by this Senate Committee, are the result of radical changes in attitudes by some, perhaps many, in our society who no longer accept or apply objective moral standards in the matter of human conduct, in the face of sickness, pain and suffering, inconvenience and discomfort, and death. The Judeo-Christian ethic, bespeaking the inherent dignity and enviability of human life, and one's duty towards one's own body has been abandoned in the name of progressive law and compassion, and in irrational abeyances to individual autonomy, even when autonomy cannot be exercised because of incompetence. It is proposed that individuals be allowed to determine, in advance of illness or disability, the kind of medical treatment to be employed or withdrawn.

By definition, court decision or statutory -- and it's contained in this bill as well -- medical care includes the administering of food and water. It is proposed that individuals be allowed to order measures which will result in the premature termination of life, and what is worse, that doctors, family members, and others may terminate the lives of the vulnerable incompetent.

Compounding this insult to morality and settled tradition, the doctors are to be immune from civil or

criminal liability. When the doctors read that, they pinch themselves because the reaction is that they died and went to heaven, sent there by the unlikely cooperation of lawyers and judges and legislators. It is unprecedented to give this kind of immunity. No one can contract away tort liability, and the Legislature cannot give this kind of immunity, nor can the Supreme Court of our State. The great goal in contemporary society is to avoid, at all costs, pain and suffering, and inconvenience and suffering. Lingering illness and discomfort are all part of the human condition. Pain is to be avoided, but not at all costs. It is no fun to be sick or to watch a loved family member linger in illness, but the remedy for this unfortunate condition is not to violate the moral law.

For the Legislature of the State of New Jersey to succumb to the demands of a newly arrived consensus medical ethic, or untried consensus standards of morality, would be irresponsible, and inevitably tragic. You may attempt to legislate solutions to problems such as the problem of pain or coma, which have bedeviled mankind from the dawn of history, but you will not succeed, not if you listen to the little voices of pragmatic philosophers, utilitarian philosophers, who relish the idea that, at long last, the forces of religion have been rowdy, and man-made solutions to the solution of life and death, imposed upon society, accepting with grace the vagaries of disability and feeble old age, while employing ethical medicine as a remedy, contains a lot less risk than tinkering with moral imperatives.

Human society is not new. Human history is strewn with the recollection of novel and immoral panaceas to the -- applied to the problem of pain. The exercise of individual autonomy is not an adequate support for those proposed options for future health care. The notion of freedom of movement and independence of decision without

undue interference from the State or others in society are fundamental to a free society and necessary conditions of the expression of free will. Free will expression, reasonably exercised, is a human attribute to be protected and jealously guarded, but not at all costs. Like most things in life, there's a wrinkle. Freedom is not a license to do as you please. Individual autonomy does not confer the right to violate objective moral standards. Furthermore, a responsibility to help the afflicted and show compassion toward others, especially the severely disabled, does not give doctors or family members or others the right to terminate the lives of those who are not dead and not dying.

The Biblical proscription against killing innocent human life binds us all. No notion of a pluralistic society or individual freedom can cancel that proscription. Furthermore, the human need to express compassion by rendering care to the debilitated is impeded by the onrushing desire to eliminate the incompetent. High medical costs threaten older people. Sophisticated technology results in expanding the span of years by medical conquest of disease. Often debilitation, brought on by age, results in a loss of faculties, resulting in diminished, "quality of life." The notion of freedom is interposed: Why shouldn't the infirm be allowed to exercise their right to die? Why should the family have to watch a loved one suffer? Why not deprive the useless life, who can no longer enjoy life, of food and water until death overtakes life?

Because we are not our own creators and we cannot be our own destroyers. Nobody likes pain and suffering, inconvenience, and discomfort. They are the human condition. No amount of social engineering will change that fact. The problem of evil, the problem of pain, is a mystery and is inextricably bound up in life. Life is sacred in all its vulnerability and debility. No

painless exit rises to a sufficient good to overcome the emphatic statement of God's law, "Thou shalt not kill," when older or handicapped or debilitated persons are considered to be a burden to themselves or their families, or the cost becomes too high. The release from pain and suffering, inconvenience and discomfort, becomes mandatory. The aged are expected to cooperate right by signing living wills, directing withdrawal of "medical treatment," now interpreted by our courts as including food and water. A person starves and dies, and society is released of a burden, which is permissible if this becomes mandatory. Why is it wrong to permit a debilitated, elderly person to exercise his free right to determine such a thing as medical treatment, a time honored and universally respected freedom?

If an elderly, imminently dying person is ready to die and meet God, why should some doctor be allowed to intervene with modern technology and prolong life? In that fact pattern, there's no moral problem in letting natural death take its course. The key is "imminent." If a person is imminently dying, death should be allowed to take its course. The problem is non-dying; debilitating persons are seeking death, or incompetent people are exercising an autonomy. They cannot violate a law of God or nature without harming society. If society cooperates in harming itself, then society will pay the cruel price of loss of freedom. Why? Because a man-made decision to permit a course of conduct in direct violation of moral law inevitably results in denial of freedom to act against the new norm. If the act is deemed permissible, inevitably it will be required; the original evil compounds and spawns greater evil.

I would call the Committee's attention, in closing, to a statement of Dr. Leo Alexander in the 1949 New Jersey -- "The New England Journal of Medicine." Dr. Alexander was a distinguished head of the medical doctors

at the Nuremberg trials. He wrote an article which is often quoted describing the horrors of the Nazi Holocaust, and what was caused by small inroads made from the '20s in Germany -- small inroads made in the early '20s, long before Hitler came on the scene, which brought about the practice of euthanasia. The camel's nose in the tent, and the foot in the door, brought on the Holocaust ultimately. Dr. Alexander warned against that, when he decided in the late '70s, he saw happening in our society, what he saw then in Germany.

I would ask this panel to give serious consideration to these bills; consideration in the sense that they are unnecessary. They are dangerous. What is necessary is ethical medical practice. Thank you.

SENATOR O'CONNOR: Any questions of Mr. Traynor? (no response)

Thank you, Mr. Traynor. Next witness is Marie Muhler of the Office of the Public Guardian.

MARIE S. MUHLER: Good morning, Senator. First thing I'd like to do is commend the Commission -- Bioethics Commission -- for the long work put into these bills and the thought given to all of the witnesses that testified there. I was one of those people. And since I make many of the decisions that are addressed by this bill, at least many that come to my office, I would like to share with you just a few items I think in the bill that should be considered. And the bill I'm addressing is S-3320, one of the package of bills you have.

And on page 7, number 7, section b, one thing we find that is very much necessary, and it is in the statute that creates my office -- the Office of Public Guardian -- and that's that we require at least two physicians, one of which should be a psychiatrist, and I think that is very necessary in an evaluation of competency.

Another area that we find a lot of problems with, because of the volume of cases we have, goes to page 9, number 10, section b, where we find if a patient is coming from a nursing home, it should be the responsibility of the attending physician to make sure the advance directive is transferred with the patient to a hospital. It seems that we find a lot is lost along the way. The first thing we do in a case is a social history on the individual and their family to find out if they had any viewpoints or directives that are in writing or verbally given to other members of their family. We put all of this information down. And in the records of a nursing home, if that information is not forwarded, and you don't decide just what individual is responsible for forwarding the information, the hospital may not have any of that, not know who to call. We've had instances where they have not known enough to call me; sometimes they call next of kin. Sometimes they don't involve family at all, or my office. So, we think that it's very important for that individual to have the information with them, wherever they are transferred.

SENATOR LASKIN: Isn't that in the bill? It goes into the patient's medical records?

MS. MUHLER: It says that, but it doesn't say who's responsible for seeing to it that it's there. So and so will say, "I wasn't on duty." For whatever reason, that information is not forwarded. And what I would like to suggest, is that we make it the responsibility of the physician to see that the information is forwarded. And I'm sure from that point on, that physician would see to it that the nursing home or facility would forward that information. Then on page 11, number 11, section 3, it refers to non-verbal expressions. I just question how reliable non-verbal expressions would be? Depending on the condition of a client, there may be times where it might be

reliable, but there may also be times when if there are not enough witnesses present, that it could be interpreted improperly. I think that bears some consideration. However, those are the only areas that we have found in our office, or that I have found, that we think need minor corrections. Other than that, I certainly agree with the intent of the bills, and urge you to move forward on them as quickly as possible.

SENATOR O'CONNOR: Thank you. Any questions? (no response)

At this point, we're going to recess for lunch. We'll resume at one o'clock. Cathy Sole or Donald Campbell, from the Alzheimer's Foundation? (no response)

John Mulholland, Socially Concerned Investors? (no response) Felix-- If you're here, please stand up or identify yourself.

Giles Shoenfeld, Citizens Concerned for Dying? (no response)

Pastor Fran Huber? (affirmative response) Pastor, you'll be our lead witness then at one o'clock. Thank you.

(RECESS)

AFTER RECESS:

SENATOR O'CONNOR: Ladies and gentlemen, if you take your seats, we'll begin. The first witness this afternoon is Pastor Fran Huber.

PASTOR FRAN HUBER: Chairman, are we expecting a few of the other Senators to arrive back? I'll be glad to wait.

SENATOR O'CONNOR: If you would prefer to wait until more are here, we'll go on to the next witness.

PASTOR HUBER: I would rather wait, and maybe the rest of the witnesses would rather wait. This is such a vitally important subject, I think it is important that we have them all present.

SENATOR O'CONNOR: Is Professor Joseph Wargantz here? (no response)

A N N C A R D O N E: He's not here. I'd like to take his place for the Olney Foundation. My name is Ann Cardone, and I'm from North Plainfield, New Jersey. I'm here to oppose S-3320.

SENATOR O'CONNOR: Identify the organization that you represent. You said speaking on behalf of--

MS. CARDONE: The Olney Foundation, which is a foundation of parenteral and emphoral patients who are on tube feedings. I'm a patient who's on total parenteral nutrition. It's called TPN. I've been on it for 18 years. I was an experimental patient, and for the first 13 years I received it as an inpatient, in and out of the hospital. And for the past five years, I've learned to manage it at home. I use it because of an intestinal disease that I was born with.

I have a central line in the subclavian vein. This is it. (gesturing) I don't have an R.N. degree, or even a college education, yet, I'm very capable of taking care of this myself. It just means using a lot of common sense, because it is a sterile technique, but it keeps me out of the hospital, and as you can see, I lead a rather normal life. And I'm not starving to death, which was what I was doing until about 18 years ago. At one point I reached 60 pounds. Six months after I came home with this tube feeding to manage myself, my mother became very ill. She had two major strokes. She was in a coma and they said she would never come out of it. And three days later

she did. The neurologist stated she was a vegetable, and she proved us wrong again. She came off her respirator, and through an emboli to the mesenteric artery-- That means she lost all her small intestines and ended up also with a catheter. There was no nursing home that would take her with this type of feeding tube. I refused to keep her in a hospital, and I would not let them take the tube out and watch her starve to death, so I took her home, and I took care of her.

And there were two of us now on these tube feedings -- I.V. poles. I infuse at night, and she did also. I did it for her at night. She learned to walk again. We communicated. She couldn't take anything by mouth. The neurologist from New York who stated she was a vegetable wanted me to take her for an evaluation. I refused to take her into New York and put her through the trip. I asked if he wanted to come to my home; he could, and when he saw what she could accomplish and what she could do, he was totally amazed.

Well, because of other complications my mother passed away after two-and-a-half years, but my mother died with dignity. She did not starve to death, and she had her senses right to the end. Shortly after my mom died, my father got intestinal cancer, and here I was again in the same situation. The hospice nurses came in, and they said for me to have any long-term care for my dad, that he would have to sign a paper that stated he refused extraordinary care, which would include I.V. feedings. Having suffered from dehydration most of my life up until my tube feedings, I refused to have him sign that paper, which meant he was only eligible for care for three weeks. So, again, I took care of my dad. And when it came time that he dehydrated, I took him to the hospital. He was put on I.V. fluids. He died two weeks later, but, again, he died with all his faculties, with his senses, and he died with dignity. And

he didn't suffer from dehydration. I am opposed to dehydration. It is a horrible, horrible thing. You are totally confused. You can't think straight. You have high fevers. You get sores in your mouth. You have terrible palpitations, shortness of breath. There are pills for pain, but there are no pills for dehydration; only I.V. fluids can help that. I'm a living example of what fluid intake and nutrition can do for you.

It's a terrible thing to have to starve to death. And this is not a procedure that is difficult to do. One of the only papers-- A woman who is legally blind is doing it for her husband, so, you can lead a normal life.

SENATOR O'CONNOR: Thank you very much. Are there any questions? (no response)

The next witness will be someone speaking on behalf of the New Jersey Eagle Forum.

ROSE BASS: Chairman O'Connor and members of the Senate Judiciary Committee. I'm speaking for Vera Roche. She is the New Jersey State Chairman of the New Jersey Eagle Forum.

A long series of facts suggest that business interests are having an unhealthy influence on New Jersey legislation. We believe bills S-3320 and S-2659 are examples of this. We request that the Senate Judiciary Committee consider these facts in-depth before voting upon these bills. Many issues being considered by the State Bioethics Commission are those which will affect the financial status of insurance companies and pharmaceutical companies. Besides the issues involved in these living will and definition of death bills, there are the areas of genetic engineering, life patents, in-vitro fertilization, and promotion of contraception. Laws involving these matters will mean billions of dollars of profit to these companies. The make-up of the State's Bioethics Commission may make it difficult for the Commission to keep in mind

the best interest of New Jersey citizens. A number of Commission members are associated with a small citizens' committee that is highly financed by insurance and pharmaceutical company foundations. This committee, the New Jersey Citizens Commission -- Committee on Biomedical Ethics, shared $400,000 with three committees from other states, money which was donated in 1987 by the Prudential Foundation. It received other grants from Prudential. It received $96,312 in 1985, from the Robert Wood Johnson Foundation, and funds from other insurance and pharmaceutical companies. The American Association of Retired Persons offers health care insurance through Prudential Insurance Company. Prudential will thus profit greatly if those it insures have their health care cut short through living wills, durable starvation of patients, etc.

AARP has been promoting living wills in its magazine, "Modern Maturity" and is also a beneficiary of grants from the Prudential Foundation. Although the New Jersey Citizens Committee describes itself as a neutral grass-roots committee, the ideas it has promoted coincide with the financial benefits of companies associated with its foundation funding. The Citizens Committee has held hundreds of talks around the State for senior citizens and others promoting living wills, starvation of certain patients, etc. The media has printed the same message from the Citizens Committee. On the State Commission on Bioethics, the members of the Citizens Committee have been active in promoting these ideas. The Declaration of Death Act, S-2659, removes criminal, civil, and professional liabilities from doctors. If enacted into law, it could result in a surge of organ removal. This would be lucrative for some doctors, hospitals, and pharmaceutical companies. Each liver transplant costs about $250,000. Every organ recipient must spend from $10,000 to $20,000 each year for the rest of his life for anti-rejection

drugs. On May 28, 1987, The Star-Ledger reported that Johnson and Johnson sat on data which showed over 300 people have acquired kidney problems from Suprol. New Jersey might look askance at any proposal by the State benefiting commercial enterprises. Johnson's foundation recently funded a conference at RWJ School of Medicine at Rutgers which, for the most part, was an attack upon the Ombudsman for the Institutionalized Elderly. This conference was one of many events clearing the way for one of the provisions of bill S-3320, a provision which weakens the power of the Ombudsman to protect the vulnerable elderly. This is a dangerous proposal. How much protection will be given to nursing home elderly by in-house ethics committees?

Attached are several articles about legal disputes of J & J and Merck on genetic engineering, generics, patents, pollution, and in-vitro ethics problems. Since the State Bioethics Commission has taken it upon itself to make legislative proposals regarding many of these issues, the presence on the Commission of so many who have been associated with the Robert Wood Johnson Foundation is unfortunate.

Not only insurance companies, but also the government has much to gain from the early termination of health care. Medicaid and medicare patients utilize a great proportion of State funds. For this reason, too, the make-up of the State Bioethics Commission should be questioned. The New Jersey Citizens Committee has placed a great stress on cost containment. Of the 27-member Commission, 14 seats are available to the public. Nine of the original 14 members named to the Commission were associated with the New Jersey Citizens Committee, which constantly refers to the economic problems regarding vulnerable patients.

