

*B. Smith*

P U B L I C      H E A R I N G

before

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

on

S-992, S-1039, and S-1751  
("Time of Death" and "Death with Dignity" Bills)

Held:  
January 26, 1977  
Senate Chamber  
State House  
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Senator Anthony Scardino, Jr. (Acting Chairman)  
Senator John J. Fay, Jr.

ALSO PRESENT:

Senator Anne C. Martindell

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SENATE, No. 992

STATE OF NEW JERSEY

INTRODUCED JANUARY 26, 1976

By Senator RUSSO

Referred to Committee on Institutions, Health and Welfare

AN ACT establishing a standard for the determination of death  
and supplementing Title 26 of the Revised Statutes.

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

1 1. As used in this act:

2 a. "Person" means an integrated, whole, living human being,  
3 and shall not include any part or parts of a human body which  
4 may continue to function following a determination, pursuant to  
5 this act, of an irreversible cessation of vital brain functions of  
6 such human being.

7 b. "Ordinary standards of medical practice" means such  
8 standards as require that, in the performance of professional acts,  
9 an individual possess and exercise the degree of skill, knowledge  
10 and care ordinarily possessed by members of the medical com-  
11 munity at the time of such determination.

12 c. "Vital brain functions" means discernible central nervous  
13 system activity in the absence of negating effects produced by the  
14 presence in the body of any drug or depressant or by the existence  
15 by hypothermia or of a similar condition or conditions.

16 d. "Natural respiratory and circulatory functions" means these  
17 body functions which exist without artificial means of support.

18 e. "Artificial means of support" means any medical technique,  
19 including administration of chemotherapy, any therapeutic device,  
20 instrument or machine, or other medical process which is engaged  
21 or administered for the purpose of aiding, assisting or sustaining  
22 vital bodily functions.

1 2. A person shall be considered dead if in the opinion of a  
2 physician, based on ordinary standards of medical practice, he  
3 has undergone an irreversible cessation of vital brain functions if  
4 such cessation is accompanied or preceded by the cessation of

5 natural respiratory and circulatory functions. Death will have  
6 occurred at the time when the vital brain functions ceased, but if  
7 said brain functions have ceased prior to the cessation of natural  
8 respiratory and circulatory functions, then death will have occurred  
9 when said natural respiratory and circulatory functions shall have  
10 ceased.

1 3. This act shall take effect immediately.



SENATE, No. 1039

STATE OF NEW JERSEY

INTRODUCED FEBRUARY 3, 1976

By Senators GREENBERG and McGAIN

Referred to Committee on Institutions, Health and Welfare

AN ACT concerning standards for the determination of death and  
supplementing Title 26 of the Revised Statutes.

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

1 1. As used in this act:

2 a. "Person" means an integrated, whole, living human being,  
3 and shall not include any part or parts of a human body which may  
4 continue to function following a determination, pursuant to this  
5 act, of an irreversible cessation of spontaneous or vital bodily  
6 functions of such human being.

7 b. "Ordinary standards of medical practice" means such stan-  
8 dards as require that, in the performance of professional acts, an  
9 individual possess and exercise the degree of skill, knowledge and  
10 care ordinarily possessed by members of the medical community  
11 at the time of such determination.

12 c. "Spontaneous" means the absence of any artificial means of  
13 support.

14 d. "Artificial means of support" means any medical technique,  
15 including administration of chemotherapy, any therapeutic device,  
16 instrument or machine, or other medical process which is engaged  
17 or administered for the purpose of aiding, assisting or sustaining  
18 vital bodily functions, or any technique, device, instrument machine  
19 or process which may effect an accurate determination of whether  
20 such bodily functions are spontaneous.

21 e. "Vital brain functions" means discernible central nervous  
22 system activity in the absence of negating effects produced by the  
23 presence in the body of any drug or depressant or by the existence  
24 of hypothermia or of a similar condition or conditions.

1 2. A person shall be considered dead if in the announced opinion  
2 of a physician, based on ordinary standards of medical practice,

3 he has undergone an irreversible cessation of spontaneous respira-  
4 tory and circulatory functions. In the event that artificial means of  
5 support preclude a determination that these functions have ceased,  
6 a person shall be considered dead if in the announced opinion of a  
7 physician, based on ordinary standards of medical practice, he has  
8 undergone an irreversible cessation of vital brain functions. Death  
9 will have occurred at the time when the relevant functions ceased.  
1 3. This act shall take effect immediately.

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#### STATEMENT

The purpose of this bill is to provide general standards for the determination of death in line with current medical thinking. It is intended to supplant the common law definition which was based entirely on circulatory and respiratory functions by providing that where a final determination by these standards is precluded because of the use of resuscitative and supportive means, the irreversible cessation of brain functioning may be used to make the determination. Such a definition is of particular pertinence in the organ transplant situation where time is a crucial element.



SENATE, No. 1751

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STATE OF NEW JERSEY

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INTRODUCED NOVEMBER 15, 1976

By Senator MARTINDELL

Referred to Committee on Judiciary

AN ACT providing for documents declaring an individual's living will and permitting, pursuant thereto, the discontinuance of maintenance medical treatment under certain circumstances and supplementing Title 26 of the New Jersey Statutes.

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

1 1. As used in this act:

2 a. "Maintenance medical treatment" means extraordinary med-  
3 ical treatment used or continued solely to sustain life processes.

4 b. "Physician" means an individual licensed to practice medicine  
5 in New Jersey.

6 c. "Terminal illness" means an illness which, in all reasonable  
7 medical probability, will result in the natural expiration of life  
8 regardless of the use or discontinuance of medical treatment.

1 2. a. An individual of sound mind who is at least 18 years of age  
2 may execute a document directing that no maintenance medical  
3 treatment be utilized at such time as he is suffering from a terminal  
4 illness.

5 b. Any document described in subsection a. of this section shall  
6 only be valid if in writing and signed by the testator, which signa-  
7 ture shall be made by the testator, or the making thereof acknowl-  
8 edged by him, and such writing declared by him to be his living  
9 will, in the presence of two witnesses at the same time who shall  
10 subscribe their names thereto, as witnesses in the presence of the  
11 testator.

1 3. a. For purposes of this act, certification of a terminal illness  
2 may be rendered only by the treating physician or physicians of  
3 the individual who is terminally ill. A copy of any such certification  
4 shall be maintained in the records of the medical facility where the  
5 patient is being maintained. If the patient is not being maintained  
6 in a medical facility, a copy shall be retained by the physician in  
7 his own case records.

8 b. A physician who certifies a terminal illness under this section  
 9 is presumed to be acting in good faith. Unless it is alleged and  
 10 shown that his action violated that standard of reasonable profes-  
 11 sional care and judgment under the circumstances, he shall be  
 12 immune from civil or criminal liability for such action.

1 4. An individual who has executed a document under this act  
 2 may, at any time thereafter, revoke such document. Revocation  
 3 may be accomplished by destroying such document, or by contrary  
 4 indication expressed in the presence of two witnesses 18 years of  
 5 age or older.

1 5. a. A physician who relies on a document executed pursuant to  
 2 this act, of which he has no actual notice of revocation or contrary  
 3 indication, in withholding maintenance medical treatment from an  
 4 individual who executed such document, is presumed to be acting  
 5 in good faith. Unless it is alleged and shown that the physician's  
 6 actions violated that standard of reasonable professional care and  
 7 judgment under the circumstances, he is immune from civil or  
 8 criminal liability when, in reliance upon such document, he has  
 9 withheld medical treatment.