Finally, there is a matter of political action

committees. Enclosed is a section of a newspaper article of page 33, Star-Ledger, July 10, 1988. It states that one New Jersey congressman had received $90,000 from insurance political action committees since 1985. Should we not begin to question whether the special groups, via foundation funding, are unduly influencing the New Jersey legislative process?

We are in opposition to bills S-3320, 2067, and 2659. We do not feel that this legislation is necessary, and will result in the deaths of the old, elderly, and handicapped who will feel that the right to die is now their obligation to die.

People die every day. And we do not want to jeopardize in any way the rights of the infirm to live as long as they want to, even if they are receiving life sustaining treatments or mechanical means of nutrition and hydration. We feel these are ordinary means of life support. Under no circumstances should a patient be starved and dehydrated to death. Too many people's lives will be at risk, if we do so. We cannot put killing in the hands of human beings. We have already seen what has happened in the abortion movement. It started out as a hard core case, and now abortion is being performed for the most frivolous of reasons. This is exactly what we must expect of this kind of legislation.

What the living will legislation does is remove all penalties for assisted suicide, and this is what is at the crux of this legislation. The head of the Department of Health has stated that there are 36,000 people in nursing homes in New Jersey, and they should have the so-called right to determine their health care. Get the message: It costs the State, Federal government, and the insurance companies who are insuring health care the most amount of money in the last years of a person's life. And this is what they want to eliminate, along with the people

who are causing them all of this expense. The health care insurers are going from state to state financing citizens groups to come up with a right answer for authoring living will legislation. In Colorado, it was the Prudential Insurance Company that financed seminars with doctors to recommend to them to accept the living will. Of course, there are tragic cases, but each and every one should be considered as an individual case. We should not give blanket approval to the health care professionals, doctors, or otherwise to disconnect life supports which include nutrition and hydration.

SENATOR O'CONNOR: Thank you. Are there any questions? (no response)

Lucille Link, Highland Park, New Jersey.

L U C I L L E A. L I N K: Good afternoon, Chairman of the Committee, and members of the Committee. I am Lucille Link, and I'm an administrator of a nursing home and have been in the health care profession for over 16 years.

I am opposed to S-3320, and S-2067. Some of my objections to the bill are as follows, but are not limited to those listed: I state that there are contradictions in the fact that the patient can accept or refuse a transfer of care. It also states that the doctor, nurse, or health care professional and health care institution can choose to transfer the patient to another health care professional and/or health care institution. Who has the final say, if the patient chooses not to accept the transfer of either or all of the above? The health care professional and the health care institution has, in fact, no rights in the situation, and these facts are contradictory in the bill.

Also, life-sustaining devices are not defined exactly. Many people view life-sustaining devices as any tube, including a feeding tube. Previously, death by starvation has not been an acceptable cause of death in the State of New Jersey. I feel that nutrition and hydration

are not life-sustaining devices, and object to them being thrown into the same category. At our facility, we hand feed and hydrate patients. We use geri-feeders, when there is absolutely no alternative; we have nastro-gastric, or gastric, for proper nutrition and for hydration. This is not a life-prolonging measure, only basic human care. The patient will then expire not because of the painful death of dehydration, but from the disease or conditions that are the result of their disease. We have been, and will continue communicating to families and patients prior to admission. Our facilities use life-sustaining measures, and we've had no one refuse to come into our facility because of these reasons. I must say that our facility has a very, very long waiting list, and other facilities in the area do not have -- do have empty beds. So, I would assume that that means families and patients are not opposed to what our views are. Approximately four years ago, we all had our consciousness levels raised when we learned of all the Ethiopians that were literally starving to death.

At that time, did New Jerseyans ask if they were young or old? No, there was a tremendous outpouring of concern and money to feed these people that were helpless. What about our infirm elderly? Are they not helpless? Are we going to allow them to starve to death, while we contemplate man's basic need for food and water with intricate life-sustaining measures?

New Jersey has always been a front runner in the health care field, and previously death by starvation has not been an acceptable cause of death for anyone, even the elderly or infirm.

The next thing that I disagree with, is with the concept of terminal condition without a determination of life expectancy required; any patient with a disease or illness without promise of life-sustaining treatment will

die. A diabetic will die without insulin. Most medications to people with an illness, heart disease, etc., are life-sustaining and the person will, in fact, die without the medication. Too many things can be interpreted too broadly.

The following thing that I disagree with, is the health care institution is being forced to promote living wills, even though ownership and administration are in total disagreement with the concept, which goes hand in hand with my next objection, where only the religious institutions are being exempt. The religious institutions have been granted the right, under this bill, to have a predetermined written policy defining circumstances in which it will decline to participate in the withholding or withdrawing of specified life-sustaining treatments or artificially provided fluids and nutrition necessary to sustain life. There are only a small percentage of religious facilities in the State, and I feel that each facility should be granted that right. The facility that I am administrator of is privately owned. Ninety-eight percent of the staff, including myself and the owners, have religious affiliations and have strong morals and principles in regard to all facets of life and object to the fact that they will not have the right to follow their beliefs because they are not employed by a religious facility. I have listed on each of my comments the page and the number of my objection, so it will be easy to follow when I hand out my material.

The next objection is the fact that the facilities will have to have an ethics committee to oversee each facility. I see no problem with the Ombudsman's Office being the overseer of the institutionalized elderly in regard to all areas of the nursing home. Our facility has never had a problem either with the Office or the observance of the law in regard to Conroy, Peters, or Jobes. I feel that the Ombudsman's Office as the overseer

in all areas will keep facilities following the law. With individual ethics committees, I feel the facilities will deviate and each one will do their own thing, and the law will be stretched beyond our imagination. People and facilities are already doing these things to circumvent the law, sending people to the hospital to avoid the Ombudsman's Office. The terms are too vague and can be indiscriminately interpreted, i.e., semi-conscious, comatose, permanently unconscious, no code, and DNR -- which means, "do not resuscitate and do not send to the hospital." These terms are all being used to the person's own benefit -- doctor, nurse, caretaker, family member -- and, in many cases, not to the benefit of the patient. They have all broad-based meanings and are being interpreted erroneously.

We had a patient-- I list three patients, and give the information about them, which I won't go into detail about, who were at our facility. Two are at our facility, and the patients' families and the doctor decided that they wanted "no code" on the patients. Each of these patients went into either heart failure or seizures. And since our facility, in following the law, could not abide by these, we helped the patients, gave them oxygen, called in the rescue squad, and they were taken to the hospital. Both patients went to the hospital. One for a short time on a respirator, and the second for a longer time on the respirator. Everyone, including the doctor and the families, felt that they would come back and be vegetables. Both of these ladies came back, are very alert, very oriented, and both ladies happen to be smokers and the first thing they asked for was a cigarette. They are doing well, and if we had followed what they said, these people would not be living.

I just feel that in a lot of instances, things are being interpreted too broadly. It's taking everything into one scope. We had one other lady come into our

nursing home and she was said by the hospital to be in a semi-comatose state. When she came to, that would be the first time we would have admitted a person who was semi-comatose. When she came in she was as conscious as you or I, slightly confused, and she spoke Italian, in a very, very low voice. So she was not semi-comatose. The doctor, when he went to see her, stated, "Well, I guess she's semi-comatose. There's nothing I can do here," and walked away. And the nurse, thank goodness, insisted that the doctor see the patient, apply the different medications and do what history and physical he was supposed to do. I have since spoken to that doctor.

In closing, New Jersey has always been a leader and is known, as well as respected, for its excellent health care. New Jersey has one of the most stringent health care laws and regulations in the nation. The New Jersey Department of Health enforces these laws through their timely and arduous inspections. I personally feel that a living will law on our books will be a total detriment to our State.

It is my strong belief that if a living will becomes law in New Jersey, it will have a very disastrous effect on the elderly, incompetent, and incapacitated people, and on our State as a whole. They should not jeopardize our leadership status. We should not blindly follow the other states who have advanced directives until we can determine the positive or negative effects of these laws. If this becomes State law, we will, in effect, have put our seal of approval on euthanasia.

I thank you. I had called about Stacey Buzzio also speaking, and Mr. Tumulty said that she could come up, you know, in conjunction with my speech.

SENATOR O'CONNOR: I'd ask you, if you're speaking on behalf of the same organization?

STACEY HERBERT BUZZIO: I represent myself individually as a social worker in hospitals. I have been a social worker in hospitals and long-term care facilities for over 13 years in New Jersey. Just as you Senators are plagued with phone calls from constituents from the elderly population, I, too, receive these phone calls daily.

My basic feeling is, what we have to do is eliminate social isolation, and provide social programs and help in dealing with these phone calls, rather than just blanketly putting many of our elderly in one group, be they infirm or non-infirm. And I just wanted to list very, very briefly my problems with bill S-3320.

The first one is on page 19, lines 31 through 39. I just feel that the protection granted in this clause is not necessarily for the patient, but for the institutions and the doctors. The Office of the Ombudsman was created years ago, not just out of a need to create a job for somebody, but because there was a definite need to protect the institutionalized elderly. I really feel that this section of the bill almost removes all of that protection from the medical standpoint that these elderly now enjoy.

The blanket immunity, as I understand it, is unprecedented and leaves the door wide open for potential negligence and abuse. As I interpret this, S-3320 gives complete immunity to doctors and institutions from civil, criminal, and professional liability.

Just in this area alone, it would appear that recipients of medical care with advance directives are losing already established rights, rather than gaining them.

The next part would be S-3320, page 16, 16a. Any living will allowing the removal of the basic human need of food and water, to me, is an assisted euthanasia with a legal, more acceptable name.

Unfortunately, we are all terminal. We are all going to die. And if we are fortunate, the Lord will take us quickly and painlessly. But the Lord also afforded to mankind, with the ability to sustain life and the common sense to sustain basic human need with food and water-- Food and water will not prolong the life of a terminal cancer patient. This individual will die of this cancer, even if nourished, and hopefully not in as much pain as when someone is starved to death. Also, diabetes and heart conditions are also considered terminal illnesses. The general public may assume that life-sustaining procedures are respirators and heart-lung machines, but, in fact, with the evolution of the living will legislation, they seem to have been extended to include medications such as insulin, antibiotics, and heart medication.

Living will legislation is not necessary to protect any rights of a New Jersey resident -- either deemed competent or incompetent. We believe we have a right to have common law rights that protect us and allow us to appoint a power of attorney to be sure that our wishes are followed. To me, the conflict truly appears to arise when individuals confuse the basic need of food and water as a life-sustaining procedure. When asked, many families would not object to the use of a gastric tube in someone's abdomen or intravenous feedings, but seem to find naso-gastric tube feeding aesthetically unattractive, and they assume uncomfortable or painful.

New Jersey must maintain the interests of all its citizens to prevent suicide and death by starvation, which, in most societies, is considered barbaric.

A society that puts to death its unborn babies will never take seriously its obligation to the weakest and most vulnerable -- the old, ill, retarded, handicapped, single mothers, children and the poor, noticeably. I sometimes feel that there is one common thread; that these

are all groups that are generally not part of the productive income-producing population.

Let New Jersey make a positive step away from this tragic scenario. Protect everyone's basic human common law right to medical care and informed consent. Do not impose legislation to protect the productive income-producing professions, and additionally strip individuals of their right to receive the basic human needs such as food and water. I thank you very much.

SENATOR AMBROSIO: May I just make a comment? We hear the same testimony over and over again. I want to make something clear. There is no blanket immunity granted by this bill, under any stretch of the imagination. The immunity granted is an immunity to a health care facility or doctor for following a health care directive, but it does not relieve that professional from the standards of care that are applicable to malpractice, because that professional is held to the standards in the terms of the bill in accordance with the provisions of this Act, and that is "accepted professional standards."

So, a physician following the terms of the advanced directive can still be liable for malpractice if he does not deal with the patient in terms of accepted professional standards. And one witness after another has talked about blanket immunity. That is absolutely not the fact in this case.

Secondly, for those witnesses who are going to testify from here on in, we're not talking about anything more than an advance directive where someone, while they are competent, decides whom they want to name as a health care representative, and what instructions they want to give for their health care. And no one else is imposing any of their own views on that individual. This is the individual making those choices.

SENATOR O'CONNOR: Ewan MacQueen.

E W A N C. M a c Q U E E N, JR.: Thank you, Senator O'Connor, for inviting me to speak before your Committee. And I thank the members [illegible] the Committee who have responded to our request for an amendment to Senate Bill No. 3320. The text of what I'm reading is the letter that I sent to Senator O'Connor, and I think I also sent copies of that letter to each member of the Committee. I do have extra copies in case you want to look at that.

First, I want to state that the Bioethics Commission has really heard from many, many groups, and I'm sure that they have done their best to hear from everyone concerned. And they were not able to be here from the Christian Scientists of New Jersey, because the one person responsible for speaking to groups like that is me, and I was not in the neighborhood at the time to speak to the Commission. Therefore, I'm addressing our needs to the Senate Judiciary Committee.

We wish to underscore our desire to have the language of the enclosed amendment, which I have here, included in the body of S-3320. Such inclusion would not only extend the provisions of the bill even more broadly, and without harm to the general public, it would also guarantee that those relying on spiritual means, such as New Jersey Christian Scientists not only would have their written desires recognized, but honored as well.

As a backdrop, I'll tell you a little bit about Christian Scientists and why we would rely on spiritual--

SENATOR LASKIN: May I ask you a question? It would be more logical and understandable for me, if, before you gave us the reason why you wanted the amendment, I saw the amendment, so I could follow your comments; so while you're talking, I can relate it to the amendment.

MR. MacQUEEN: I have other copies if you need them.

SENATOR LASKIN: I have it here, okay.

MR. MacQUEEN: The Christian Science Church is a worldwide church with 3000 branches in this country and overseas. It was founded 110 years ago by Mary Baker Eddy, and has its headquarters in Boston, Massachusetts. Recognizing that God is an ever-present help in trouble, Christian Scientists rely on God for total health care. Prevention, health maintenance, and healing are typical of this reliance.

For instance, instead of relying on medical treatment when experiencing illness or injury, Christian Scientists rely wholly upon spiritual means through prayer for healing. This we do, not because medical treatment is an anathema to you, but because we feel daily prayer brings sure results, especially in those times when they need and desire it. We turn to, as a Christian Science practitioner, the one who is experienced in helping to find the effective health they need through prayer. Should physical care be necessary during the time of need, there are Christian Scientists' sanitariums, such as the Tenacre Foundation in Princeton, New Jersey, where a Christian Science nurse can work in support of needed healing.

Also, many Christian Scientists have health insurance policies which provide-- I should also point out that many families in New Jersey have relied on the above-described treatment system for at least five generations. That is to say, ever since the Christian Science Church was first founded in 1879, they have relied on Christian Science for all their health needs. They've never had physical examinations, medical treatment; never taken drugs nor medicine of any kind, unless mandated by State law in the interest of the common good.

Also, many have passed the number of years beyond which our society would commonly refer to them as elderly. As mentioned when faced with a problem needing healing, they turn wholly to God and the application of

Christian Science, as naturally as others would turn to medicine and medical doctors for their relief.

It is this last point which leads me to why the enclosed amendment is so important to us. Should this amendment not be included, it would then be possible that something which someone has relied upon for a lifetime, in this case, Christian Science care and treatment, and something which has provided them with health and longevity, might be withheld when, indeed, they would most desire it and most need it.

SENATOR AMBROSIO: As the sponsor of the bill, I have to tell you, I've looked at your amendment. I'm not going to accept the amendment, because I don't think the amendment is needed at all. There's nothing in the Act that does prohibit the provision of spiritual treatment through prayer alone. The Act does not in any way prohibit that. It's not, in my judgment, necessary for us to state that as a negative, because the Act already allows an individual to make an advance directive, and to state those types of health care that the individual wishes or wishes not to have applied. So, my judgment is, this in no way infringes upon the rights of a Christian Scientist now, and I don't want to build into the bill individual religious exceptions or religious criteria that apply to one religion over another. Your amendment is not needed, because I don't think the bill infringes upon that right now.