10 b. For purposes of this act, a physician may presume that an  
 11 individual who executed a document pursuant to this act was of  
 12 sound mind when it was executed, in the absence of actual notice  
 13 to the contrary.

1 6. The execution of a document pursuant to subsection a. of  
 2 section 2 of this act shall not restrict, inhibit, or impair in any  
 3 manner the sale, procurement, or issuance of any policy of life  
 4 insurance, nor shall it be deemed to modify the terms of an existing  
 5 policy of life insurance. No policy of life insurance shall be legally  
 6 impaired or invalidated in any manner by the withholding or with-  
 7 drawal of maintenance medical treatment from an insured qualified  
 8 patient, notwithstanding any term of the policy to the contrary.

1 7. This act shall take effect immediately.

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#### STATEMENT

The purpose of this bill is to permit an individual over 18 years of age the right to execute an enforceable document declaring that no medical treatment be used simply for the prolongation of his life at such time as he is suffering from a terminal illness. Such document may, thereafter, be revoked by the individual. Pursuant to the bill, a physician must certify a terminal illness.

The bill is modeled on a bill prepared by the Society for the Right to Die in New York.



The bill is intended to encompass the sentiment of the late Pope Pius the XII in his now familiar expression that normally individuals are only held to the use of ordinary medical means, under the circumstances, to preserve life.

One final section provides that the exercise of rights under this bill cannot be considered suicide in construing a life insurance policy. Many such policies contain a "suicide clause" providing that payment under the policy will not be made if the person commits suicide within a fixed period of time following the effective date of the policy.



SENATOR ANTHONY SCARDINO, JR. (Acting Chairman): Good morning. I am now going to open this public hearing for the purpose of adducing testimony pertaining to the time of death bills, S-992 and S-1039, and one living will bill, S-1751. I am Senator Anthony Scardino, Jr., and next to me is Senator John Fay, and on my left is a member of our legislative staff Mike Bruinooge.

The morning session will be devoted primarily to the time of death bills, S-992 and S-1039. We will hope to conclude the morning session approximately 12:30 and break for lunch, resume an hour later and continue the hearing on the living will bill, S-1751. It is my understanding that we have approximately 10 witnesses signed up for each session, and we have some people who have indicated an interest in testifying who have not previously given us notification. It will be my purpose to try to, within reason, allow everyone who has something to say on the subject to have an opportunity to do so, provided the time that we have allowed ourselves is sufficient.

We have on the list of participants, Senator John Russo who is the sponsor of one of the bills, S-992, and Senator Martin Greenberg who is sponsoring S-1039. Previously these legislators had indicated that they would be here this morning to testify and talk about their bills, but we have just received word that neither one of them will be with us this morning. The third person on our list is Dr. Joanne Finley, and following Dr. Finley on the list is Robert Del Tufo, Director of the State Division of Criminal Justice. Just to sort of set the pace and clarify the issues, so to speak, I understand that Dr. Finley, our Commissioner of the Department of Health, and Mr. Del Tufo will be discussing all of the bills that are on the agenda today, since their interests involve all of those areas. However, in the case of other witnesses who will be giving testimony, it is my understanding that they will address their comments specifically to the two bills we will be covering this morning.

With that, I would like to call upon Dr. Finley. Is Dr. Finley with us at this time?

MEMBER OF THE AUDIENCE: Senator, she will be here in about five minutes.

SENATOR SCARDINO: Okay, is Mr. Del Tufo here?

MEMBER OF THE AUDIENCE: He will be here any second.

SENATOR SCARDINO: Running down the list, Donald Collister, Morris County Prosecutor. Are you prepared to testify?

MR. COLLISTER: I think it would be best for Mr. Del Tufo to testify first.

SENATOR SCARDINO: Dr. James S. Todd. Would you be prepared to testify at this time?

DR. TODD: Yes, sir.

SENATOR SCARDINO: We would appreciate it if you would be good enough to give us a copy of your prepared testimony. It will be entered into the transcript, and also if your testimony is rather lengthy, we would like to attempt to allot each person ten minutes, and hopefully within that time they can respond to any questions that the committee may have. If it is possible, too, I might like to suggest that you condense your written testimony, sort of outline it and give us the highlights, particularly if other speakers have already covered the points that you intend to raise. I think that would expedite matters and also give other people who are here to testify an opportunity to express themselves. With that, we have with us, Dr. James S. Todd representing the Medical Society of New Jersey. Welcome.

D R. J A M E S S. T O D D: Thank you, Senator, we appreciate this opportunity to present some very brief views concerning this legislation. I am James S. Todd, M. D.,

Chairman of the Board of Trustees of the Medical Society of New Jersey, and a practicing general surgeon from Ridgewood.

At least three committees of the Medical Society of New Jersey have given careful consideration to S-992 and S-1039. Their conclusions and that of the Board of Trustees of the Medical Society has been that the legislative criteria on the determination of death are indeed indicated and necessary, but that any legislative act must recognize the constant evolutionary developments of science and the emotional stress placed upon the patients and their families.

S-1039 presents, what we believe, the soundest concept since it allows the exercise of sound clinical judgement under diverse circumstances.

One area that the legislature should consider - which is not encompassed in the legislation being proposed - is a clear determination of "a responsible member of the patient's family." That should be made. The comatose patient obviously cannot consent to a termination of treatment, so the physician often looks to the family to authorize the cessation of such treatment. One of the recurring difficulties we experience as physicians is that the spouse of a patient may render a decision which differs from the opinion of the parents. We urge you to consider that issue quite carefully and to establish an order of priority in this regard.

This concludes my brief formal remarks, but as a practicing physician, however, I would like to mention some brief additional concepts that are of concern to us, and would be happy, following that, to answer any questions. From a practical point of view, we all have to agree that medicine always has been and probably always will be a most inexact and evolutionary science. What we accept as routine today may be obsolete at any time. The circumstances and the peculiarities surrounding any given case have infinite variations. And until such time that there are two identical patients and two identical situations, there never can be a routine as far as the medical profession is concerned. So whatever legislation is considered must have latitude and the flexibility to accommodate the vagaries of the clinical situations and the unanticipated developments in medical technology.

With the current concern for consumerism, the right to life, the right to die, and for the other groups interested in this area, coupled with our tremendous technological advances, there is a real danger that the physician's judgement is going to be substituted by regulation or legislation, and no one would defend the current system as perfect and no one would defend the physician as infallible, but under the circumstances in which most of these cases addressed by this legislation occur, decisions must be made rapidly and often on inadequate information at the time. We have to understand that there still is an art and an intuition to the medical profession. It is incumbent upon the physician to perform his very best but no legislation will insure perfection. It is also incumbent upon the physician not to further complicate an already delicate situation with the imposition of futile sophisticated equipment so that he may fulfill some artificial criteria. Do not be deceived into thinking that the cases that we are talking about are rare, because they are not. Everyday in every hospital emergency room arrive patients who by all common standards are dead or irretrievably dying. And the selection of treatment in these circumstances has to reside with the physician who first sees that patient, and he must decide in a frightenly brief instant the proper course of treatment, and if he is to be true to his oath, his training, and society, he cannot be fettered by the hazards of legal liabilities. Also do not confuse these instantaneous decisions often required in the emergency rooms with the more leisurely decisions that are afforded those patients who are already on life support devices when more

sophisticated standards may be applied. The physician at all times must act in the best interest of the patient and only then can considerations of societies legal responsibilities and survivors be considered.

The purpose of any legislation relating to this particular subject has to have at least three purposes: One, to guarantee the physician latitude in the exercise of his professional judgement; secondly, to establish clearly who is the responsible member of the family or guardian in the event the patient may or may not be able to act for himself; and, thirdly, to define the conditions under which the patient through previous action or the responsible member of his family may dictate or request certain limitations on treatment. We believe that these options should not be dictated by the medical profession but the public. And, if, under certain circumstances, people wish to commit legal suicide or refuse treatment, this is a societal decision, not a medical decision. But the physician does need immunity to act in the best interest of the physician, and in accordance with the wishes of the patient.

Therefore, we urge very strongly the maintenance of professional flexibility which will ultimately provide to those we serve the most secure type of care which our technological resources will supply, all the while maintaining the dignity of the individual patient. Thank you very much.

SENATOR SCARDINO: Thank you very much, Dr. Todd. Would you remain with us a few minutes. Senator Fay.

SENATOR FAY: Doctor, I just wanted to know whether you were involved with this group that had the press conference the other day and came up with these guidelines. Were these particular bills involved with the guidelines that Dr. Finley and the Attorney General and Dr. Albano, the President of the State Board of Medical Examiners, offered? I am just wondering, are these two bills enough by themselves, or after this pronouncement is made, do they need amendments, particularly when we are dealing with the dilemma of the wife saying, "Yes, get rid of him," and the family taking a secret ballot and saying, "No."

DR. TODD: Well, I was not at the press conference, but I served on the original committee that worked with Dr. Finley and the Attorney General's office and we did not consider these bills specifically, because in some degree we are talking about two different situations.

We in the Medical Society see these two bills on the determination of death applying more to the immediate situation where decisions have to be made quickly. Once an individual has been placed on life support systems, then obviously there is considerably more time to view the situation and the purpose of the committee and its guidelines was to deal with the patient already on life support systems. The bills under consideration this morning, we feel, are important because they may well apply to the patient being brought to the emergency room. It is inconceivable that every patient in a comatose state or in a critically ill or desperate situation can be put on life support systems. This is just physically impossible. So we feel that the legislation is important to allow the physician to make the instant decision, and also the guidelines are terribly important once the individual is on a life support system.

SENATOR FAY: The law as it is now, Doctor, not even using the Karen Quinlan case as the one example that has received national and international press, but the law as it stands now where you did have a man or woman in this situation, just what would happen? Would the doctor say we find the person incurable or comatose and we are telling you as a family? What position do you put them in? What position

is the attending physician or the hospital in when this kind of conclusion is arrived at by everybody involved?

DR. TODD: Well, the difficulty is that both the law and indeed medical usages are essentially silent on this. As I said earlier, every case has its own particular idiosyncracies and vagaries, but we feel it is important that there is some degree of definition available for the physician. One of the problems - and it is no secret - that every physician worries about is the legal implications of his actions. We think it is terribly important that he be free to exercise his professional judgement under these circumstances without fear of recrimination or indecision.

SENATOR FAY: Does the Medical Society have the number of malpractice suits in cases such as these?

DR. TODD: They are hard to get. Fortunately they appear to be very few in this particular instance. But I think with the publicity that has been given to it we can see increasing numbers of problems arising.

SENATOR FAY: Thank you, Doctor.

SENATOR SCARDINO: Dr. Todd, why is S-1039, that is Senator Greenberg's bill, in your judgement better than S-992, Senator Russo's bill?

DR. TODD: Well, it is the more practical approach, because it recognizes the two situations that the physician is faced with, one, when he must make an instantaneous decision, shall he resuscitate any given patient; whereas, Senator Russo's bill only speaks to brain death. This means that the determination of brain death on an instantaneous basis is practically impossible, and we feel that it would run the risk of putting people on life support systems for whom, under the circumstances as outlined in Senator Greenberg's bill, it would not be necessary and not be indicated.

For example, if you have a patient arriving in the emergency room who is comatose, unresponsive, who shows no signs of respiration or heart function, under Senator Russo's bill, are you not mandated to make a determination of brain death before you pronounce this patient dead? Whereas under Senator Greenberg's bill there are two criteria, the one of irreversible cessation of function of respiration and heart action, and if they should be on the life support systems, then it is possible to revert quite directly to the definition of brain death.

SENATOR SCARDINO: A question that comes to mind is, has there ever been a case where a person is brought to the hospital in a situation similar to what you described where for all intents and purposes the patient appears to be dead and that patient was put on a life support system and was revived?

DR. TODD: Not to my knowledge. You get anecdotal reports of almost anything happening in the medical profession, but I think it would be most unlikely that an individual who by the standard criteria would be accepted---

SENATOR SCARDINO: I appreciate your answer. I was merely looking for --- You have given me a response in terms of it not having happened in any of your experiences or anything you have heard. Of course, if there were instances where it did happen, one would wonder whether or not that precaution ought not be taken in every case.

DR. TODD: I would think it very difficult to find any examples of where this occurred.

SENATOR SCARDINO: In Section 2 of both bills, I guess, it talks in terms of



"a physician." Is it your opinion that one physician is sufficient?

DR. TODD: Again, recognizing the difference between the need for an instantaneous decision as to the initiation of life support, from a practical point of view it would be impossible to set up a system whereby more than one physician would be available. In all honesty, I don't think this would add anything to the value of the legislation. I think, yes, one physician is adequate to make the initial decision as to treatment. Once treatment has been undertaken and you begin to get the uncertainties of brain waves, life support systems and whatnot, then a group decision does become more important.

SENATOR SCARDINO: I want to make an admission at this point, particularly since it is early in the testimony. I really question the need for the legislation inasmuch as I have not really heard, perhaps, that much in terms of a reaction to the "system" that is being used presently. I am wondering if in promulgating law, in a sense, it would not in fact compound the problem and maybe open the door to litigation where at this point it is a vague possibility; whereas, under a specific law it might be paramount?

DR. TODD: Yes, we of the Medical Society looked at this and considered this very issue. This is why we think Senator Greenberg's bill is the better of the two because it does provide for flexibility in the manner in which this is done but does indeed lay down some standards that the public can look at and say, "These events are occurring and they are within the purview of the public demand." We think that this is important, that there be some standards to guide both the public and the profession as to how to proceed.

SENATOR SCARDINO: Just to get a clearer picture, again, from my standpoint, can you elaborate to some extent on the difficulties that exist with the present system? What problems have you confronted or experienced through others?

DR. TODD: Well, it is hard to get at that, because I think basically there is an uncertainty at this time in the medical profession as to just what their responsibilities are under the law. There is no clear definition of what they may or may not do in the procedures and methods of treatment, and they vary greatly from hospital to hospital, from state to state, and there is a feeling that we do need some sort of codification and indication as to what the public is expecting.

It is a very difficult and frightening situation to be faced with a patient who may be irretrievably dying or dead and to have to decide whether or not this patient goes on a life support system or not, and recognizing the climate of society that is very interested in this, also a very litigious society, a physician may in that instant consider other things other than the well being of that particular patient in his decision, and we feel that the physician when he is faced with this situation should be able to make his decision on his own best professional judgement without fear of recrimination from either side of the public spectrum.

SENATOR SCARDINO: Doctor, just one more question. To expound a bit on Senator Fay's comment about the decision between the wife and the members of the immediate family or the parents of the victim, so to speak, how do you feel we can get around that kind of thing? How can we specifically pinpoint some decision making criteria?