MR. MacQUEEN: It's not the intention that our religious preference would infringe upon anyone else, and, in fact, our practice of religion generally doesn't infringe on other people's rights. We're just trying to--

SENATOR AMBROSIO: I'll tell you what I might also do: I might have that language included in a statement to the bill which is not a part of the bill. In terms of the legislative statement, it goes with the

bill. We may have that language included in there. But I do not want that specific language included in the bill. I don't think it's needed.

MR. MacQUEEN: The statement would be very much appreciated, Senator Ambrosio.

SENATOR O'CONNOR: Does that address your concerns, since you are basically testifying with respect to your amendment?

MR. MacQUEEN: Yes. Yes, it does.

SENATOR O'CONNOR: Thank you very much. Mary Lertola, Medical Ethics.

M A R Y L E R T O L A: As I told you, I was going to try to get 10 minutes out of this video of Dr. Paul Byrne, who is head of the Neonatology Department in a hospital in Tulsa, Oklahoma. It's from a talk at Seton Hall last year. He's an eminent and very knowledgeable person on brain death. So, I've just taken the last few minutes of it.

SENATOR O'CONNOR: Can you hold that for one second? If anyone would like to come up in this area and take a seat, you're welcome to do that. I can't see shutting you out of this for the next 10 minutes. (witness plays video)

MS. LERTOLA: I'd like to thank the Senators for letting me show that. I have a four-page paper by Dr. Byrne. It has a lot of the information here, and I'll leave -- a less than perfect copy, but you can understand it -- for the Committee. I'm sorry, I only have nine copies.

SENATOR O'CONNOR: Next we have an organization known as the Coma Recovery Association. We have four individuals from the organization. I'd ask that one be the spokesman for the organization. You can decide among yourselves whom that will be.

BARBARA PASSALAQUA: My name is Barbara Passalaqua. I am here to represent the Coma Recovery Association. My objective here today is to represent Dr. Dimancescu who is the Chairman of the Board of our organization.

I have a tape here for you to view of Dr. Dimancescu's message. He is Chairman of the Board of the Coma Recovery Association. His credentials are numerous. He is a graduate of Yale and Harvard Universities, the University of Toulouse in France, and President of the New York State Neurological Society. He has nine staff positions in New York hospitals. He is internationally known as a pioneer in coma research, and he is the Director of the International Coma Association.

I have my son here, Dennis, who is living proof that you can come out of a coma. Dennis had his accident eight years ago. As he lie in the hospital, he was comatose. We were told that he would not live. If he did, he would be a vegetable.

At one point in time, I had an argument with the doctor, a surgeon who was on his case, and he said, in front of Dennis, "He is never going to survive. He is going to be a vegetable if he does." Also, this doctor told me that I had no right as a parent, because Dennis was over the age of 21, and that he was the one in charge. He was the head of the department of staff of surgeons and he would make all decisions on Dennis.

As you can see, Dennis is here. He's functional. He's rational. He is contributing to society. And if this bill was in effect at that time, probably Dennis would not be alive today.

SENATOR LASKIN: Why do you say that? I want to make sure that we're talking about the same bill. We're talking about the living wil. .ill, where the individual

signs a paper in advance when the individual is competent. Am I missing something? Why would his situation be different?

MS. PASSALAQUA: Dennis was 22 years old at the time of the accident. Who expects a 22-year-old fellow to die? We didn't even have a will on Dennis.

SENATOR LASKIN: So there would not be a living will--

MS. PASSALAQUA: Okay, yes.

SENATOR LASKIN: --which means this bill has nothing to do with whether or not his situation would have been any different. A lot of people are testifying today about things that aren't really the living will legislation. I've heard that a lot of times today. This bill is strictly one of several. I think a lot of the discussion today has been about the others.

This bill says, if you write, consciously, competently, a living will, meeting certain guidelines, it will be followed. That's all we're talking about today. But we're mixing up a lot of other concepts. I just want to make sure you understood it.

MS. PASSALAQUA: If Dennis had signed something before that, I know he wouldn't have survived.

SENATOR AMBROSIO: No, as a matter of fact, you wouldn't have had the problem, because you would have been in charge of making those decisions. The doctor couldn't refuse you, because you would have the written authority to make those decisions.

So, the fact of the matter is, if Dennis had a living will, there would have been no problem at all. You could have said, "This is my decision as Dennis' health care representative."

R A Y M O N D P A S S A L A Q U A: I went to court on that and got [illegible]al action. I am Dennis' guardian, and I had it from the court. And the doctor still refused me.

SENATOR AMBROSIO: You didn't have the authority to make the health care decisions that this bill would have allowed Dennis to make. You simply are his legal guardian.

This bill, if it was in place and Dennis had a living will, there would have been no need to go to court. All those decisions would have been made by you as his health care representative.

MR. PASSALAQUA: As legal guardian, he was comatose. He didn't even know which end was up.

SENATOR AMBROSIO: The point is, this bill would not interfere with those decisions and probably could have helped the situation.

MR. PASSALAQUA: What would happen if somebody didn't do like I did; didn't have the nerve to go to court, or was afraid to do something, or didn't know what to do? He probably would have been dead right now.

SENATOR AMBROSIO: As Senator Laskin said, we're limiting it to somebody while competent who wrote out a living advance directive or living will. Your case has nothing to do with this legislation.

MR. PASSALAQUA: I think it does. Please--

MS. PASSALAQUA: A lot of people who are in coma-- A lot of people aren't even aware that you can come out of a coma; that you can survive with various types of therapy. And I think if this was, say, 10 years ago, before Dennis' accident, I might have signed one of those living wills, not even realizing that, "Hey, if there is hope, if you do come out of a coma, if you are brain dead--" You might be brain dead one minute because nothing is functioning, but if you are viewed over a long period of time during the course of the day, you do have some stimulation. There was a point when we told Dennis to raise his arm in the hospital. He did that. But his neurosurgeon that was on his case did not believe us. He said, "No, oh, it was just the brain, a twitch or

something," because they did not believe that he would come out of this coma. Would you view the tape of Dr. Dimancescu?

SENATOR O'CONNOR: How long is the tape?

MS. PASSALAQUA: It's about eight minutes. (witness plays video)

SENATOR O'CONNOR: Thank you. The eight minute film, for the record, was fifteen minutes.

MS. PASSALAQUA: I'm sorry. I didn't realize it.

SENATOR O'CONNOR: We're going to take a two minute recess.

(RECESS)

AFTER RECESS:

M A X S H A C H T E R: I'm a representative of the Ruth Zavatchel Kidney Foundation. I just wanted to state our position on the proposed brain death legislation. The Foundation is a nonprofit, all-volunteer organization of over 30 years, involved solely in helping end-stage renal patients. We provide equipment for home dialysis, funds for suppressive drugs, and provide funds for transportation. We also fund a special section of the YMCA to enable them to enjoy the same camping experience, coming from many backgrounds.

We have an understandable interest in the availability and procurement of organs for transplantation. We are afraid the bill proposed will not accomplish this. We're concerned, based on our understanding of the report of the Bioethics Commission, and the bill proposed.

In the bill which is the subject of this hearing, we suggest that consideration be given to the following:

The Committee has given much consideration to the "religious and moral convictions of those who desire that death be declared solely in accordance with long accepted, traditional criteria based on cessation of cardiac and respiratory activity."

It appears that section 5 of the proposed bill adequately addresses this concern, insofar as it stipulates that the death of an individual shall not be declared on the basis of neurological tests, when such a declaration would be diagnosed, on the basis of moral convictions of that individual, and when that fact has been communicated to, or should reasonably be, authorized to declare death-- In this reading, I've eliminated the phrase in section 6, for reasons which I'll now state.

The provisions of section 6 appear to be overkill. It may very well act to deter provisions from use, for determination of death, which would first require "reasonable efforts in good faith to determine whether such a declaration would violate the personal religious beliefs or moral convictions of that individual." The section goes on to specify what that effort should include:

Section 5 directs the physician not to violate the personal beliefs of the individual when those beliefs have been made known, or should reasonably be known to the physician.

Section 6 imposes on the physician the need to determine those views, apparently, in every case where the use of neurological criteria is considered. Please note that the informed consent law treats this provision essentially the same, so that when, "There is any reason to believe that anatomically, the family should be able to donate, the option shall be offered, and the family should be called in the absence of actual notice of contrary indication by the decedent, or actual notice of opposition." And the Act goes on to establish a hierarchy, whose consent would be accepted.

The changes that we propose, in the brain death act, would bring its operation to consonance with the informed consent law. This law is effectively addressing the same concerns; that is, religious and moral consent of the individuals.

As to the proposed legislation, two years of experience have shown the procedure to work. Why change it? And I think the position I've taken here simply is to take the burden of determination off the physician-- Or here it is going to make the physician the responsible individual who would make a declaration of death; that is, taking from him the burden of determining whether he is opposed to a brain death legislation, rather than asking the surgeon or the physician not to make such a declaration. If he has reason to believe -- and, I think, in every case where it is addressed -- there is any objection, the family's objection would be made known to him, one way or the other, without his necessarily going out on his own to make that determination. As the Act says, it indicates, he's got to go to the family -- he's got to go to family and friends -- to make a reasonable good-faith effort, whatever that may mean. Thank you very much.

SENATOR AMBROSIO: I just want to briefly comment: The dilemma you pose by your objection to the bill is what our dilemma is going to be whenever we deal with these issues. We're never going to reach a bill that suits everyone. If we were to adopt your recommendation, there would be wholesale objections to this bill. There's no way-- I think your objections go much too far, and we've tried to craft a bill that balances the needs and the rights of people. I just think your suggestions would go much too far.

MR. SHACH[illegible]: My thought is that those needs and rights-- If we mandate the physician to express them, when they were made--

SENATOR AMBROSIO: We would rather err on the side of caution.

MR. SHACHTER: I know what I've heard from some of the doctors; that doctors rather put themselves in the possible realm of legal action. Did they exert proper care, and so forth, to make a determination? They would rather just skip the whole issue, not to expose themselves to possible suit. And I do think, that--

SENATOR AMBROSIO: You want to make it easier for them to declare brain death?

MR. SHACHTER: No, no, they shouldn't declare brain death unless all the scientific criteria have been met. I believe the family would have plenty of opportunity to say, because of our religious beliefs, or what this man believed, who is now dead, he would not want a brain death declaration. You have plenty of opportunity to say that.

I'm taking the burden from the physician's back to go out and find somebody who would give them that information. That's the only change I propose. Thank you.

SENATOR O'CONNOR: Thank you, Mr. Shachter. Mr. John Tomicki, New Jersey Right-to-Life.

R I T A M. M A R T I N: We are both representing New Jersey Right-to-Life, and I also represent Citizens Concerned for Life. Mr. Tomicki is not here at the moment.

SENATOR O'CONNOR: The clock is ticking, in either event, so--

MS. MARTIN: Thank you for the opportunity to speak. I speak here today as Legislative Director for Citizens Concerned for Life. And I very briefly want to address S-2659, the determination of death, and then a little more in-depth, S-3320.

Citizens Concerned for Life does not oppose this bill, but we have two suggestions for amendments.

O:- the bill calls for the Department of Health to adopt, and the Board of Medical Examiners to adopt

regulations or interpretive guidelines setting forth requirements for compliance. We would ask this be done by regulation only. Regulation would require compliance; guidelines would allow for interpretation. Regulations would create a more uniform response from all parties involved.

Second, we would like to see included a requirement for an objective clinical test to determine cessation of brain function. This would establish a safeguard for the patient, and would also be a help to the family. Neurological death, "brain death," can sometimes be a difficult concept to accept; to be shown a clinical test result verifying no brain activity could help make the concept more real. We would like to see a requirement for such a test included in the bill.

Regarding S-3320, the Advance Directive for Health Care Act, we have some concerns. We recognize the time and effort that went into preparing this proposal. We also recognize that it addresses some of the issues raised by pro-life groups regarding living will legislation in the past. However, it still leaves us with some problems. Our principal concern is the provision allowing removal of all treatment, including fluids and nutrition from non-terminal patients. The bill creates a class of patients termed "permanently unconscious," and includes in that class those patients in coma and persistent vegetative state -- both conditions difficult to diagnose with certainty. The bill adds the definition is without limitation, meaning other categories can be added. These patients, for the most part, are not terminally ill, do not have any underlying pathology, but are vulnerable simply because they are in a state of dependency. The bill creates a discrimination against a class of patients simply because they are disabled, denying them the safeguards available to other patients, making them candidates for death by starvation.

Presently only two categories are noted. What other non-curable conditions might at some time be added to that list? AIDS patients? Alzheimer patients? They would seem to be candidates for inclusion if the only requirement is to have a condition from which you are not expected to recover. All life is precious. We should not give up on people because they are dependent and disabled. We do our best to keep them comfortable. We recognize their uniqueness, and we help them to live with dignity until death takes them. We recognize the heartache and suffering of the families of such patients, but the pain of the family does not justify taking the life of the patient. Treatment withdrawal decisions should become applicable only in the case of terminally ill patients. Moreover, decisions to withhold or withdraw artificially provided fluids and nutrition should not be permitted, if doing so, would, in itself, cause death, rather than death being caused by the underlying illness or injury.

We feel the "permanently unconscious" category should be deleted from the bill. Our other difficulties with the bill include the lack of a pregnancy exception clause. A number of other states have included such clauses in similar legislation. We would like to see included here a statement similar to Florida's Life Prolonging Procedures Act, which states that an advance directive shall have "no effect during the course of a pregnancy." A woman who has opted to continue her pregnancy would certainly want her baby protected. We believe that most younger people who write living wills or advance directives assume they will become operative in the future when they are old, and are not considering what they might want if the condition arose tomorrow; For instance, the mother who is pregnant not wanting the living will operable until her baby is born. This could raise questions in other cases, too. Certainly, most people

would gamble more on treatment at age 30 than we might at age 80. Revocation of a living will or advance directive should be simple and easy to do, to cover such cases.

Our last major difficulty with S-3320 deals with limiting the right of institutions to refuse to participate in treatment withdrawal decisions to only religiously affiliated institutions. This places an unfair burden on institutions and staff who have strong moral convictions against treatment withdrawal, but are privately or publicly run. We feel the right to refuse to participate in treatment withdrawal decisions should be extended to all institutions whose staff and institutional policies conscientiously object to such participation. Citizens Concerned for Life supports the amendments as proposed by the Catholic Conference, but did not feel it necessary to go over all of them in this testimony. We wanted principally to address those provisions of the bill which we feel undermine the value of life and put innocent persons in jeopardy.

SENATOR AMBROSIO: We're going to accept that recommendation.

MS. MARTIN: Fine.

SENATOR O'CONNOR: Any questions? (no response)

MS. MARTIN: And, if I may just add a personal concern that I have, I am troubled by portions of the bill which deal with the patient with a serious irreversible illness or condition and allows him to refuse treatment.

A strict reading of the bill makes it sound like it's a benefits burden test, which is legitimate, but I worry that it can be expanded and it seems to be accepting suicide or assisted suicide in some cases. A person diagnosed with serious irreversible illness sometimes suffers periods of depression, and in one of those periods of depression, could maybe make him make a decision, "No

treatment; I can't take it." And treatment is stopped, and his life ends.

But if somebody came in and gave him encouragement and helped, his life may be more satisfying than he really imagined.

SENATOR AMBROSIO: Can we really build that into the bill?

MS. MARTIN: It's sort of an encouragement to giving up, rather than going on. And it troubles me. I don't quite know how to fix it.

SENATOR AMBROSIO: I really think the bill is neutral on that. People think in terms of advance directive that limits, or terminates. Advance directive can give instructions to take heroic measures.

MS. MARTIN: I understand that, but the wording in the bill seems to be saying that we, the State of New Jersey, approve taking this action even when, you know, your death is not imminent. You've got a serious illness, and you know eventually it will cause your death, but other people have lived years with it. But it allows, if you look ahead and think that your life is going to be more burdensome than you can handle, it allows you to say you can refuse treatment.

SENATOR AMBROSIO: And that's our law today?