DR. TODD: Well, we think that this needs to be done probably by legislation in establishing a clear chain of responsibility in the family structure, so that the chain of command will apply equally to medical situations as it does, perhaps, to more classic legal situations, but we need to know as a profession, when we have an individual,

who do we consult, and clearly, who do we consult in order to get advice and consent to care for this patient. This is not clear now. There is a great confusion and we are faced with this problem all the time of the spouse, the parents, or the siblings of the patient, and there may be a tremendous difference in opinion as to what should be done. We feel this is a terribly important area for the legislature to address.

SENATOR SCARDINO: We thank you very much, Dr. Todd.

DR. TODD: Thank you.

SENATOR SCARDINO: We have with us the Commissioner of the Department of Health, Dr. Finley. Good morning. We have asked everyone who has a written statement to submit them to the committee and we have also asked if we could try to stay within a ten-minute time period, if possible. Of course, we can extend that if we have questions. Everyone is asked to stay within the limit, except those who are Commissioners; they are only given two and a half minutes. (Laughter)

COMMISSIONER JOANNE E. FINLEY: Actually, Senator, I have a few procedural questions first. On the bills, S-992 and S-1039, I have a very short statement and I make reference to Dr. Rigolosi who is here, who doesn't seem to have gotten on the agenda but who is really necessary to expand on my remarks.

SENATOR SCARDINO: I understand you are also going to involve yourself with Senator Martindell's bill.

COMMISSIONER FINLEY: Yes, and I am not able to be here this afternoon, so I can do the definition of death bills and take my seat and be called back.

SENATOR SCARDINO: Just to clarify what I had stated earlier, we understand that both Mr. Del Tufo and you are going to address your comments to all three and that was made clear earlier, and that is understood.

COMMISSIONER FINLEY: But, my remarks on the definition of death bill should be followed by Dr. Rigolosi. And then you can do what you wish on the other.

SENATOR SCARDINO: Fine.

COMMISSIONER FINLEY: Thank you very much, Mr. Chairman, and members of the Senate Institutions, Health and Welfare Committee and sponsors of S-992 and 1039. I would like to thank you for giving me the opportunity to testify on what I regard as needed legislation.

I come before you not only as the State Health Commissioner but as a Board Certified and New Jersey licensed physician and a concerned member of the professional medical community. I will be really speaking particularly on the need for a legal definition of death in New Jersey on behalf of transplant physicians who are in a life saving and life prolonging business, in my opinion. For example, kidney transplant specialists, with whom I do work in the Department, and other physicians have had to assume the responsibility for a determination as to the time and the definition of a patient's death without, in New Jersey, any clear legal interpretation of what exactly constitutes death. I urge the adoption actually of either of the pieces of legislation before you, although, for the reasons expressed so ably by Dr. Todd before me, I do find a slight preference for the Mc Gahn and Greenberg bill.

For the first time, this bill would give us a legal framework by which to determine death, a framework which I believe will reduce the uncertainty which has plagued and even frightened medical people for too long. Until now, the lack of a comprehensive determination of death statute in New Jersey has prevented many physicians from carrying out the wishes of patients under the Uniform Anatomical Gifts Act or recommending to families that they agree to, for example, a kidney transplant from a dying relative to a person suffering from irreversible kidney disease.

I could not possibly begin to calculate how much suffering could be caused by lack of such a law in the past, but I do strongly urge that this deficiency in the New Jersey statutes be corrected as soon as possible.

Renal transplant physicians in New Jersey now perform about 60 such operations annually. Members of our Chronic Renal Disease Advisory Committee and I believe the passage of this "determination of death" legislation could create the proper atmosphere for as many as 50 additional such operations.

In addition, I believe this legislation will reduce the fear of legal action against the conscientious physician who strives to bring new life potential to chronically ill patients without prematurely terminating the life of another person.

Dr. Robert Rigolosi, Preseident-elect of the Bergen County Medical Society is Chairman of the Health Department's Chronic Renal Disease Advisory Committee and a member of the New Jersey Association of Renal Physicians. I have asked him to come here today to expand further on my comments.

SENATOR SCARDINO: Welcome, Dr. Rigolosi.

DR. ROBERT RIGOLOSI: Thank you for allowing me to testify.

SENATOR FAY: Before we get into that, I would like to direct a question to you, Dr. Finley, about your statement of the other day on this. Were these two bills considered in your meeting with the Attorney General on the guidelines you handed down to the hospitals and the nursing homes?

COMMISSIONER FINLEY: I think there are --- Well, they were considered, but let me explain that further. They were considered, or the legislation, or the need for the definition of death was considered and set aside. I think we really have three different situations which may in the end make a coherent and legalized process. But we all recognize that the New Jersey Supreme Court decision did not define death. It perhaps is said to define a process whereby a non-cognitive, really, non-functioning patient could be determined not to have any hope of recovering a cognitive state, but that was not defined as death and there was no attempt, and I think in fact the Supreme Court decision states it is not trying to define death.

So a definition of death is a separate situation, a separate need. The Supreme Court decision dealt with the comatose patient, to use common English, and the rights and protections of institutions, physicians, and families, guardians, and so forth. Senator Martindell's bill deals with a third situation, as far as I am concerned.

SENATOR FAY: So, therefore, the guidelines that were handed down to the hospitals and nursing homes are just for comatose patients. With or without these bills ever going through and becoming law, these guidelines would now be in effect?

COMMISSIONER FINLEY: As far as being set forth yesterday by the three professional societies-- They are, as far as the institutions and practitioners of the professional societies are concerned.

SENATOR FAY: Now, this prognosis committee, would this be a prognosis committee separate for each and every hospital and each and every nursing home, or would they be ---

COMMISSIONER FINLEY: Actually because of the recommendations in the guidelines as to the composition, the expert composition of the prognosis committee and the requirement in the guidelines is that it not be made up solely of physicians from a given hospital, for example.

SENATOR FAY: Let's say each hospital and each nursing home would have their own prognosis committee?

COMMISSIONER FINLEY: No, the hope was that in smaller hospitals or hospitals or nursing homes that do not have a neurosurgeon, for example, on their staff, that there would be a kind of regionalized process. So I am trying to say, Senator Fay, that it would be better if every individual hospital did not try to have its very own, but that there be a kind of collective process in certain regions of the State.

SENATOR FAY: Okay, thank you, Doctor.

SENATOR SCARDINO: Dr. Rigolosi.

DR. RIGOLOSI: In regard to the legislation we had on the Renal Physicians Committee, examined the act and we felt that there were certain additions and deletions that we would recommend to you in trying to make the bill more clear and more ---

SENATOR SCARDINO: Would you specify which bill?

DR. RIGOLOSI: I am talking about specifically S-992. In examining both bills, we find that primarily they are the same in many ways, and in some cases the words are exactly the same.

If you have the bill in front of you, on line 12, in Senator Russo's bill, we would recommend under 12C, "Vital brain functions means discernible central nervous system activity including spontaneous and unassisted respiratory functions." That would be the addition, "including spontaneous and unassisted respiratory functions." Now, the reason we would like that in is to clarify and expand on the statement as it is written. We feel it would make the law and the sentence more clear.

In addition, under paragraph 2, we have made a recommendation; where it says, "A person shall be considered dead if in the opinion of a physician," et cetera, we would recommend the insertion of "after undergone a total and irreversible cessation of vital brain functions" and delete from "if" to line 5 "functions." It doesn't sound clear, but if you follow me, I will reread it as we recommend it. Beginning with, "Death will have occurred at the time when vital brain functions ceased, even if circulatory functions shall remain intact." And delete lines 7, 8, and 9. So that the sentence would read thusly, "A person shall be considered dead if in the opinion of a physician based on ordinary standards of medical practice he has undergone a total and irreversible cessation of vital brain functions. Death will have occurred at the time when vital brain functions ceased even if circulatory function shall have remained intact."

We feel that is important to delineate that you can have brain death without having had respiratory and circulatory death and that a patient can legally be declared dead in the event of brain death alone, irreversible brain death. We think that is an important key in this whole law. We think this is a vitally important law.

SENATOR SCARDINO: Thank you, Doctor. Senator Fay.

SENATOR FAY: Doctor, the status quo with the Supreme Court decision on Karen Quinlan, with the guidelines on the comatose patient, is this bill absolutely necessary? Has enough been said by the Supreme Court already on what is legal and what is allowable now which wasn't there beforehand? Is this bill redundant or is it absolutely necessary for the medical profession, for the person who is sick and the family?

DR. RIGOLOSI: At the present time, there is a great deal of confusion when a patient enters a hospital who has been wounded and his brain is wiped out, so to speak. He is dead for all intents and purposes; he will never, ever have a recovery. This is not the case of Karen Quinlan. It is completely separate. It is not at all the same case. Karen Quinlan has brain activity. Karen Quinlan breathes on her own

without the assist of a respirator. The people we speak of depend on a respirator to maintain their respiratory status. They may or may not depend on agents to maintain their blood pressure, and if an EEG is done on these patients, if the electrical activity of the brain is determined, you will find what we call a flat EEG. They have no brain wave activity. That patient will never, never recover. That patient is the ideal patient for a transplant and is a candidate for a donor.

SENATOR FAY: Isn't that same patient's life expectancy hours?

DR. RIGOLOSI: Well, it may be hours and it may be days. There is no way one can determine that. But after --- To answer a question that you asked previously of Dr. Todd, as far as who can determine, there is a regulatory mechanism for consent in this instance, the Uniform Anatomical Gift Act of the State of New Jersey which was enacted in 1969 - which incidentally was one of the first states in the country to enforce this act - which provides for that. I have given Senator Scardino a copy of a brochure which is handed out to different hospitals, and in Bergen County every emergency room and every hospital has a copy of this, including this organ donor.

SENATOR FAY: Doctor, this is what is so difficult about being a layman and dealing with life and death matters as we do. For example, what is in my mind is, here is my brother who is a policeman who could very easily - God forbid - be in a situation like that, and his wife - or if he wasn't married, the mother and father - would say, "No, we don't want him on a machine, a respirator; we want him to die without that kind of agony for him and for the family." Just what would happen in a case like that where you would say you could prolong his life for days, weeks, maybe and the family or legal guardian says, "No, we don't want his life prolonged like that." What would be the status of you as the doctor there?

DR. RIGOLOSI: Commissioner Finley may have a comment on that. That does not pertain to this bill.

COMMISSIONER FINLEY: We have to deal with those questions, Senator Fay, when we discuss Senator Martindell's bill. As I said, I think we have three different pieces of a spectrum, the guidelines for health care facilities to implement the Karen Quinlan decision have been annunciated and that deals with just one small area. The definition of death really means the most to the transplant physicians and Anne Martindell's bill would deal with the situation that you are talking about.

SENATOR FAY: So, therefore, if Senator Russo's bill or Senator Greenberg's bill becomes law, death will then be defined in this case. Then when a decision comes it would be Senator Martindell's bill becoming law for that kind of a dialogue between the family and the doctor?

DR. RIGOLOSI: Yes, basically, how this bill helps the dialysis patient who requires the treatment to maintain his life because he has no kidney function, this helps him in the sense that the patient who has irreversible brain death can have a circulatory function which is maintaining his kidneys intact, and he will become a potential donor and can be declared legally dead without repercussion. And the criteria for that specific determination are clearly spelled out in guidelines laid down by all the hospitals as far as the flat EEG and absence of spontaneous respirations, et cetera. That patient can be declared dead and then become a candidate or a donor candidate.

SENATOR FAY: Thank you, Doctor.

SENATOR SCARDINO: Thank you, Dr. Rigolosi. I have one question, do you have

anything in writing to present to the Committee?

DR. RIGOLOSI: Dr. Capelli, who is the representative from our Committee has written to Senator Russo and Senator Greenberg and has given them the suggestions which we have made, which we feel would clarify the law and make it more applicable to the hospitals.

SENATOR SCARDINO: Can you submit a copy of that to Mr. Bruinooge?

DR. RIGOLOSI: Yes, I can.

SENATOR SCARDINO: If in your judgement the basis of irreversible brain death, as you call it, is the basis for the determination of death, in your professional judgement, when are the first indications of brain functioning in a human being?

DR. RIGOLOSI: What are the first indications of brain function or no function?

SENATOR SCARDINO: Say in the early stages of life. This is a question that has been raised several times, and I have not been able to get an answer. I have gotten different viewpoints on it. When is the earliest detection of brain function?

DR. RIGOLOSI: Brain function would be the first time a child breathes.

SENATOR SCARDINO: None noted before, during the fetal stages?

DR. RIGOLOSI: The respiratory and circulatory center are in the brain. As soon as a child has respiration, that infant, that child has brain function. The patients we speak of cannot breathe. They cannot sustain life. If taken off a respirator they would be dead within a minute.

SENATOR SCARDINO: The other question I had is in line with the irreversible damage question. You are very specific and, I guess, firm in your opinion that there is absolutely no possibility.

DR. RIGOLOSI: There is no possibility of recovery in an irreversible brain death patient. There are no cases in the literature where a patient has recovered. Now, on that, an overdose patient in a suicide attempt can have a flat EEG and because of that they are excluded from being a candidate for a donor, because you can simulate a flat EEG with an overdose.

SENATOR SCARDINO: What happens? After a certain period of time you begin to get an indication that life is there?

DR. RIGOLOSI: Well, an attempt is made to revive this patient by means of dialysis and the drug is dialyzable; that is, it is able to come out with the treatment, then the patient may develop brain wave activity and you may bring them around. There are certainly drug overdosers that do not make it because they take drugs that cannot be filtered out. But these people are not candidates for a transplant patient.

SENATOR SCARDINO: Dr. Finley, Dr. Rigolosi, thank you very much.

COMMISSIONER FINLEY: I have one more comment on the definition of death legislation which perhaps Dr. Rigolosi did not stress sufficiently. I had hoped you would be surprised by the fact that there were only 50 transplants performed in New Jersey. I feel that one of the reasons was--this whole climate that we are talking about--that the transplant physicians became much less clear about the circumstances under which organs could be donated, and remember this is not mandatory or forceable, it is with the consent either of the patient having signed the Anatomical Gifts Act or with the consent of the whole family. So that the lack of a definition of death to the transplant physicians - not just kidneys but eyes and other organs that people wish to donate - is one of the clear reasons why we have had such limited successful surgery going on in this state.

SENATOR SCARDINO: You are going to discuss the living will bill at this time, Commissioner?



COMMISSIONER FINLEY: Yes.

SENATOR SCARDINO: S-1751, Senator Martindell's bill.

COMMISSIONER FINLEY: Now, I am here to testify as an individual in personal and very strong support of S-1751. I stress that I am speaking as an individual because in this instance I am not giving the official position of the State Department of Health. In the case of the definition of death bill, I was.

SENATOR FAY: Doctor, are the death bills a major predicate to S-1751, or could 1751 stand by itself?

COMMISSIONER FINLEY: Senator Fay, there is, again, as far as I am concerned, little or no relationship between the two bills. They are both needed, in my opinion, but each one could also stand by itself.