MS. MARTIN: Is there some way we can encourage people more? I'm troubled with it. I don't know how to handle it. It seems to me we're encouraging giving up, and I don't think we should be doing.

SENATOR O'CONNOR: Thank you very much. John Tomicki.

J O H N T O M I C K I: My name is John Tomicki, New Jersey-- Executive Director of New Jersey Right-to-Life. Thank you, Senator O'Connor, for remaining to hear the testimony. I'm also grateful to the Chairman that at least for this session of the Committee hearings, you have

provided a stenographer; therefore, those Senators who are not with us will be able to read the transcript and perhaps, possibly, draw some information from the transcript by way of a determination.

You've already heard our president this morning, more eloquently than I could ever have done, set forth our position regarding the definition of death.

SENATOR AMBROSIO: Who is the president?

MR. TOMICKI: Richard Traynor. Regarding the definition of death, our position is very clear. We believe that no statute can be drawn to say when you are dead, that you should not be declared until the circulatory, respiratory and brain -- including the brain stem -- are incapable of ever functioning again. That is the position of our committee. It's something that we have been delving into, holding our own meetings and conferences, and have shared in at least two or three state conventions, on behalf of our 40,000 members of our organization. This is the crystal clear position of our Committee.

In addition to that, as we look to the definition of death, we see the situation: If you have two individuals with the same physical condition, one lying in bed A, and one lying in bed B, and one has no religious belief, and one has a particular religious belief; based on that, one can be declared dead, and the other cannot be declared dead. It seems to be clear, when you're dead, you're dead. Until the circulatory and respiratory systems are incapable of ever functioning again, then, and only then, are you dead.

Regarding the advance directives, we still do disagree with Senator Ambrosio. First of all, this is the work product of the Commission. We also disagree with him on -- maybe it's not a blanket relief of liability, nevertheless, there it sits as the intent of the bill. If

the directives are, in fact, followed on a good faith effort, then the health care provider is released from certain amounts of liability. Conversely, if, based on your conscience, you do not follow the advance directives or the living will, then and only then you might be subject to some criminal -- no, there is no criminal -- there is some civil and monetary provisions, if I read the bill correctly.

SENATOR AMBROSIO: That's a total misstatement of the bill. The second part in particular.

MR. TOMICKI: I'm rereading, with the convoluted-- As to the first one, you and I do totally disagree. We've been involved in the Right-to-Life work for four or five years, and I never thought there would come a day when my prayers would be answered. There was a statement made by Paul Armstrong that I finally found that I could agree with. In many cases, these are case-by-case situations, and the New Jersey Right-to-Life Committee also believes that the fact that people have had to come forward to courts to look for relief-- Why is this happening? Because we've shifted from a life ethic to death ethic. We've always taken extraordinary care. Extraordinary measures should not be indicated, or be caused to be had. We are distressed.

I wish Senator Codey was still here today. We are distressed that the Pallone bill, which would have established a level of care, at least, in the nutrition-hydration area -- which also in the questioning at the last session by Dr. Hufeland, they were not uncomfortable with that bill. They could, in fact, support that bill. We are begging Senator Codey to bring that bill back up to Committee, and we are begging Senator Russo to post the bill, as he said he would do.

We would ask that this Committee somehow use its great efforts, and its stature, to try to get that bill up, because, as the rabbi said this morning, there's a lack of

confidence out here. We believe you're either a killing doctor or curing doctor. We think that's happening in our society. Could we establish a minimal level of care? I didn't say treatment. I'm using the word "care": food, water, shelter, clothing. So the Right-to-Life proposal, as put forth by former Senator Pallone, said there should be a level below which we should go; that food and water, nutrition, and hydration should not be withheld from an individual if the withholding would cause that person death by starvation or dehydration. We still want that to be done.

In response to Senator Laskin, I would just read for him the writings of Dr. Chris Hufeland which impressed Dr. Alexander. Dr. Hufeland wrote in the early 1800s, "If the physician presumes to take into consideration in his work whether a life has value or not, the consequences are boundless and the physician becomes the most dangerous man in the state." That's what Dr. Alexander saw happen in pre-Nazi Germany.

Lastly, I had the opportunity to appear on the Geraldo Rivera show with this boy, Joseph Hartman. He was the patient whom Dr. Byrne had initially treated. When the other doctors said, "Wait a minute, the boy was born premature, flat EEG. There's no chance he's going to recover, and if he does--" Joseph appeared on that program. An objective, some would say, ordinary; some would say not ordinary, but he is a teenager with all the curiosity and concerns and awkwardness of a young boy of that age.

And although the doctors had written him off, Dr. Byrne wouldn't give up. He knew that the body was different. The brain would not function because the boy had been born prematurely. That is the case that brought Dr. Byrne up to -- Dr. Dimancescu on the video. He takes patients that other doctors say they are in the persistent vegetative state, or coma. He would only take

the cases that the other doctors say there is no chance. And he has a 62% recovery rate based on the techniques he's using.

We say, "Come back to the life ethic." Please do not pass this bill, and take the other bill, Senator Ambrosio's bill and send it back to the Bioethics Commission. Thank you very much.

SENATOR O'CONNOR: Pastor?

PASTOR HUBER: I ask this question before I give my statement, which will not, most likely, encompass the ten minutes. But I really ask this in honest respect to the Chairman: What is the purpose of this hearing? I'm new to the legislative process as far as giving testimony. I've been here once before, but I ask that in earnest.

SENATOR O'CONNOR: This is a meeting which is open to the public. Pastor, we've listed on today's agenda three bills on which you've heard testimony. Our purpose is to elicit comments from members of the public, for or against the three bills that we're taking into consideration, and will be voting on in the very near future.

PASTOR HUBER: May I then ask why has there been-- Considering now the bills that are at hand, which are truly life and death issues, why has there been such an evident lack of interest shown by some members of this Committee? I say that because I've observed it for two sittings, and from my own observation there has been clearly a lack of respect shown to both sides, not by all members, because some members of the Committee have shown what I have felt to be a keen interest in what has been shared. But the majority of the men who have been representative of such a major piece of legislation -- pieces of legislation -- I want to just go on record as saying that I'm appalled at that lack of respect shown to the people on both sides.

SENATOR O'CONNOR: That's a subjective opinion on your part.

PASTOR HUBER: That's a very objective evaluation.

SENATOR O'CONNOR: That's your opinion.

PASTOR HUBER: It's been stated by people on both sides of the aisles today.

SENATOR O'CONNOR: It would be subjective on your part.

SENATOR AMBROSIO: Many of the statements that were given today, we have written statements and even had them in advance of the meeting. So many of the members of this Committee know what the people want to testify to, before they testify.

A good portion of the people that testified gave us advanced written statements.

Secondly, I'm one member that has followed this every step of the way. This is my bill. I know exactly what's going on here. Very frankly, about 75% of what I heard, maybe 80% of what I heard, is totally irrelevant to the two pieces of legislation, and many of the members feel that way.

I watched the two tapes. One of the tapes I didn't watch because I was a participant in the dialogue. I've heard everything Dr. Byrne said before. Most of what I heard had nothing to do with either one of these bills in terms of the testimony that was given, and a lot of the other members felt that way, too.

PASTOR HUBER: I understand that, and I understand this information has been passed on to people and can be passed on to the Senators prior to this.

I understand that. What I'm saying is there truly has been a demonstration of lack of respect when people have been sitting at this table coming to grips with

life and death issues in their own heart and receiving very little respect in regard to that hearing.

It's a difference between-- I have seen from your vantage point a clear interest in the things that have been stated by people on both sides of the aisle. Unfortunately, that hasn't been a general evaluation of the rest.

SENATOR O'CONNOR: Please, can we get to the bills now?

PASTOR HUBER: I am. T.S. Eliot wrote these words -- T.S. Eliot is the 20th century -- "The greatest treason is to do what we believe is right but for the wrong reason." Is not truth that which all of us seek? Is that not what is happening in this room? Are not the testimonies of each one of us trying to communicate what each perceives as truthful, albeit not without much struggle?

I'm sure if each one who has testified this day, and days prior, was asked "Do you base your presentation on truth?" Each would, I hope, respond with an emphatic "Yes." Those who would do otherwise -- knowingly or unknowingly-- None of us who seek truth could accept their testimony as being valid.

Simple logic speaks to us who remain, that not all can have the truth. Hence, it becomes obvious by listening to the sharp opposing views that either all of the testimonies are not true, or part are true, but all cannot be true.

We therefore have a dilemma, and our dilemma is further complicated by the fact that we are asking you gentlemen before us to determine which of our presentations are true. But, you, too, like us, have opposing and varying views on these issues. Another very prominent theologian of this century, still alive, Presbyterian, Richard Lovelace, has written these words, "The best

efforts at forming righteous governments fail because there is no one we can actually trust to watch the watchman." "Nothing works," he goes on, "because there are no governing hands upon our systems but our own, and these, also, namely, our own, are soiled." Therefore, is there a solution, or are we faced with a quagmire of unanswerable problems that only political legal compromise will somehow appease?

And that philosophy, my dear friends, is currently becoming today's norm. Yet tragically this same philosophy, if continued, will ultimately lead to society's demise, as we presently know it. Yet, there are some benefits to our dialogue, for fortunately these bills are forcing us all to examine our hearts and minds as to our own moral values. And I propose that we should face this squarely -- what's before all of us -- with integrity, knowing these bills are attempting to answer medical and legal problems, yet their very nature cries out for moral solutions.

If we believe, as some have stated or implied, that all morality is relative, and therefore of no consequence, then we deny or reject the possibility that a truthful solution can ever be reached. A modern day maxim reads this way: "To understand and accept all, is to forgive all." You can hear it in religious quarters, and in the halls of Congress in Washington presently. It's a modern day maxim which appeals to our generation, for it puts all men outside of the constraints and demands of moral law.

What we are experiencing all around us throughout this nation is moral law being swept aside as though, in the final analysis, moral law really does not matter at all. History has repeatedly taught us that whenever such denial of moral law occurs, social chaos is not very far behind.

You older legal statesmen were trained under "leges est rex: the law is king." And what was the basis for attributing such a magic title to all moral law? God's law. History shows Parliament in England and constitutional law were built out of and from the laws of God. What I'm about to read from the same book that these laws were derived from, contains that law, and I will be so bold to declare before all here present that not only does it contain the solution to the debate before us, but it also contains the words by which every one of us in the solemn assembly will some day give to almighty God in account, and I quote out of II Timothy, the New Testament, Chapter 3: "All Scripture is inspired by God." The Lord's words, in Mark 13: "Heaven and earth shall pass away, but my words shall never pass away." Hebrews Chapter 4: "The word of God is living and active and sharper than any two-edged sword, and appearing as far as the division of both joints and marrow, and able to judge the thoughts and intentions of the heart."

Out of the Old Testament in Deuteronomy, XXXII Chapter, "See now that I am he and there is no God beside me. It is I who puts to death and it is I who gives life." From the XIV Chapter of Job: "Man who is born of woman is short-lived and full of turmoil, since his days are determined and the number of his months is with Thee, O' God, his limits thou hast said, so he cannot pass beyond them."

Out of the XXV Chapter of Matthew: -- and I'm coming to a close -- "Whether the son of man comes in his glory, and all the angels with him, then he will sit on his glorious throne and all the nations will be gathered before him, and he will separate them from one another, as the shepherd separates the sheep from the goats. And he will put the sheep on his right, and the goats on the left. Then the King will say to those on his right, 'Come, you

who are blessed of my father, inherit the kingdom prepared for you from the foundation of the world. For I was hungry and you gave me something to eat. I was thirsty and you gave me drink.' Then the righteous will answer him saying, Lord, when did we see you hungry and feed you, or thirsty and give you drink? And the King will answer and say to them, truly I say to you, To the extent that you did it to one of these brothers of mine, even the least of them, you did it unto me.

And my last verse is out of Hebrews, Chapter IX, verse 27: "It is appointed for men to die once, and after this comes judgment."

Gentlemen, there is a divine appointment for everyone in this room -- not man's appointment, but God's appointment. Death is God's decision and not man's.

And, in closing, just a simple paraphrase from the words of Jeremiah the Prophet: "Your fathers did righteousness and justice, then it was well with them. They plead the cause of the afflicted and the needy, then it was well with them. Is not that what it means to know me, declares the Lord?"

I believe this legislation that's been proposed must, out of necessity, include the very oracles of God in its final form. If, indeed, this legislation is set aside outside of the authority of God's word, you set into motion -- by the very nature of it, without the very conferring with what he says -- the possibilities of tremendous outcomes which can be tragic to the people of this State, and possibly even to this nation, knowing that New Jersey is supposedly a forerunner with this type of bill.

So, I submit this to you in respect to your position, and, as the rabbi prayed, I pray earnestly, myself, for divine understanding upon your deliberations, and I thank you.

SENATOR O'CONNOR: Thank you. At this point, I think we've gone through the entire list of witnesses, unless any of those that we called--

UNIDENTIFIED MEMBER OF AUDIENCE: I believe we were on the list from the last meeting.

SENATOR O'CONNOR: Come up. We'll hear you. I would ask you to be as brief as you can. At this point, we have heard testimony from New Jersey Right-to-Life, from your President.

P A T C O Y L E: I don't have written testimony, but I do have illustrations that I would like to explain, and I'm very disappointed that the other Senators are not here.

I was not permitted give this information at the State Bioethics Commission, and I think it's very important. Nobody else has given this information today. Although I explained to the Bioethics Commission how important it was, they still did not give me permission to present it to the Commission.

I'm representing myself. I belong to New Jersey Right-to-Life. Now, when they talk about brain death, people are mixing it up with death of a person. Death of a brain would be destruction of the brain. It is death of the person-- What is not realized is when a doctor says that the person has died because of a condition of the brain, he is making a philosophic judgment. He is not making a scientific or medical judgment. The reason for that is, there is no scientifically valid data that shows that destruction of the brain is equal to the death of a person.

Senator Zane wanted to know, how can they say that the brain has been destroyed? I'm not talking about death of a person. I'm talking about destruction of the brain. They have three things they can do: Three vessel angiography, putting in a dye, and x-raying. This is very dangerous. It can cause brain death; it can cause

destruction of the brain. It's very rarely done in the United States. Besides, it's not valid, because if something can cause what you are looking for, it's not scientifically valid.

The second is rostral-caudal herniation. Very, very few people get this. It's not usually a cause of brain death. It only leaves us with one thing; that is, a clinical test. This is how doctors determine if the brain-- While the brain has been destroyed, as it was mentioned today, they put ice water in the ears to see if they contract, see how the eyes flutter. They shine a light in the eye, put cotton to the eye to see if you blink. They put a gag down the throat. They shake the face back and forth to see how the eyes go, and then they disconnect the ventilator to see if they breathe on their own. This is how they test for the functions of the brain.

Then they were interpreting lack of function as destruction of the brain. Why are they saying that those tests can show destruction of the brain? Because those things that I just showed on that page, test the brain stem activity. And they are claiming, if the brain stem is gone, you don't really have to test all these other things; because they are saying, if the brain stem is gone-- Since that is the thing which wakes you up in the morning and activates your mind, they say, that is gone. Well, is that actually true?

In 1985, there was a study of people who were said to be brain dead. They were on the operating table to have their organs removed, and in 85% of the cases, as soon as the scalpel went into the body, the blood pressure and heart beat went up, and that supposedly should not happen because the brain stems controls those activities.

Another 1980 study-- And there were other studies, but, I don't have time to go into them all. There are others in the "Journal of Pediatrics". There are

studies that show where people who have total brain stem failure, recovered: one after 35 weeks; one after 48 hours; one after 80 hours, and they have recovered.

Another problem is locked-in syndrome. A person may have no reactions. The only way the doctor may know that this person knows what is happening is they usually can blink their eyes. That's called a locked-in syndrome. The person is aware of what's happening -- they have complete sensation -- but they are not able to express it. (referring to chart)

In a recent study-- That happens when the lesion is high in the brain stem. When the lesion happens lower in the brain stem, which happened in a certain case, the man-- His eyes were paralyzed and this part was paralyzed, but he was able to move his arm and point to his head. If this man had that problem, and suppose the lesion were in both spots, the person would not be able to show with moving his eyes or with moving his hands that he was conscious, so, he could possibly be declared brain dead.