In the process of Chairing the Committee to make guidelines to implement the Supreme Court decision with regard to Karen Quinlan, and like patients, the comatose patients, I learned for the first time -- this committee, you will understand, was formed at the request of the Attorney General so that such guidelines could be developed -- that the so-called living will has no status in the eyes of the law except now in the State of California, which has subsequently passed a law such as the one that you are considering. Therefore, I regard Senator Martindell's bill as a healthy and a very necessary extension of the Supreme Court decision in this State which did deal with the process of support and diffusion of the decision to withdraw life support but only in the case of the non-cognitive or comatose patient. So, in other words, the Supreme Court decision did not deal in any way with the expression of future intent, of the future right to decide for a presently competent patient or of a patient who might become terminally ill as defined in the law but who was not comatose, non-cognitive and so forth.

In other words, it did not deal with the whole area of persons ill or dying or dead from other than comatose, non-cognitive, lack of brain functioning conditions. For example, it does not deal at all with the rights of the terminal cancer patient and so forth.

Further reasons in my mind that it would be much in order for New Jersey -- who has plowed so much meaningful, ethical, legal and attractive ground in this whole area -- to be at least the second state, after California, to adopt a so-called living will statute is because of the recognition both in the statute and in the New Jersey Supreme Court decision of the sanctity and rights of persons in the United States of America. This is expressed in the California legislation as follows: "Adult persons have the fundamental right to control the decisions related to the rendering of their own medical care, including the decision to have life sustaining procedures withheld or withdrawn in instances of terminal illness or terminal condition." And with regard to patients in the solely non-cognitive or comatose state, our own Supreme Court addressed the rights of patients and their families in the following paraphrases: Our own Supreme Court did determine that a patient's right of privacy could be asserted in the case of Karen Quinlan on her behalf by her guardian. This right may be asserted under circumstances of carefully delineated expert support against such great "bodily invasions" as the continuance of a life support system -- and recognize the reference to the bodily invasion or the invasion and incursion on the privacy or really the right to one's body where, of course, the prognosis has a reasonable doubt, and in the case of the Karen Quinlan decision of return to a cognitive, sapient state.

Now, again, Senator Martindell's legislation extends that definition to, I think, a very acceptable definition of terminal illness, terminal being that there

is no possibility of return to wellness, there is only the possibility of a gradual approach to natural death. And I will explain in a moment why I emphasize the word natural.

Our own State Supreme Court also recognized something that I think is very important for us to discuss with regard to the need for Senator Martindell's legislation. Again, in the matter of Karen Quinlan, our court recognized that "modern technological marvels present monumental new questions that this court at least felt it must answer with its most informed conception of justice in the previously unexplored circumstances presented to it." But as I said, again, the court does not address the concept of the living will or the right of a cognitive but terminal patient to request the same release from mechanical life support or the concurrency of a special body to back that.

Frankly, I think it would be interesting to know from lawyers how far in behalf of a different kind of patient we might stretch that court decision, and I have felt on reading it and rereading it and talking in my own committee on the guidelines that we referred to, that the court decision could not be stretched to other than the non-cognitive patient. But again let me read what the court found in regard to patients in the condition of Karen Quinlan, "A respirator cannot improve or cure her condition but at best can only artificially prolong her inevitable slow deterioration and death, and the interest of the patient must be evaluated by the court as predominant." I think what Senator Martindell's bill tries to do is give further extension to the interests and the rights of patients. Remember, we are talking about a voluntarily entered into testament or will, a document expressing a competent person's intentions, which presently has no standing in the law.

I think if we put it in terms of any one of you or me going to see a physician when we are well or we have a minor problem, we know, we clearly know that we have the right to say to the physician, "Well, that seems a bit much, what you are recommending; I think I would like to get a second consultation." We have the right to refuse certain bodily invasions. Even in our mandatory immunization laws we give the right to people for religious reasons to refuse immunizations.

Now, in terms of those of us who are able to walk around and express our rights, we have taken care of all that. We have been very careful to take care of these rights. In terms of the patient who has been told, who understands, for whom there is a proper back up in making the determination that they are terminally ill and that there is going to be a natural death which cannot be prevented by any means that will occur in an unexplained or perhaps unknown amount of time, why cannot we extend the same right to express their will against any extraordinary means and bodily invasion that we extend to those of us who are able to walk in and out of a doctor's office?

I think I would like, if I may, to tell one very personal story about why I feel so strongly about this legislation. I have just been a very close party to the death of a very close person to me. If I say it was my black housekeeper, I do not want you to misunderstand, because this person was in my life - I am going to cry - for eleven years and was as close as an immediate and dear member of my family. This woman recently expired from breast cancer which, I am horrified to say, if it had been discovered earlier would not have killed her. She had very strong views about how she wished to have her dying state managed. Actually, she was taken care of in another state, and fortunately by physicians who did not feel as much turmoil in acceding to her verbal wishes. She had not had time to write these down. She was

given every possible pain relief; she was certainly fed and very well cared for, but when extraordinary surgical procedures which had a less than one percent chance to ameliorate her situation - further surgical procedures - or when chemotherapy that had not worked but made her extremely ill, feeling worse than the cancer, were again presented to her by these very courageous physicians whom I had specifically chosen, she determined in my presence and in the presence of her family that she did not wish to continue with these extreme measures. It meant a great deal to her and it meant a great deal in terms also of being on a very modest income, and I think we have to face this kind of thing too, the fact that they had no health insurance, and the family was not eligible for Medicaid because there was enough income in the family to be above that level, and she was absolutely determined that her daughter's college education which is in the middle - on scholarship, I might add - and that her son's vocational education which was very much in the middle, and that her husband's livelihood not be interfered with by extraordinary bills. This meant a great deal to her. That was her living will to her family, that the insurance money that she was able to leave not have to go to pay bills that she herself did not wish to have.

Now, if this beloved person to me had been in the same situation in New Jersey because of the turmoil we have been through about these definitions and these statutory sanctifications of individual rights, I really wonder if she could have quite literally comfortably and peaceably died in the arms of her husband and the doctor could have felt as comfortable about carrying out her will. This is one reason, having been through this experience, that I feel very strongly about this. In a very personal and very deep way, to honor the memory of this person who was very beloved to me, I hope we do underline this right in New Jersey, which is a voluntary right.

I have one or two clarifications and improvements to suggest. I believe that when the Attorney General's office speaks, they will have a much more lengthy list, from the legal point of view, of suggestions to make. I also know that Senator Martindell is clearly aware of the need for some of these clarifications. I think that possibly in keeping with the spreading and diffusion and protection, if you will, of patients and families rights expressed in the Quinlan guidelines that the bill might consider having the certification of more than one physician. Now, as a physician, certification as to state of terminal illness and the approach of natural death, I do not feel this is absolutely necessary, but I say it would be more in keeping with practice. Where there are controversies and questions about what is death and what is natural death and so on, perhaps physicians themselves and some patients and their families would feel protected from arbitrary decisions if more than one physician had to certify to the terminal nature of the illness.

One feature in the California law which is not presently in Senator Martindell's bill that I feel is very important is the provision that health insurance carriers may not require execution of a living will as a condition for being so insured. That I think you could understand would be an important addition to make. I feel, and I don't have any exact suggestions to make, that there may be the need to simplify the procedure for changing one's mind while in the state of terminal illness. You have executed the document and you may wish to change your mind. Also, in the California legislation, while this may seem a bit stringent, I know if I were to execute such a document now I don't think I would change my mind, but there is the provision in California that the document must be re-executed every five years. That is a consideration that you could go into. Again, if I am asked, what are the

protections with regard to mind changing, if the patient in the terminal stage of illness also becomes comatose and cannot express themselves, there I would say that the guidelines just issued with regard to the comatose patient would set up a process that would take up that matter when the patient can no longer express himself or herself; there is the process now for those protections.

Finally, in the California legislation, it is made clear that the witnesses to the living will may not be related, may not be the attending physician, or may not be persons who would have any interest in the estate, and I think these are clarifications that we might like.

Finally in closing, I would like to express my understanding, as a religious person myself, that the legislation as written and the definition of terminal illness as Senator Martindell has expressed it is in no way in conflict with the theological teachings. That is why I said the word natural death is so important to express. There may be others who will be able to speak more directly or quote from the various encyclicals or pronouncements of several popes but there is a clear distinction made in these between natural death which does come to us all in due time, and the artificial prolongation of life.

SENATOR SCARDINO: Thank you, Dr. Finley.

SENATOR FAY: Doctor, there is just one thing that is not clear in my mind, and that is, why in the case that you just gave us, your friend who died, couldn't this happen in New Jersey? I brought up the example before of the policeman or the person with the complete and total brain damage and the family says, they don't want his life prolonged. In the case you are talking about where a person had a terminal illness of incurable cancer, why couldn't the family say to a doctor in New Jersey, "No, she wants to die peacefully; we want her to die peacefully." Why shouldn't that occur in New Jersey if it could occur in New York or Pennsylvania?

DR. FINLEY: Well, first of all, in the case of my beloved friend that I spoke of, I had chosen the physician for her, and it was somebody I knew very well, and we discussed this at length. Actually, this death occurred before the Karen Quinlan decision, but the doctor that I had chosen for her constantly talked to me about the fact that maybe two or three years from now he will not be able to listen to the patient the way he would like to, because all these suits are coming or because of malpractice issues and because, quite frankly, of the growing litigation which has made doctors feel subject to charges of medical homicide. He himself felt that he was doing what he felt was right for the best care of the patient. He was a good doctor, and I chose him because he would listen to patients and talk to them and tell them the truth. I feel strongly about that, too. But doctors are getting very nervous about being able to do the things that doctors should do, because of things like the Karen Quinlan case having to come to court.

SENATOR FAY: Doctor, the cases we are talking about, the family absolutely insists they don't want the person on the machines; they don't want this extra cancer treatment; they have no money for it, and they don't want it, and they are insistent that they are taking the legal and the moral responsibility for this kind of a final decision, and now you are telling me that the doctor can still insist upon the machinery, and can still insist upon the expensive and painful cancer treatments?

DR. FINLEY: Some doctors do now, perhaps because partly they think they know best, and some of them, because I think of the whole defensive medicine issue, and as I say, overriding even the fear of charges of murder.

Now, again to stress, Senator Martindell's bill relates to an individual, an adult individual's expression of their own will. The family or guardian is dealt with with regard to the patient who cannot speak for himself or herself, such as in the Karen Quinlan decision. But we are even talking here about an individual's expression of their own will - yours and mine, not our families speaking for us, but us.

SENATOR FAY: That is what I am talking about. I am insisting that I don't want this cancer treatment. I am insisting that I do want to die without being brought over to New York and without running up a bill that will bankrupt my family. You are saying that a doctor could overrule me and send me for this treatment after I insisted on this course of treatment in sound mind?

DR. FINLEY: If they were going to send you some place else, you could always fail to show up. But let's take a person like my friend who is in a specific hospital, who is having IV's, whose cancer has metastasized to both the bone and the brain, which is an actual fact; she is now blind from the brain metastases. The bones are so riddled with cancer that she can't walk. That patient could become a prisoner, against her will, of the expressions of, let's say, "overly-something" doctors, if she had not been cared for by somebody who felt free and comfortable in the legal and moral sense to listen to her. Again, you are beginning to find doctors also speak with great ambivalence. They wish that the living will had some status in the law.

Remember, again, Senator Martindell's bill also exempts a physician from civil or criminal liability if they follow the wishes of the patient. We don't have that expressed in the law at this point. And, yes, I myself personally - after all, each doctor has their own personal convictions - have been in situations particularly in my training in very famous institutions such as the Yale University where I felt that extensive unnecessary surgery such as a recommended hypophysectomy, the removal of the pituitary gland, was performed in the case of cancer patients---

SENATOR FAY: Against the will of the patient?

DR. FINLEY: In the situations I am speaking of, I would not have been cognizant of the will of the patient. I am just speaking scientifically.

SENATOR FAY: I am just saying that about the only place they will get me to is maybe Lourdes. But if I don't want to go to New York or Philadelphia, I don't see how the doctor could---

DR. FINLEY: But they do because of their own human fears. We have had a growing body of need to bring these issues to court. Ten years ago, I am not sure that the Karen Quinlan decision would have come to court. It was really something. I have not spoken to her original physicians, but there was something in the air that made the physicians afraid to follow the wishes of the family and really their own original advice. And somehow it was felt the courts had to decide that issue. Now, in order to prevent that kind of hassle of every individual will of every individual patient, you or me, having to go through the courts, this statute is proposed.

SENATOR SCARDINO: Thank you very much, Dr. Finley. Our next witness is Mr. Del Tufo, Director of the State Division of Criminal Justice, representing Attorney General William Hyland. Welcome, Mr. Del Tufo.

ROBERT DEL TUFO: Thank you, Senator. I want to thank you especially for the correct pronunciation of my name.

SENATOR SCARDINO: I don't find it difficult at all.

MR. DEL TUFO: I was introduced at a luncheon on Sunday as Robert Del Fufu.

SENATOR SCARDINO: There was somebody on one recent occasion who couldn't pronounce my name, so for the rest of the evening I was known as Senator Smith.

MR. DEL TUFO: I rather like Del Fufu after awhile. At the outset, let me say that Attorney General Hyland is very regretful that he is not able to be here himself. He has a very great interest in this subject matter and in this pending legislation, and only having to be out of state prevents him from appearing before you today. With me is Mr. Baime, who is head of the Appellate Section of the Division of Criminal Justice and who is very knowledgeable in these areas. I appreciate, however, the opportunity which you have afforded me to appear on Attorney General Hyland's behalf and to read a statement of remarks that he would have made, had he been here. The issues here are, of course, of major significance. We have prepared and distributed statements which comprehensively explore the issues posed by the pending legislation, both the dying death bills and also Senator Martindell's bill. I would service little to read those detailed memoranda here, so I think what I shall do is touch upon the more salient features of that and leave, of course, the statements to speak for themselves.

Senate bills 992 and 1039 seek to give legal sanction to the medical concept of brain death. It has become apparent that advances in medical technology starkly reveal serious deficiencies in the traditional legal concept of death. In short, existing law does not reflect present medical realities. Therefore, the Attorney General's office, Attorney General Hyland, supports the present legislative initiative to fill this void.

I must emphasize to you that this endorsement is premised upon legislation which insures that brain death may only be declared upon complete cessation of all brain functions. Moreover, the legislation should be sufficiently flexible to permit future advances in medical science and to protect physicians in their reasoned medical decisions.

Now, a bit later in this statement I will point to the bills - this is all detailed in the statement itself - to show you where some minor changes in at least one of the bills would serve these ends.