Now, Senator Ambrosio referred the Senators here today to look at the testimony that was given by Dr. Belsh at the State Bioethics Commission. This is what he said. This is what they do in his hospital, at Robert Wood Johnson Hospital: clinical tests, the then EEG, and this clinical test again after six hours. But the doctor also said he did not recommend that the Commission require an EEG, because he said there are only ten qualified persons in New Jersey who can really interpret the EEG properly, so it would be a hardship for other hospitals. So, what he was suggesting was, clinical tests taken twice, six hours apart. Those are the tests which I pictured before.

Now, let's look at what they are actually doing in the hospital where Dr. Belsh is. Is this adequate to show that a person has died? When they give a person an

EEG, they put the electrical apparatus on the brain. They don't want the person's body to move. So, what they do is give them the muscle paralyzer, succinylcholine. Usually the muscle-- It so happened that there was a case on record where a man was given the muscle paralyzer, succinylcholine and when they were putting a tube down his throat-- There are a certain number of people who have a congenital condition in which they can't really metabolize certain things. Usually, with succinylcholine paralysis, you only have a minute or so.

In this particular gentleman's case, he stayed paralyzed for three or four hours. The doctor thought he was brain dead. He did not have any reaction whatsoever. However, the doctor did give him an EEG. When he gave him an EEG, he realized that this man was conscious, and the man said he was aware of everything. He heard the doctors talking. He saw the light in his eye. The thing is, Dr. Belsh said, "Don't give an EEG." It could happen here in New Jersey. There is nothing in this bill that requires an EEG. People who are alive and are even conscious could be declared brain dead.

The NIH study, this was the major study that was done in the United States. This was the major study of brain death. They were not able to prove that death is -- that brain destruction is equal to the death of the person.

And they were not able to show in a scientifically valid way that the tests they were using really showed destruction of the brain. When they did autopsies, in 60% there was no destruction; in 10%, there was actually nothing wrong with the brain; and for those that met all the tests, only 15% had destruction of the brain.

The President's Commission said we don't have to worry about these tests not being valid because the President's Commission said the published criteria have been uniformly successful in diagnosing death, for which

reasonable medical experts testified that the risk of a mistake with a competently performed EEG was infinitestimal. That's what the President's Commission has said, and this was what was quoted in "New Jersey Monthly."

Dr. Schumann who is an expert in mathematical statistics has shown in many of the writings that he's done that by using the probability data base with what they have at this present time, if the above methodology were applied to present data bases, the theoretical risk would hardly turn out to be negligible, let alone infinitesimal.

A Dr. Pitts said there are no special precautions for pronouncing brain death in infants and children.

SENATOR O'CONNOR: Excuse the interruption. How close are you to concluding?

MS. COYLE: I'm hardly-- I wanted to give this information. I'm rushing this. I know I sound very rushed, because I know how much material is there. This is material that you should know, and I was not able to give it in the Commission.

SENATOR O'CONNOR: I would invite you to submit a written report to the Committee, and we'll circulate it. We have abided by a ten minute per person presentation throughout, and you're beyond the ten minutes. Also, these confirmatory tests are not valid.

MS. COYLE: Well, I have much more material, and I'm disappointed that Senator Zane is not here, because I could have answered the question that he asked this morning.

I'll submit something.

SENATOR O'CONNOR: Is there anyone else?

M A R I E N E I M E Y E R: Senator O'Connor and Senator Ambrosio, I would like to have presented part of a film called "Are the Donors Really Dead?" I know you have seen it, and we have shown it also to Senator Orechio. We do

feel that it is very important because it does explain the concepts of brain death, which is a very complicated issue.

Now, I would just like to show part of it. Unfortunately, most of the members are not here.

SENATOR AMBROSIO: Mr. Chairman, since you've seen the film, I'm not interested in seeing it. I would suggest with the hour being what it is, that you not allow the film to be shown.

SENATOR O'CONNOR: I don't see the point in showing the film. I have seen it.

MS. NEIMEYER: You've seen it, and no one else is here. I would like to say something about the film. It's a British documentary done in 1980, and it is a study about the practices of declaring brain death in the United States. In the film there are four cases in the United States of people who were declared brain dead and then subsequently revived, and are leading happy, normal lives at this time.

One of the things in the declaration of death bill before this Committee today states is that physicians may use accepted medical standards. The problem with that is that the clinical test done at the bedside are what can be used, and those alone. In the Strachan case here in New Jersey, that is what the New Jersey Supreme Court ruled. They ruled that brain death on that young man was valid if done by an emergency room physician within only twenty-five minutes after he entered the hospital without any EEG, just with the clinical tests. That's the ice water in the ear, cotton ball in the eye, okay? That is a very dangerous thing.

It has not been scientifically validated as has been stated here before. The film also shows that. It shows the studies that have been done in nationally famous hospitals and here in New Jersey. And I think the film is very impressive. I think it explains very well about

the brain, how it functions, and how these tests work, and also about the confirmatory tests.

There are also serious problems with these tests. Besides them not being valid -- like wax in the ear would make the ice water test invalid; an injury near the eye would make the eye test invalid. There are many problems associated with these tests.

Also, it has never been scientifically validated that brain death is equal to the death of the person. I really feel this bill should not be voted out of this Committee because it really puts patients in New Jersey in a very precarious position. And I would ask that you do not release it.

I also would like to just go into one area on the living will. I am a widow. My husband died of cancer of the stomach and the esophagus which is considered one of the most painful types of cancer there is. He was also on the hypoalimentation feeding tube that the woman talked about before, so he could no longer eat nor drink, and he was in a lot of pain. He was in the Sloan-Kettering Hospital in New York, and they did manage his pain by putting him on a morphine drip, and that was something that he had constantly, that could be adjusted to his pain. He was conscious and aware of what was going on.

I had him transferred from that hospital. They told me there was nothing more they could do for him. He had undergone surgery and chemotherapy. At Christmas time they told us he was cured, and at Easter time there was nothing else they could do for him.

When I had him transferred to a local hospital in New Jersey, that day they discontinued the morphine drip. The hospital that he was transferred to did not use that as a matter of procedure. And when he got there, they didn't really know how to adjust the dosage and stuff. I was very upset because he was in a tremendous amount of

pain was wondering if I had made the right decision in transferring him. But eventually they did get that under the right dosage, and he was doing well with the pain.

The reason I'm bringing this up is, sometimes people feel that they want a living will because they are going to be in pain which cannot be controlled. But according to doctors, 97% of the pain with the terminal cancer can be controlled; unfortunately, 40% of the pain in patients is not controlled, and in terminally ill patients -- the acutely terminally ill patient -- that rises to 60% to 70%. Through my own personal experience, although I saw that my husband's pain was controlled, the man in the next bed at the local hospital in New Jersey, they did not want to give him this type of treatment. They were afraid that he may become addicted to it. And, so, the means that are available to reduce pain and control pain are not being adequately used.

I think if we promote education among the doctors and the staffs, and even people in general in this area, that that would go a long way in maybe even saying that, you know, that they would not be wanting to be assisted in suicide or to commit suicide.

I ask that you do not release either of these bills. Thank you.

SENATOR O'CONNOR: Thank you very much. Now, we are concluded for today. Thank you all for--

SENATOR AMBROSIO: I want the record to note that Alan Weissbard from the Bioethics Commission was here all day and would have been available to answer any questions that the Committee members had on the bill, to the extent that any members of the Committee have any questions, he will remain at their disposal to answer them.

SENATOR O'CONNOR: Thank you, Senator.

(MEETING CONCLUDED)

APPENDIX

NEW JERSEY
STATE BAR ASSOCIATION

NEW JERSEY LAW CENTER, ONE CONSTITUTION SQUARE
NEW BRUNSWICK, NJ 08901-1500
201-249-5000

TESTIMONY OF THE NEW JERSEY STATE BAR ASSOCIATION

ON SENATE BILL NOS. 3320 AND 2067

June 8, 1989

The Senate Judiciary Committee has before it today legislation which has the potential to provide great assurance for those who desire to express their wishes regarding medical treatment in anticipation of a day when they can no longer participate in those decisions themselves. Senate Bill Nos. 2067 and 3320 would regulate for the first time in the New Jersey statutory law, advance health care directives and medical decision powers of attorney.

In <u>In The Matter of Nancy Ellen Jobes</u>, the New Jersey Supreme Court clearly expressed its preference that the Legislature, and not the courts, resolve issues concerning the withdrawal of life sustaining treatment. The Court stated:

> Courts are not the proper place to resolve the agonizing personal problems that underlie these cases. Our legal system cannot replace the more intimate struggle that must be borne by the patient, those caring for the patient, and those who care about the patient . . . . Ideally, each person should set forth his or her intentions with respect to life supporting treatment. This insures that the patient's own resolution of this extraordinarily personal issue will be honored . . . . As we have previously explained, the Legislature is better equipped than the Judiciary to form comprehensive guidelines and procedures for the withdrawal of life sustaining treatment. Accordingly, we urge it to pass legislation in this area.

The New Jersey State Bar Association shares the Supreme Court's desire for legislative action. As lawyers, we are frequently called upon to reduce our clients' health care wishes to legal documents. Although we can state that the document we have drawn will be valuable evidence of their wishes, without enabling legislation we cannot assure our clients that their efforts to thoughtfully anticipate their future circumstances will be respected.

After almost a year of study involving our members with expertise in legal issues relating to health care, probate and aging, we developed a proposal which formed the basis for Senator Zane's legislation, S-2067. The aim was to provide a simple set of easily understood guidelines within which advance medical directives (living wills) or health care decision powers of attorney can be drafted. In developing the proposal, we specifically resisted including language which would dictate the types of decisions which individuals would be permitted to make. Instead, language was included which reflects the current state of the law relating to health care decision-making, leaving to the individual decisions regarding the specific treatment to be received when the declarant is no longer competent to express that desire to health care providers and family members. To provide security to the health care community called upon to honor advance directives, the legislation provides immunity for those individuals who in good faith follow directives; it also provides an opportunity for health care providers to refuse to honor directives under limited circumstances.

We believe S-2067 provides a neat, fairly "mechanical" set of guidelines which will afford sufficient flexibility for the individual to express wishes regarding a wide range of treatment

decisions, consistent with recent case law, and provides necessary formality to assure that people who want to have "living wills" appreciate the solemnity of their acts in executing medical directives or powers of attorney. In essence, Senate Bill No. 2067 provides an accurate, concise statement of the current law and avoids the moral and ethical issues which the Legislature created the Bio-Ethics Commission to address.

In contrast, Senate Bill No. 3320, developed by the Bio-Ethics Commission, addresses the moral and ethical issues which Senate Bill No. 2067 does not. In addition, S-3320 establishes specific procedures to be followed by health care facilities in implementing living wills, which we purposely avoided in S-2067. Therefore, S-3320 and S-2067 are not contradictory; they are generally complementary. Accordingly, the New Jersey State Bar Association also supports S-3320.

Our support for S-3320, however, is qualified. In general, the extreme complexity of this bill creates the potential for error and confusion.

In a more substantive vein, S-3320 does not address the effect of an advance directive when the patient involved is pregnant. We recognize this as an exceedingly sensitive issue, but one which we believe must be addressed.

Secondly, the Bio-Ethics Commission bill introduces the concept of institutional review boards whose function and authority are virtually unprecedented in our laws. In addition, although there is no consensus even within the Association on the issue regarding the review board provisions, we generally agree that these provisions

may result in another layer of complex procedure which could delay action in cases where directives should be honored and which create the potential for court challenge. We are also concerned about the privacy rights of individuals and family members who may not want to bring a particular case before a review board which might be comprised of members of the patient's community.

Third, as lawyers, we have concerns about the formalities required under this legislation for the execution of an advance directive or medical decision power of attorney. The witness requirements seem more stringent than we would propose. We would prefer that either an advance directive or power of attorney be valid if acknowledged before a notary or attorney without the need for witnesses.

Fourth, as drafted, provisions which address situations where there is disagreement among the patient, health care representative, and attending physician appear to require resolution by means other than the court. The right of access to the courts should be preserved, and courtroom alternatives available as an option.

Finally, we have reservations about the exclusion of mental health facilities from the definition of health care institutions to which S-3320 would apply. This creates the potential for unequal treatment of individuals who have executed medical directives or who have designated health care representatives.

We commend the Bio-Ethics Commission on its years of work on the exceedingly complex issues addressed in its legislation. The choice which the Legislature must make is whether the more comprehensive approach of Senator Ambrosio's bill or the simpler approach of Senator Zane's bill is more appropriate for New Jersey at the present time. In either case, we urge the Legislature to dedicate itself to fulfilling the present need for a statutory framework to guide patients and their families, health care providers, and lawyers in the preparation and observance of advance health care directives.

TESTIMONY

ON

"NEW JERSEY ADVANCE DIRECTIVES
FOR HEALTH CARE ACT"

S-3320 AND

'NEW JERSEY HEALTH CARE DIRECTIVE ACT"

S-2067

BY

ANNE M. PERONE, ESQ.

490 SOMERSET STREET

NORTH PLAINFIELD, NEW JERSEY 07060

(201) 769-6574

6X

TESTIMONY OF ANNE M. PERONE

The proposals which are before this committee are premature and have been prepared in a vacuum. The enabling statute, P.L. 1985 Ch. 363 of the New Jersey Legislature required that the Bioethics Commission shall:

3(b) Gather data about how New Jersey and other jurisdictions handle decision making regarding the termination and refusal of care and treatment.

Where is this data? Where are the reports?

Further, the Commission had a duty to:

3(c) Assess the need for additional programs and services relating to medical decision making.

Where is this data? Where are the reports?

Finally, the enabling statute provides in Par.6:

"The commission shall ...make its report to the Governor, Legislature and public.... The <u>initial</u> report ... shall include:

a. A report on the current status of the law in New Jersey and other jurisdictions regarding the termination of treatment, surrogate decision making, and related issues;

b. An examination of existing practices and procedures for decision making, such as Quinlan ethics committees and Grady and Conroy procedures, and a determination of how well they work and where change is needed...."

Where is the data? Where are the reports?

The commission has provided no such report of current

7X

practices and procedures, or how New Jersey and other jurisdictions handle medical decision making, or any assessment of a need for change,and no reports regarding how well current practices work.

Rather the Commission just forged ahead , putting the "cart before the horse" ignored the mandate of the New Jersey legislature and prepared the S-3320 proposal.

Even S-3320 states on page 24 that, "This commission was established by the Legislature in 1985 to

> provide a comprehensive and scholarly examination of the legal and ethical dilemmas in the delivery of health care posed by modern advances in science and medicine."

Where is the report of the required scholarly examination?

No studies or reports of practices in hospitals or nursing homes in New Jersey have been done. The Commission has not followed its mandate. It jumped right into preparing living will legislation without providing the necessary framework that was required.

In addition to opposing this legislation because it did not follow the legislature's mandate to **study** and to **report** on the use of advanced directives in other jurisdictions and in New Jersey , the commission was to report on whether the use " has promoted the preservation of life" among other issues. Par.6 (f) provided that "Accompanying the reports, the commission shall submit any proposed legislation which it may desire to recommend for enactment"

By not providing the mandated reports to the public, to the Governor and to the Legislature, this proposal is premature and fatally flawed.

IT IS DANGEROUS

The major protection that is granted by a living will is not to the patient but to the doctors/professionals/ institutions. Complete immunity is granted to doctors, and institutions from civil, criminal and professional liability. No profession or livelihood has ever been afforded such sweeping and complete immunity.

Every carpenter, builder, lawyer, doctor is held liable for their negligence or malfeasance. Patients are not gaining any civil rights ----they are losing their rights to proper, beneficial, caring medical treatment.

A person granted "power-of-attorney" over the financial affairs of a patient is still liable for abuses of the fiduciary relationship between the principal and the agent. The powers of attorney are spelled out and he/she must follow the powers granted. If a patient wants to grant complete immunity to his/her attorney-in-fact, then it can be granted by each individual in their own document.

Sweeping legislation granting across-the-board immunity is dangerous and does not protect the patient.

Patients normally sign a one-page Living Will document. They are usually not informed of the language in the statute giving complete immunity. The elderly and the nursing homes

are being sold a bill of goods regarding the "benefits of this legislation". Rather then gaining a right, the patients are losing protection of the law.

Another danger in this proposal is that our well-meaning citizens and legislators are being lulled into believing that somehow this legislation is giving them protection which is not all ready in place. This is not the case. Patients and families have common law rights, they have rights under the power of attorney statites in place.

A "living will" is not the end product of a "rights" movement--it is the means to an end.

The "Living Will" was formulated in 1967 by the Euthanasia Educational Council (now called Concern for Dying) as a tool to promote acceptance of euthanasia. Because the public was not yet ready to accept the total concept of euthanasia, it was intended that the document would gradually shape public opinion, thus leading to a recognition of the "right" to choose when, where, why and how to die.

All "Living Will" legislation currently in effect allows for involuntary euthanasia and assisted suicide. No "Living Will" legislation excluded medications upon which a patient was previously dependent (insulin, digitalis, etc.) from the categories of medical procedures which can be withdrawn or withheld. The "Living Will" allows for euthanasia by omission of even necessary and ordinary care, such as removal of food and water.

The next step toward full acceptance of the "right to

choose" death-on-demand is the proposal for euthanasia by commission--already initiated with the introduction of the "Humane and Dignified Death Act" which would allow for "physician administered aid in dying (lethal injection)." It is significant that this act was initially introduced in California, the first state to pass "Living Will" legislation, and that it is not new legislation but is, instead, being proposed as a series of <u>amendments</u> to existing "Living Will" legislation. Currently, bills to pass "aid-in-dying" are being introduced in Florida, Arizona, Oregon, California and other states. A Living Will is not the <u>end</u>; it is the "means to an end" - death on demand!

In California, although the "aid in dying" people state that 60% of the people want this legislation, they could only get 200,000 signatures out of the entire population of California, when they tried to get an amendment on the ballot. Euthanasia proponents declare there is a <u>need</u> and a demand for this legislation, when they are the ones demanding it.

After the 1960's, the Euthanasia Society of America (now known as the Society for the Right To Die), and the Education Council (now called Concern for Dying) decided to create a climate in which euthanasia legislation would be possible. The "Living Will" was the suggestion of Luis Kutner at the 1967 Euthanasia Society meeting - as a means for creating such a climate.

Abby Van Buren, a long time euthanasia advisory board

member, promotes Living Wills regularly in her column.

A slow, steady, inch-by-inch movement with carefully constructed language (for acceptability) has progressed from California to New Jersey.

Euthanasia advocates sugarcoat the bitter pill of euthanasia by using acceptable language for the unacceptable.

Titles such as "Right to Die Act" (N. Mexico); "Death With Dignity Act" (Delaware); "Rights of the Terminally Ill Act" (some states). Each word is weighed carefully by euthanasia proponents for its impact on any opposition.

Common phrases founded in living wills are "my attending physician"; "unable to make treatment decisions"; "final stages of a terminal condition"; "death is imminent", and "life sustaining procedures".

A Living Will signer assumes a particular meaning for each of these phrases. But how are they, and how can they be interpreted?

The general understanding of "attending physician" is a physician in whose care one has been for some time. In realty, "attending physician" refers to the physician who happens to be in charge of a person's care at a particular moment. It is entirely possible that, within the course of a day, a hospitalized patient could have as many as three or more attending physicians, any one of whom could put a Living Will into effect.

While the signer of a Living Will may think "unable to make treatment decisions" means that one is in a coma, the

words can be interpreted to mean that one is mildly senile. No Living Will law gives any objective-criteria for making the determination that the patient can't make these decisions. The individual attending physician can make this crucial judgment based upon purely subjective considerations.

Picturing "final stages," one may assume this means the last few days of life. However, "final stages" is rarely defined in legislation and, when it is, it is described as meanig that death will occur in a "reasonably" or a "relatively short time," interpreted as meaning days, weeks, months or longer, varying from illness to illness and patient to patient.

"Life-sustaining procedures" are generally perceived as respirators, heart-lung machines and other advanced technological procedures. In fact, "lift-sustaining procedures" have been interpreted to include medications such as insulin, digitalis or antibiotics.

These phrases are not the only illusory protections found in Living Will legislation. In passing such legislation, many pro-life legislators have often insisted that a strongly worded statement prohibiting mercy killing be included in the law. California's Natural Death Act states, "Nothing in this article shall be construed to condone, authorize, or approve mercy killing..." But recently, new legislation was introduced to amend the California law. The amendments would allow for the provisions of "aid in dying" which means "any medical procedure that will swiftly,

painlessly, and humanely terminate the life of the qualified patient.

Euthanasia by lethal injection would then be allowed under California's Living Will Act.

But how would this be possible under the California law with its prohibition of mercy killing? It's really quite simple. **"Aid in dying" will be an exception.** Mercy killing is still prohibited, but "aid in dying" is not to be construed, under the law, as mercy killing.

The protective words still remain. It's only the protection that's removed.

At the 1984 meeting of the World Federation of Right to Die Societies, the goals of the euthanasia movement were clearly outlined--goals culminating in the establishment of suicide clinics where anyone can request "self-deliverance."

In order to reach this final goal, the steps of acceptance of the Living Will, legalization of assisted suicide and the lethal injection for the terminally ill must first be taken.

At that time, Professor Curt Garbesi of Loyola Marymount Law School in Los Angeles said, "We are focusing on the first short step of this process." He was referring to promotion of the Living Will. Garbesi is one of the authors of the amendments to California's Living Will Act.

At the same meeting, Dr. Helga Kuhse of Australia's Voluntary Euthanasia Society said, "We are blinded by the myth that withdrawal of treatment is morally different than

killing." She went on to explain that once it's legal to remove all types of treatment and care, it will be a small step to obtain acceptance of direct killing, since the public will then recognize that withdrawal of some types of treatment leads to a very painful death.

"They'll realize that this is clearly not in the patient's best interest and that, given an injection, the patient could have died quickly," she said.

It appears that the euthanasia movement's agenda is moving ahead on schedule--with the help of well-meaning, unsuspecting people. It will only be stopped if we take the time and the effort to learn its language and to oppose it unequivocally.

UNNECESSARY

An Advanced Directive Law is unnecessary under the two common law Principals which currently exist.

The first

1. Requires the health care providers to provide appropriate and beneficial medical treatment, and

2. Patients are the final decision makers since and unconsented-to treatment would constitute "an unconsented to touching or battery" See W. Prosser, Handbook of Law on Torts (4th ed.) 161-164 and 34-37.

These decisions of a competent patient are always balanced and weighed against the state's interests in preserving life, preventing suicide; protection of third parties, protection of the integrity of the medical and

health care professionals, and keeping the public's confidence in the the medical professionals and institutions, and protection of the public health.

Our state laws regarding assisted suicide and homocide are examples of our state's interest in protecting life and preventing any wrongful or irrational termination of life.

In addition to the citizen's common law rights to agree to or to refuse medical treatment, each person has a fundamental Constitutional right to life protected by the 14th Amendment. This gives the State a compelling interest in protecting the procedural and substantive due process rights of each person. The language in the advanced directives herein deny this fundamental protection.

The real purpose of a living will is not to protect the patient or to give the patients more rights or authority than already exist. These rights are already in existence whether the patient is competent or incompetent.

Incompetent patients have families-physicians making their medical treatment decisions. The only controversy is in rare cases where the doctor or institution refused to terminate food and fluids without a court order because of the state's opposing interests which are to prevent suicides, homicide, preserve medical integrity and confidence in the profession, etc.

Patients without relatives have the right to use the traditional and existing power-of-attorney law to have a particular person handle financial matters, and can also have

that same person appointed to make medical decisions. The law is on the books in New Jersey. We don't need a living will law to appoint a person to make decisions if we are later judged incompetent. In fact on page 26 of this proposal, Paragraph 26 (b) recognizes the "right of a patient under existing law (N.J.S.A. 46:2B-8) to appoint an attorney-in-fact to make decisions, however, the present proposal rips away all patient protection.

The Supreme Court of New Jersey upheld the use of a power of attorney used by Hilda Peter for her friend to make medical decisions for her. The only problem was the document did not give her friend the right or power to withdraw food and water. In Matter of Peter by Johanning, 108 N.J. 365 (1987).

It is interesting to note that the case of Hilda Peter has been widely criticized because of allegations by the third wife of the guardian (Johanning) that he was brutal, and tried to poison her. Neighbors of Johanning's second wife stated that she had complained a week before she was found in dead, that Johanning was trying to kill her. Johanning's second wife was found under similar circumstances as Hilda Peter, with alcohal and sedatives in her system and bruises on her body.

It is unfortunate that the Supreme Court was unaware of the investigations of the guardian Johanning before it rendered its decision.

The power of attorney law as it exists however would

permit persons to designate an agent for medical decision making, but does not take away the patient's rights for a due process hearing if the attorney -in-fact attempts to exceed his or her powers. Just as an attorney in fact is liable if he appropriates the moneys of an incompetent, he should be held liable if he does not follow the medical powers given to him.

The leading case, State v. Kennedy, 61 N.J. 509 (1972) involved a 99 year old woman who signed a power of attorney and the agent appropriated her life savings to himself. He was convicted of embezzlement and fraud. It is inconceivable that the legislature should protect an elderly woman's assets with a full due process hearing and consider removing the same kind of protection of her life.

The real purpose of a living will is not to protect the patient or to give the patients more rights or authority. These rights are already in existence whether the patient is competent or incompetent.

This bill takes away the rights of incompetent patients in many ways; which is contrary to the traditional actions of the New Jersey Legislature.

The legislature in New Jersey has always tried to protect vulnerable patients by affording them their 14th Amendment due process rights and the full protection of the law.

For example, Developmentally Disabled Patients are protected in N.J.S.A. 30:6D-5 (a) (4), which provides:

> No person receiving services for the developmentally disabled at any facility shall: be subjected to shock treatment, psychosurgery, sterilization....without the express and informed consent of such person...if a minor or incompetent , that person's guardian ad litem shall petition a court of competent jurisdiction to hold a hearing to determine the necessity of such procedure at which the client is physically present, represented by counsel, and provided the right and opportunity to be confronted with and to cross-examine all witnesses alleging the necessity of such prcedure. In such proceedings, the burden of proof shall be on the party alleging the necessity of such procedure. In the event that a person cannot afford counsel, the court shall appoint an attorney not less than 10 days before the hearing.

N.J.S.A. 30: 6D-(b) requires every developmentally disableed person to be provided with a nutritionally adequate and sufficient diet.

Mental Patients have rights similiar to the disabled

rights wherein he must be judged incompetant in a court hearing and cannot be subjected to experimental treatment or sterilization without due process protection. See N.J.S.A. 30:4-24.2 d (2).

IN the case In re Grady, 170 N.J. Super 98 (1979) parents of a Down's Syndrome child applied for permission to have their daughter sterilized. The Court held among other factors that there must be a court finding of the patient's incompetancy, that the incomptetancy was permanent, that all\ procedural safeguards have been satisfied (ie. a guardian -ad litam to represent the incompetant in court), and the patient had a right to examine all proofs and cross examine witnesses. Id. at 125-126.

It is proper and appropriate for the legislature to continue to protect the vulnerable elderly from coercion to sign a Living Will whether that coercion be by family or institutions which are mandated " to educate" all new arrivals and periodically thereafter about the so-called benefits of an early demise.

Many patients are in a depressed state due to the physiological after effects of a stroke. A full competency hearing which is currently mandated before sterilization can be performed, is certainly appropriate regarding life and death decisions.

The Child Abuse Statutes of 1984, 42 U.S.C.A. sec.5103 (supp.1985), a federal statute defining the withholding of medically indicated treatment from children born with

disabilities as child neglect, require that nutrition and hydration be provided to all disabled children regardless of whether their condition places them in a category in which medical treatment is not required.

The federal legislature took cognizance of the fact that withholding or withdrawing medical treatment may not result in a patient's death, but it is impossible for a patient to survive the withholding of food and fluids. Such action is final; death is a certainty.

Many patients in a coma, or because of senility are also as dependent as an infant. Removal of food and water is a cruel and inhumane death and should never be permitted.

CONSIDER THE SOURCE OF LIVING WILLS

In 1982, at a meeting in the Countway Library of Medicine, Boston, Mass., the Society for the Right to Die Society of New York paid for and invited ten doctors to formulate policy on withholding and withdrawing medical treatment. The result of this meeting which was sponsored by the euthanasia society were published in the New England Journal of Medicine, April 12, 1984 as " The Physician's Responsibility Toward Hopelessly Ill Patients." These doctors , four of whom are board members of the Euthanasia Council concluded that "it was morally justifiable to withhold antibiotics and artificial nutrition and hydration, as well as other forms of life sustaining treatment, allowing a patient to die. They said this is permissable for patients in a p.v.s. state, or severely and irreversibly demented

patients (who do not initiate purposeful activity but passively accept nourishment and bodily care)..."the physician must always bear in mind that senseless perpetuation of the status quo is decision by default."

Regarding patients categorized as" pleasantly senile"-- the physician should provide emergency resusitation and intensive care sparingly, "guided by patients wishes, if known, by patient's family and assessment of patients's prospects for improvement.

Dr. Leo Alexander, who assisted at the Nurenburg trials after W.W.II. said before his death--regarding the above referenced publication, that the euthanasia climate in the United State is exactly like that in pre-Nazi Germany.

I am sure Dr. Leo JAlexander is turning over in his grave regarding the latest publications by 9 out of the same 10 doctors. "The Physicians Responsiblity Toward Hopelessly Ill Patients--A Second Look", New England Journal of Medicine, March 30, 1989. The meeting was held at the same library. The entire document was geared toward assisted suicide. All but two doctors concluded and reported "that it is not immoral for a physician to assist in rational suicide of a terminally ill person." Id. at Vol. 320, No. 13, p.848. The Right to Die Society has carefully orchestrated the 1982 and 1987 meetings which resulted in edicts by a mere ten doctors.

These ten physicians consist of four members of the Euthanasia Board and other physicians who have published pro-

death medical articles. These two reports are no more or no less than the bio-medical beliefs of the President Emeritus of the Society of the Right to Die, Dr. Joseph Fletcher. See attached article " Indicators of Humanhood: A Tentative Profile of Man.", published by the Hasting Center in 1972. Fletcher decided that a person is not a person if he has less that a 40 I.Q.; is not self-aware (unconscious or irreversible damage to the brain); is not controlled by self; lacked sense of time or futurity , or past; not capable of relating to others; lacked concern for others; was unable to communicate; lacks control of existence (ie. degenerative psychosis); lacks curiosity (to be without affect such as many mental patients); lacks change both physically and mentally; lacks rationality and feeling. To be fully human Fletcher argues you must be cerebral and a creature of feeling.

The Godfather of the euthanasia movement has outlined his views on what is a person. (Note non-persons lack constitutional rights) The 10 physicians in Boston at the behest and cost of the Right to Die Society have outlined the approved agenda. The Right to Die Society thought up the "living will" concept as a means to arrive at their end which is Death on demand. "Rational Suicide" will occur at clinics--called deliverance centers. One of Dr. Fletcher's famous quots is:

" What has taken place in birth control
and birth selection, must take place

in death control and death selection."

My Jewish friends often say "never again" regarding the holocaust of W.W.II. where thousands of demented, disabled, retarded, vulnerable people were killed at the "mercy" of physicians and institutions.

Lately many T.V. shows have shown the Holocaust. Good people carried out many "**unacceptable actions**" when the actions and language were made "**acceptable.**" This bill is a carefully worded document to permit **unacceptable** treatment of the elderly and vulnerable in New Jersey. It is not an end in itself--but a means to an end that the proponents of euthanasia have very careullly assisted in crafting not only in New Jersey but across the United States.

You may wonder if my criticism of the euthanasia is unwarrented. Allow me to point out a few facts.

1. The Bioethics Commission had fourteen seats for appointment of members of the public. Nine out of the fourteen seats were initially held by members of / or financial supporters of the New Jersey Citizens Commitee.

2. The Citizen's Committee has conducted workshops performed plays, and shown filmstrips dealing with the economic problems of longterm care and the promotion of advance directives/ living wills at more than 300 different locations.

3. The Citizens Committee has sponsorred workshops where powerful proponents and Board members of the Euthanasia Educational Council have promoted living wills and the

removal of protection of patients by the Ombudsman.

4. The Citizen's Committee has received hundreds of thousands of dollars from the Prudential Foundation directly and via funnelling through the Hastings Institute. It also received huge grants from the R.W. Johnson Foundation.

5. A National Bioethics Citizen's group is in the planning stages and was also funded by the Prudential Foundation and R.W. Johnson Foundation.

The Prudential Insurance Company will certainly benefit economically for every patient who is removed from its medical insurance payment rolls. This is a fraud upon the millions of elderly patients who have paid premiums for their medical care throughout their lives.

The Robert Wood Johnson Foundation will certainly benefit economically under several proposals before the Commission.

It is time for our Legislature to take action. Send the proposals back to the Commission and demand that it provide the mandated reports and studies for which the Commission was convened.

SPECIFIC FLAWS in S-3320

2.b. States " **modern advances in science and medicine...etc.**" Tubes providing nutrition and hydration are not modern or advanced. They have been in use for more than eighty years. Today, nasogastric tubes are less than 1/8 inch in diameter and are used in every medical facility and

at home.

... **This State recognizes that the fundamental right of individual choice...** New Jersey has always recognized a common law right but has not decided on the basis of the Constitution that there is a "fundamental" right of individual choice in these cases.

2.c. **"patient loses decision making capacity"** How will this be determined? Will the patient be afforded a due process hearing regarding incompetency as disabled and mental patients are afforded?

2.d. "The right ...to forego life-sustaining treatment" is subject to a list of state and societal interests. How is it subject?

3. " Decision making capacity". What standard will be used to determine a patient's decision making capacity? How will it be "evaluated relative to the demands of a particular health decision? Is the standard objective or subjective?

" Do not resusitate order" Who gives the doctor the authority to write this order?

" Health care decision" Includes a decision of a patient "to refuse a transfer of care". Suppose a doctor or nurse refuse to abide by a patient's wishes, will they be required under the patient's refusal of transfer right to violate their professional conscience and/or ethical standards?

" Life sustaining procedure" according to this definition will exclude any i.v., or tube administering food,

water, medication, antibiotics, insulin, digitalis or any other stabilizer used in certain medical situations. "thereby increase the expected life span" Every drop of insulin, or food and water or digitalis would provide an ordinary life span. The deprivation will **decrease** the expected life span.

"Permanently unconscious" This definition is frought with problems. Very few doctors can say a coma is irreversible. The PVS state is also a recent name for brain damaged patients. The "without limitation" language is there specifically to include demented Alzheimer patients without"capacity for interaction with the environment". It appears that Dr. Fletcher wrote this definition back in 1972.

"Terminal condition" No determination of a life expectancy is required? Why not? Of course the prognosis of life expectancy of six months or less will always be accurate "without the provision of life-sustaining treatment". Most people die in three weeks without "life-sustaining food and water". Some will die in a day without insulin.

4. Declarant may sign a Living Will at any time. If the declarant gives only a directive but does not appoint a representative, the declarent is waiving all rights to making and giving informed medical consent regarding the benefits and burdens of any and all treatment in a given situation.

5. b. (1) and 5.d. What if a patient revokes orally to one "attending physician" but fails to revoke with all subsequent medical personnel? What if the patient wants to

revoke but can't communicate?

6.b. Instruction directives waive the patient's right to informed medical consent.

7.a.(2) A patient may lack decision making capacity temporarily because of injuries or stroke or drug overdose; does this trigger the termination of treatment?

8. Who is the "attending physician? Someone who knows the patient or one of many during the hospital day?

8.c. Mental and disabled patients will not be afforded due process rights with this language in contravention to existing statutory protections.

8.e. There are many elderly who are hard of hearing and /or speak a foreign language, how will their rights of being informed be protected?

10a. Does the attending physician have " an affirmative duty " to inquire of the patient, his family or others of a revocation? How will the attending physician gain knowledge of the modification or revocation?

10.b. It is interesting to note that a doctor's refusal to withdraw or withhold life-sustaining treatment will be protected however, the patient who is not provided the care/ medicine/ food/water to sustain his life is said to be " abandoned or treated disrespectfully" if not transferred in a timely manner for the treatment of non-treatment! George Orwell could not imagined a better example of " double speak" or "new speak". Food and water and medical treatment are abandonment! Transferring a patient to his death is

respectful!

10.c. Ditto.

11.b. How can some patients who can not communicate for various reasons avail themselves of right to demand food and water? Does moaning qualify? Will the patient be drugged against pain so they can't communicate?

13 a.(1) Interferes with the operation of nursing homes and hospitals in that private institutions are <u>required to inquire</u> and thus subtlely promote living wills among its patients. The "shall adopt" language is mandatory in nature and impinges on the rights of private corporations of freedom of contract and to decide corporate policy.

13 a.(2) Interferes with the operation of an institution by requiring it to "educate" families and patients about living wills and to" assist patients in discussing and **executing** a living will!

13. a.(4) How can a an institution assure the patient is not abandoned or treated disrespectfully when the purpose of transfer is to terminate treatment?

13.a.(5) The current rules regarding disputes is easy , call the Ombudsman for the elderly in nursing homes. For all others petition the court/ expand the office of the Ombudsman. It is impractical to expect nursing homes to have an effective ethics committee wh hospitals don't have them. Further, it is a duplication of many committees with varying understanding of the statute. A disinterested state appointed person / or a court of competent jurisdiction which

affords proper protection in disputes.

13.b. Is inadequate since it only exempts religiously-affiliated institutions. All private institutions may be forced by this provision to either close down or forced to commit acts against th. conscience of the owners, the administrators and/or the staff. All institutions should be permitted a clause protecting the conscience of the owners, administrators, and/ or staff.

13.c. This clause does not protect any institution, since a Catholic Hospital was ordered by the court to starve and dehydrate a patient to death. The Peters, Jobes, and Farrell trilogy effectively extinguished any rights of an institution to refuse to withhold or withdraw treatment unless this Legislature protects the rights which have been removed by judicial activism.

14.a. The Ombudsman should be appointed to investigate conflicts. The second level should be the Court.

15.c. There is no Constitutional right of privacy under the federal or state constitution to refuse medical treatment.

16.a.(1) Food and water is never futile in prolonging life, it's a necessity. One will never know if the death is "immenent" if food and water is removed. It is a self-fulfilling prophecy. This Par. is dangerous because it is written in the disjunctive "or" rather than the conjunctive "and". Therefore (1) or (2) or (3) all permit the removal of food and water. Patients have come out of a coma after months

and even years. Patients have been erroneously diagnosed as P.V.S. The only situation where water is withheld for medical reasons is in severe burn cases. All other conditions allow fluids by i.v. or hyper-alimentation.

17.a. Does this mean the patient decides "Do not resusitate/ or the doctor?

17.c. What legal authority does a doctor have to write a "Do not resusitate order"?

18.a. Unnecessary duplication of time and effort. We have an Ombudsman. Expand the powers of that office.

18.b.(1) Penalty makes this unworkable. (2) and (3) O.K.

19.b. Invades and withdraws protection afforded these patients in other statutes.

20. and 21. Most dangerous. Legislature will abdicate its authority in most crucial area of patient protection. Most citizens are unaware of rules and regulations promulgated by Department of Health.

22. Complete immunity deprives patient of protection and possible life-threatening decisions. "Good faith" standard difficult to assess. Is "good faith" similar to "taking a whack at it"?

All health care professionals are immune from any liability. How many Living Will declarants in New Jersey were aware of this when they made (or shall make) a Living Will? Why absolve a complete industry from liability? No other profession is immune for its negligence. Suppose a patient executes aliving will requiring all life

saving procedures? Would the health care professionals be immune from liability for failure to provide same? Under this blanket immunity, YES!

23. The absence of an advanced directive most certainly should create a presumption **against** assuming a patient wants the removal of treatment.

26.a.and b. Effectively remove protections afforded under the power of attorney statute.

26.c. Gives power to self-supporting youths / pregnant girls under the age of 18, the right to terminate treatment without parental interference.

29.a. and b. provides the "stick" to enforce removal of treatment if the" carrot" of immunity doesn't work.

CONCLUSION

IN CONCLUSION , I URGE THE SENATE TO REJECT THIS PROPOSAL SINCE IT IS

1. PREMATURE
2. DOES NOT COMPLY WITH THE ENABLING STATUTE
3. IS DANGEROUS
4. IS UNNECESSARY
5. IS A "MEANS" TO A EUTHANASIA "END" THAT IS, DEATH-ON-DEMAND
6. IS REPLETE WITH LANGUAGE FORCING A LIVING WILL AND A DEMAND FOR WITHDRAWAL OF TREATMENT ON PATIENTS, INSTITUTIONS, AND OTHER PROFESSIONALS

TESTIMONY

ON

"NEW JERSEY ADVANCE DIRECTIVES
FOR HEALTH CARE ACT"

S-3320 AND

"NEW JERSEY HEALTH CARE DIRECTIVE ACT"

S-2067

BY

LUCILLE A. LINK

239 B South 8th Avenue

Highland Park, New Jersey 08904

(201) 572-0038

Some of my objections to the bill are as follows, but are not limited to those listed:

3.25 9.b 10.c 13.a(4) 1. All of these are contradictory in the fact that the patient can accept or can refuse a transfer of care. The doctor, nurse or health care professional, and health care institution can choose to transfer the patient to another health care professional and/or health care institution. Who has the final say? If the patient chooses not to accept the transfer of either or all of the above, the health care professional and the health care institution has, in fact, no rights in the situation.

4.20 16. 1 2. Life-sustaining devices are not defined exactly. Many people view life-sustaining devices as any tube, including a feeding tube. Previously death by starvation has not been an acceptable cause of death in the State of New Jersey. I feel that nutrition and hydration are not life-sustaining devices, and object to them being thrown into the same category. At our facility, we hand feed and hydrate patients; we use geri-feeders. When there is absolutely no alternative, we have nastro-gastric or gastric tubes placed in patients for proper nutrition or hydration. This is not a life prolonging measure, only basic human care. The patient will then expire, not because of the painful death of dehydration, but from the disease or conditions that are the result of their disease. We have been, and will continue communicating to families and patients prior to admission, our facility's views on life-sustaining measures.

Approximately, four years ago, we all had our consciousness levels raised when we learned of all the Ethiopians that were literally starving to death. At that time did New Jersians ask if they were young or old? No, there was a tremendous out pouring of concern and money to feed these people that were helpless.

What about our infirmed elderly? Are they not helpless? Are we going to allow them to starve to death while we complicate man's

basic need for food and water with intricate life-sustaining devices?

New Jersey has always been a front runner in the health care field and previously death by starvation has not been an acceptable cause of death---for anyone---even the elderly or infirmed.

5.7 3. I disagree with the concept of terminal condition without a determination of life expectancy required. Any patient with a disease or illness without promise of life-sustaining treatment will die. A diabetic will die without insulin. Most medications to people with an illness, heart disease, etc., is life sustaining and the person will, in fact, die without the medication. Too many things can be interpreted too broadly.

13.(2)3 4. The health care instituion is being forced to promote "Living Wills" even though ownership and administration are in total disagreement with the concept, which goes hand in hand with only religious institutions being exempt. This will also create an enormous amount of extra time and work for each facility.

14.6b 5. Only private-religiously affiliated facilities have been granted the right under this bill to have a predetermined written policy defining circumstances in which it will decline to participate in the withholding or withdrawing of specified life-sustaining treatments or artificially provided fluids and nutrition necessary to sustain life. There are only a small percentage of religious facilities in the state, and I feel that each facility should be granted that right. The facility that I am the Administrator of is privately-owned. Ninety-eight percent of the staff including myself and the owners, have religious affiliation, and have strong morals and principal in regard to all facets of life; and object to the fact that they will not have the right to follow their beliefs because they are not employed by a religious facility.

14.14a 6. I object to the fact that facilities will have to have ethics committees to oversee each facility. I see no problem with the Ombudsman's Office being the overseer of the institutionalized elderly in regard to all areas of the nursing home. Our facility has never had a problem either with the office or the observance of the law in regard to Conroy, Peters or Jobes. I feel that the Ombudsman's Office as the overseer in all areas will keep facilities following the law. With individual ethics committees, I feel that facilities will diviate and each one will do their own thing, and the law will be stretched beyond our imagination. People and facilities are already doing things to circumvent the law, i.e., sending people to the hospital to avoid the Ombudsman's Office. The terms are too vague, and can be indicriminately interpreted, i.e., semi-conscious, comatose, permanently unconscious, no code, DNR (Do Not Resuscitate), Do Not Send to Hospital. These terms are all being used to the person's (caretaker, doctor, nurse, family member, etc.) own benefit, and in many cases, not to the benefit of the patient. They all have broad based meanings and are being interpreted erroneously.

New Jersey has always been a leader and is known as well as respected for its excellent health care. New Jersey has one of the most stringent health care laws and regulations in the nation. The New Jersey Department of Health enforces these laws through their timely and ardous inspections.

I personally feel that having a "Living Will" law on our books will be a total detriment to our state. It is my strong belief that if the "Living Will" becomes law in New Jersey it will have a very disastrious effect on the elderly, the incompetent and the incapacitated people, and on our state as a whole. We should not jeopardize our leadership status. We should not blindly follow the other thirty-seven (37) states who have "Advance Directives", until we can determine the positive or negative effects of these laws.

If this becomes State law, we will in effect, have put our seal of approval on "EUTHANASIA".

Mrs. C was admitted to Bridgeway Convalescent Center on May 31, 1985 from home. This 78 year old widow was alert, oriented and friendly. Mrs. C's greatest enjoyment was socializing in the smoking lounge and smoking cigarettes. Despite her need for medical treatment for minor lung congestion, Mrs. C was not willing to give up her favorite vice.

In early 1988, Mrs. C became very ill, had difficulty breathing and was transferred to the hospital. While at the hospital, Mrs. C was put on a respirator. The unofficial medical opinion was that Mrs. C would be dependent on a respirator for the rest of her life. Her family contacted the facility upon the hospital's request to attempt to locate a bed that could accomodate a patient on a respirator. Our facility's social worker found a northern New Jersey location that would take respirator patients.

Over a two month hospitalization, Mrs. C's condition improved. She was weaned off the respirator, and her first request was for a cigarette.

Mrs. C was readmitted to Bridgeway Convalescent Center on April 27, 1988. To date, she is alert, oriented and smoking.

Noticeably the one common thread, these are all groups that generally are not part of the "productive" income producing population.

Let New Jersey make a positive step away from this tragic scenario - protecet everyone's basic human common law right to medical care and informed consent. Do not impose legislation to protect the productive income producing professtion and additionally strip individuals of the right to receive basic human need, such as food and water.

I urge that Senate bills S-3320 and S-2076 be tabled or rejected.

New Jersey Eagle Forum

P.O. Box 137, Brookside, New Jersey 07926 (201) 543-7626

VERA ROCHE
N.J. STATE CHAIRMAN
P.O. BOX 137
BROOKSIDE, NJ 07926
(201) [illegible]

PEGGY DICK
MEMBERSHIP CHAIRMAN
5 SUMMIT RD.
BROOKSIDE, NJ 07926
(201) 543-7181

MARION FISHER
LEGISLATIVE AIDE
212 OCEAN AVE.
MANTOLOKING, NJ 08738
(201) [illegible]

June 8, 1989

To: Chairman O'Connor and Members of the Senate Judiciary Committee

Re: Bill S 2659 and Bill S 3320

A long series of facts suggest that business interests are having an unhealthy influence on New Jersey legislation. We believe Bills S 3320 and S 2659 are examples of this. We request that the Senate Judiciary Committee consider these facts in depth before voting upon these bills.

Many issues being considered by the State Bioethics Commission* are those which will affect the financial status of insurance companies and pharmaceutical companies. Besides the issues involved in these living will and definition of death bills, there are, for example, the areas of genetic engineering, life-patents, in vitro fertilization, and promotion of contraception. Laws involving these matters will mean a difference of billions of dollars of profit to these companies.

The make-up of the State Bioethics Commission may make it difficult for the commission to keep in mind the best interests of New Jersey citizens. A number of commission members are associated with a small citizens committee that is highly financed by insurance and pharmaceutical company foundations. (See pages "A")

This committee, the N. J. Citizens' Committee on Biomedical Ethics, shared $400,000 with 3 committees from other states, money which was donated in 1987 by Prudential Foundation. It received other grants from

* N. J. Commission on the Legal & Ethical Problems in the Delivery of Health Care

Prudential. It received $86,312 in 1985 from Robert Wood Johnson Foundation, and funds from other insurance and pharmaceutical companies. (Pages "B")

American Association of Retired Persons offers health care insurance through Prudential Insurance Company. Prudential will thus profit greatly if those it insures have their health care cut short through living wills, durable power of attorney, starvation of certain patients, etc. AARP has been promoting living wills in its magazine Modern Maturity and is also a beneficiary of grants from Prudential Foundation.

Although the N. J. Citizens' Committee describes itself as a neutral, grass-roots committee, the ideas it has promoted coincide with the financial benefit of companies associated with its foundation funding. The Citizens' Committee has held hundreds of talks around the state for senior citizens and others promoting living wills, starvation of certain patients, etc. The media has printed the same message from the Citizens' Committee. On the State Commission on Bioethics, the members of the Citizens' Committee have been active in promoting these ideas. (See pages "C")

The Department of Human Services is also represented on the Bioethics Commission. Prior to taking office as the commissioner of that department, Drew E. Altman was the vice president of Robert Wood Johnson Foundation.

Robert Wood Johnson Foundation committed 60 million dollars to a coalition of private medical providers and state governments who joined to provide health services, including school-based clinics. Under its School-Based Adolescent Health Care Program, the Johnson Foundation granted $16.8 million to providers in 20 cities. (See "D") Ortho, a J & J subsidiary, has 42% of the contraceptive pill market. The contraceptive pill is the birth control prescribed in school- based clinics across the country. (See "E")

In the New York Times, November 30, 1986, Commissioner of Human Services, Drew Altman, stated, "Because the state should help troubled adolescents cut through the social services bureaucracy of offering health care in high schools, school-based clinics will be a priority for my administration." (See "F")

Johnson Foundation spent great sums of money promoting school clinics and its former vice president, Drew Altman, made it his priority to create clinics in New Jersey schools in which contraceptive pills might be promoted. The same type of scenaria is occurring with the proposed legislation being considered today.

The Declaration of Death Act, S 2659, removes criminal, civil, and professional liabilities from doctors. If enacted into law, it could result in a surge of organ removal. This would be lucrative for some doctors, hospitals, and pharmaceutical companies. (Each liver transplant costs about $250,000. Every organ recipient must spend from 10 to 20 thousand dollars each year for the rest of his life for anti-rejection drugs.)

On May 28, 1987, the Star Ledger reported that Johnson & Johnson sat on data which showed that over 300 people had acquired kidney problems from Suprol. (See "G") This incident underlines why the New Jersey public might look with askance at any proposal of the State Bioethics Commission which has the side-effect of benefitting commercial enterprises.

Johnson Foundation recently funded a conference at R. W. J. School of Medicine at Rutgers which for the most part was an attack upon the Ombudsman for the Institutionalized Elderly. (See "H") This conference was one of many events clearing the way for one of the provisions of bill

S 3320, a provision which weakens the power of the Ombudsman to protect the vulnerable elderly. This is a dangerous proposal. How much protection will be given to nursing home elderly by in-house ethics committees?

Attached are several articles about legal disputes of J & J and Merck (which has merged with J & J) on genetic engineering, generics, patents, pollution and in-vitro ethics problems. (See "I") Since the State Bioethics Commission has taken it upon itself to make legislative proposals regarding many of these issues, the presence on the commission of so many who have been associated with Robert Wood Johnson Foundation is unfortunate.

Not only insurance companies, but also the government, has much to gain from the early termination of health care. Medicaid and Medicare patients utilize a great portion of state funds. For this reason, too, the make-up of the State Bioethics Commission should be questioned.

The N. J. Citizens' Committee has placed a great stress on cost-containment. Of the 27 member commission, 14 seats are available to the public. Nine of the original 14 members named to the Commission were associated with the N. J. Citizens' Committee which constantly refers to the economic problems regarding vulnerable patients. (See "J")

Finally, there is the matter of political action committees. Enclosed is a section of a newspaper article of page 33, Star Ledger, July 10, 1988. (See "K") It states that one New Jersey congressman had received $90,000 from insurance political action committees since 1985. Should we not begin to question whether commercial groups, via foundation funding or political action committee funding are unduly influencing the New Jersey legislative process?

The
Robert Wood Johnson
Foundation

P.O. Box 2316
Princeton, New Jersey 08540

Program Summary

December 19, 1985

Statewide initiatives on legal and ethical issues
in the care of the critically ill

THE CITIZENS' COMMITTEE ON BIOMEDICAL ETHICS, INC. -- I.D. #10668

$86,312 for a two-year period, beginning January 1, 1986

For further information contact: Mary S. Strong
Chairperson
The Citizens' Committee on
Biomedical Ethics, Inc.
24 Beechwood Road
Summit, NJ 07901
201/277-3858

In late 1983, a group of interested citizens in New Jersey organized a public forum to discuss the implications of reports that had been released a few months earlier by The President's Commission on Medical Ethics. From that first meeting grew The Citizens' Committee on Biomedical Ethics, which in turn convened eighteen other meetings in different parts of the state.

During this time, The Citizens' Committee found itself responding to widespread public concerns over such issues as the medical costs and social goals of health care, the legal climate affecting health care decisions regarding dying patients, and the growing impact of technologically applied health care on human values, autonomy and dignity in particular.

With this grant, The Citizens' Committee will launch a statewide project entitled Your Health, Your Choices, Whose Decision. Over the next two years it will conduct some 300 town meetings to enhance public understanding of, and survey public opinion on, a wide range of medical-ethical issues. Each

(more)...For Informational Purposes Only...

The following members of the State Bioethics Commission are associated with the Citizens' Committee. Commission Chairman Daniel O'Connell is a financial donor of the Citizens' Committee. Commission Vice Chairman Paul Armstrong is a trustee of the Citizens' Committee. Other trustees are Mary S. Strong, Joseph F. Fennelly, Mary K. Lindner, and Patricia Murphy. Advisors are Michael Nevins, and David Eckstein. William Strasser is an associate. (Dr. David Eckstein was a past member of the commission.)

Invited to speak to the commission as expert witnesses were Henry R. Liss and Russell McIntyre, also associated with the Citizens' Committee as advisor and trustee, respectively.

The State Bioethics Commission heard from witnesses associated with the Hastings Center, which is also highly financed by insurance and pharmaceutical foundations.

The Hastings Center collaborated with the Prudential Foundation in the promotion of citizens' committees in several states with the intention of affecting public opinion in the bioethics issues.

New Jersey Eagle Forum

P.O. Box 137, Brookside, New Jersey 07926 (201) 543-7626

VERA ROCHE
N.J. STATE CHAIRMAN
P.O. BOX 137
BROOKSIDE, NJ 07926
(201) 543-7626

PEGGY DICK
MEMBERSHIP CHAIRMAN
5 SUMMIT RD.
BROOKSIDE, NJ 07926
(201) 543-7131

MARION FISHER
LEGISLATIVE AIDE
212 OCEAN AVE.
MANTOLOKING, NJ 08738
(201) 892-2012

June 8, 1989

Chairman and Members of the Senate Judiciary Committee

We are in opposition to bills S 3320, 2067 and 2659. We do not feel that this legislation is necessary and will result in the deaths of the old, elderly and handicapped who will feel that the right to die is now their obligation to die.

People die every day and we do not want to jeopardize in any way the rights of the infirm to live as long as they want to even if they are receiving life sustaining treatments through mechanical means of nutrition and hydration. We feel this is <u>ordinary</u> means of life support. Under no circumstances should a patient be starved and dehydrated to death. Too many peoples lives will be at risk, if we do so. We cannot put killing in the hands of human beings. We have already seen what has happened in the abortion movement. It started out as a hard core case, and now abortion is being performed for the most frivolous of reasons. This is exactly what we must expect of this kind of legislation.

What the living will legislation does is remove all penalties for assisted suicide, and this is what is at the crux of this legislation. The head of the Department of Health has stated that there are 36,000 people in nursing homes in N.J. and they should have the so-called "right" to determine their health care. Get the message. It costs the state, federal government and the insurance companies who are insuring health care the most amount of money in the last years of a person's life, and this is what they want to eliminate, along with the people that are costing them all of this expense.

The health care insurers are going from state to state financing citizen's groups to come up with the right answers for authoring living will legislation. In Colorado, it was the Prudential Insurance Co. that financed seminars with doctors to recommend to them to accept the Living Will.

Of course, there are tragic cases but each and every one should be considered as an individual case. We should not give blanket approval to the health care professionals, doctors or otherwise to disconnect life supports which include nutrition and hydration.

By adopting euphemisms, euthanasia backers have hidden their mission

By Rita L. Marker

The euthanasia movement seems to be engulfing the country. Radio, television and newspaper coverage of the "right to suicide," the "need" for euthanasia and the respectability of "death by request" has snowballed in recent months.

In 1985, 13 states passed "right-to-die" legislation, bringing the number to 35 states and the District of Columbia.

How could this happen? How could the euthanasia movement so effectively advance in such a short time?

The answer, it appears, is twofold.

First, the euthanasia movement didn't advance overnight. Much like the entertainer who is "discovered," the apparent overnight success is the result of years of patient, painstaking work. It's a matter of being in the right place at the right time. It's a matter of knowing what to do and when to do it. And it's a matter of moving inch by inch to reach a goal.

Euthanasia advocates have been working since the 1930s to urge passage of laws allowing euthanasia, but their early efforts met with failure because the public wasn't ready to accept the concept of killing the elderly, the terminally ill or the chronically infirm.

The first "big break" occurred in the 1960s when members of the Euthanasia Society of America (now known as the Society for the Right to Die) and the Euthanasia Education Council (now called Concern for Dying) gave serious thought to the need to gradually create a climate in which euthanasia legislation would be possible. At a 1967 meeting of the Euthanasia Society, Luis Kutner suggested a new document — the Living Will — as a means for creating such a climate.

The idea of the Living Will caught on rapidly, thanks in large part to its promotion by Abigail van Buren ("Dear Abbey"), who has been a member of the euthanasia organization's advisory board for a number of years.

But it was another nine years before the first Living Will legislation, California's Natural Death Act, was signed into law.

Careful, slow progress continued following that first victory for "right-to-die" proponents, but still they faced opposition from many state Catholic conferences and from various right-to-life organizations. However, by paying close attention to what their opposition was saying, euthanasia advocates were able to make cosmetic changes in their proposals, leading opponents to believe such legislation could, indeed, be passed and not lead to the feared abuses.

The second factor in the euthanasia movement's advance was its careful attention to language. Euthanasia proponents succeeded in sugarcoating the bitter pill of euthanasia, leading many dedicated pro-life people to believe the protective-sounding language found in Living Will legislation was actually protective.

Even the titles of Living Will legislation were carefully honed to gain acceptability. Such legislation rarely mentions the words "Living Will." Instead such names as "Right to Die Act" (New Mexico), "Natural Death Act" (California), "Death With Dignity Act" (Delaware), "Rights of the Terminally Ill Act" (under consideration in some states), "Patients' Rights Act" (currently being promoted in other states), "Life-Sustaining Procedures Act" (Louisiana) are used. The title given to Living Will legislation seems to make a difference in its approval by legislative bodies. In Florida, for example, one of the major changes affecting passage of the Living Will act was the change of title from "Natural Death Act" to 'Life-Prolonging Procedure Act."

Often the generic term "Living Will" is also omitted from the wording and is instead referred to by a variety of descriptive words or phrases including "advanced directive," "directive," "declaration" or "directive to physicians."

At just the time euthanasia proponents were weighing each word for its impact on the opposition, pro-life people were neglecting the new terminology and the new language that was developing.

This lack of familiarity with the "right-to-die" movement's vocabulary is perhaps the most important reason euthanasia forces have been able to make such great strides. Assuming that words meant the same to everyone, pro-life people were lulled into a sense of security, failing to recognize what Father William Smith, professor of moral theology at Dunwoodie Seminary in New York, has called "pro-life language shrouding basic right-to-die presumptions."

The tactic is to use acceptable language for the unacceptable.

The Living Will itself is generally described as a signed, witnessed document directing one's attending physician to withhold or withdraw life-sustaining procedures which only prolong the dying process if the signer is unable to make treatment decisions and is in the final stages of a terminal condition. This is deceptively simple. At first reading, one would find little to criticize in what it says.

Although Living Will declarations vary in language, they commonly include such phrases as "my attending physician," "unable to make treatment decisions," "final stages of a terminal condition," "death is imminent" and "life-sustaining procedures."

A Living Will signer assumes a particular meaning for each of these phrases. But how are they, and how can they be, interpreted?

75X

The general understanding of "attending physician" is a physician in whose care one has been for some time. In reality, "attending physician" refers to the physician who happens to be in charge of a person's care at a particular moment. It is entirely possible that, within the course of a day, a hospitalized patient could have as many as three or more attending physicians, any one of whom could put a Living Will into effect.

While the signer of a Living Will may think "unable to make treatment decisions" means that one is in a coma, the words can be interpreted to mean that one is mildly senile. No Living Will law gives any objective criteria for making the determination that the patient can't make these decisions. The individual attending physician can make this crucial judgment based upon purely subjective considerations.

Picturing "final stages," one may assume this means the last few days of life. However, "final stages" is rarely defined in legislation and, when it is, it is described as meaning that death will occur in a "reasonably" or a "relatively short time," interpreted as meaning days, weeks, months or longer, varying from illness to illness and patient to patient.

"Life-sustaining procedures" are generally perceived as respirators, heart-lung machines and other advanced technological procedures. In fact, "life-sustaining procedures" have been interpreted to include medications such as insulin or antibiotics.

These phrases are not the only illusionary protections found in Living Will legislation. In passing such legislation, pro-life legislators have often insisted that a strongly worded statement prohibiting mercy killing be included in the law. California's Natural Death Act states, "Nothing in this article shall be construed to condone, authorize, or approve mercy killing. . . ." But recently, new legislation was introduced to amend the California law. The amendments would allow for the provision of "aid in dying" which means "any medical prodecure that will swiftly, painlessly, and humanely terminate the life of the qualified patient.

Euthanasia by lethal injection would then be allowed under California's Living Will act.

But how would this be possible under the California law with its prohibition of mercy killing? It's really quite simple. "Aid in dying" will be an exception. Mercy killing is still prohibited, but "aid in dying" is not to be construed, under the law, as mercy killing.

The protective words still remain. It's only the protection that's removed.

At the 1984 meeting of the World Federation of Right to Die Societies, the goals of the euthanasia movement were clearly outlined — goals culminating in the establishment of suicide clinics where anyone can request "self-deliverance."

In order to reach this final goal, the steps of acceptance of the Living Will, legalization of assisted suicide and the lethal injection for the terminally ill must first be taken.

At that time, Professor Curt Garbesi of Loyola Marymount Law School in Los Angeles said, "We are focusing on the first short step of this process." He was referring to promotion of the Living Will. Garbesi is one of the authors of the amendments to California's Living Will act.

At the same meeting, Dr. Helga Kuhse of Australia's Voluntary Euthanasia Society said, "We are blinded by the myth that withdrawal of treatment is morally different than killing." She went on to explain that once it's legal to remove all types of treatment and care, it will be a small step to obtain acceptance of direct killing, since the public will then recognize the withdrawal of some types of treatment leads to a very painful death.

"They'll realize that this is clearly not in the patient's best interest and that, given an injection, the patient could have died quickly," she said.

It appears that the euthanasia movement's agenda is moving ahead on schedule — with the help of well-meaning, unsuspecting people. It will only be stopped if we take the time and the effort to learn its language and to oppose it unequivocally.