Historically, the judiciary has employed the common law definition in determining the time and occurrence of death. Specifically, the common law defined death in terms of a "stoppage of the circulation of the blood, and a cessation of animal and vital functions." Despite the judiciary's rigid adherence to the common law definition, increased medical understanding and technological advances have led physicians to reject spontaneous cardiovascular and respiratory functions as dispositive measurements of death. Medical technology has made possible the prolongation of life despite circulatory and respiratory failure. So, too, there has been stunning progress in the field of organ transplantation. Consistent with these advances has come the recognition that life continues until the brain ceases to function, resulting in what has been denominated as brain death.

Unfortunately, only recently has legislative consideration been given to the moment and attributes of death for purposes other than allocation of proprietary rights or imposition of criminal liability. To date, brain death has been adopted as the appropriate criterion by the legislatures of a relatively small number of states. For your convenience, these statutes have been reproduced in the statement on these bills which has been distributed to you. I think it of note to state that each of those pieces of legislation require that there be a total cessation of all brain activities.



It is my firm view that a legislative definition of brain death must refer to the irreversible cessation of all brain functions, including the brainstem and midbrain. As you know, the cerebrum is the seat of all human attributes. It controls human communication, psychomotor coordination and sensory perception. The brainstem and the midbrain are thought to control the more primitive, perhaps animal, if you will, bodily functions. These include respiratory, circulatory and involuntary reflexes. Cerebral death implies destruction of human cognition, emotion, and volition. Total brain death, however, encompasses not only cerebral demise but also destruction of the brainstem and the midbrain. In the vast majority of cases, total brain death occurs. However, where brain deterioration results from anoxia, that is, lack of oxygen, cerebral demise precedes total brain death. Consequently the higher functions, including those associated with intellectual and perceptual activity, perish first.

I strongly believe that adopting a standard that is anything less than a total brain death standard would be extremely dangerous. The alternative theory is based upon a value judgement that human existence must be premised upon the utility and the quality of life. We must recognize that human life, in whatever form, is the principal concern of the State and is deserving of governmental protection. Surely, it is not for the Executive, the Judicial and it is not for the Legislative Branch of government to evaluate the quality and the usefulness of life, and based upon that assessment to conclude that a citizen's existence is not worth preserving. The bills presently under consideration are conceptually sound, but do not unequivocally require total and irreversible destruction of the entire brain; rather, both proposals refer only to the destruction of vital brain functions - though I add that as I continue to read the Mc Gahn-Greenberg bill, I believe that in the reference to vital brain functions it is intended to refer to total cessation of brain functions.

For this Committee's convenience, we have prepared an amendment to the bills which makes it abundantly clear that brain death is to be defined as the destruction of all human brain activities. As I mentioned to you before, this provision is contained in the detailed statement which has been submitted to you. As revised, also, the bill is sufficiently flexible to permit future advances in medical science to come into play as they are developed in accordance with what Dr. Todd mentioned to you previously. Now, I believe that the amendments which we have proposed to the legislature accord with the intent of the drafters of the Mc Gahn-Greenberg bill, 1039. And I believe that our proposed amendments also accord with Dr. Rigolisi's intent in setting forth amendments to you, because he added the word spontaneous to the definition in the beginning.

I believe that 1039 is a better model to operate with than 992 because of the clear language it has in defining the moment of death. Also, the language in Senator Russo's bill could be construed to refer only to cerebrum death, rather than total brain function in the second part of its conclusionary statement. Now, if I may impose on you to look at 1039, the essential changes are simply that in the reference to vital brain functions we have in our amendment deleted the word vital and simply included brain functions and the definition as set forth in the legislation. We have added, to make it crystal clear, a sentence which says, "The terms shall include all brain activities including those of the cerebrum, the midbrain and the brainstem."

We have, in section 2 of the bill, in lieu of the words vital brain functions - and David, you will follow with me as I go along here and make sure that I am stating this accurately - we have substituted the words, "he has undergone an irreversible cessation

of total spontaneous." So for the word vital we are talking of total spontaneous brain functions.

And with those suggestions, we certainly endorse the adoption of that legislation. Would you like me to move on to 1751?

SENATOR SCARDINO: We have a few questions, if we may, Mr. Del Tufo. You are talking about an area that obviously wasn't raised before, at least not within my experience thus far, and when you talk about the brainstem and the midbrain and the fact that you are suggesting that the word vital be eliminated so that we can take in the total function of the brain, in this case, and we should not allow a determination of death unless it is crystal clear that all functions within the brain have ceased.

Now, to react as a layman to that statement, and from what I have heard thus far from the medical profession and what I understand on the subject, how does one determine when there is brain death? As I understand it, it is by mechanical means, primarily, in that others were speaking about the blip or not being able to see anything on the scanner, and this is what determines that. Do you know from your research and from having come to this conclusion that there are in fact ways of judging whether or not there might be some life somewhere in the brain?

MD. DEL TUFO: There are, as I understand it, ways of making this judgement and determination. I think the thing that creates the problem is the existence, today, of life sustaining mechanisms and the like. That has reference to the word spontaneous. Were we not to have these life sustaining devices, this determination could be done far easier by a variety of mechanical means. Once somebody is on, let's say, a respirator or something of that type, there still are, to my understanding of it, scientifically medically sound mechanisms for determining whether there still is a spontaneous reaction.

COMMISSIONER FINLEY: No, sir.

SENATOR SCARDINO: Let me see if I can clarify that. You are raising a question in my mind. Again, I am reacting to what I have heard previously today and what I have read on this subject. Your testimony raises an additional question in my mind as to whether or not vital brain function does not in fact include the total cessation of life within the brain. It leads to the question as to whether or not the doctors themselves in this case understood that there might be a possibility of some life within the brainstem and midbrain, as you put it. I am just wondering about that. I am not clear on it.

MR. DEL TUFO: What I am saying is that the use of the term vital brain functions in the bill as it stands now, while I believe that the proposers of that legislation intended a total cessation of brain functions to be encompassed by that phrase, it may very well be somewhat ambiguous in the matter of its draftsmanship now. It might be construed to refer only to the cerebrum and not to the total brain function.

The amendments which we have proposed seek to remove that ambiguity and to make it crystal clear what we are talking about which is total brain situation. Now, in the statement which you have for your consideration, at some point, in footnote 23 - not to go into it in depth at this point - there is a reference to articles and a variety of tests which have been developed to make a determination as to whether there is any spontaneous brain reaction both in the cerebrum and in the other areas of the brain, even if someone is on a respirator or on some type of life sustaining equipment. You know, if you don't refer to the total brain function, you are in a situation where

perhaps there is no cognitive function in a person, yet that person is alive and living with certain aspects of the brain intact. It is our view - and it has been the view of every legislature that has passed upon this in the past - that it is not for society to kill a person who is living in that state. That is why the suggestion is set forth.

SENATOR SCARDINO: We appreciate the fact that you have raised the issue, because it certainly approaches it a little differently than what I had understood.

MR. DEL TUFO: You get into --- Unless you go on a total theory, in our judgement, you get into a never, never land or perhaps some ad hoc types of judgements which may not be, in the longrun, in the best interest of society.

SENATOR SCARDINO: Senator Fay.

SENATOR FAY: I have no questions.

SENATOR SCARDINO: You also wanted to speak on 1751.

MR. DEL TUFO: May I, please?

SENATOR SCARDINO: Yes, of course.

MR. DEL TUFO: Turning to Senate Bill 1751, the threshold question for the Committee and for the Legislature to consider is whether the area of "living wills" is an appropriate subject for legislation. During the research and preparation by the Attorney General's Office in the Karen Quinlan Case, our office had the opportunity to explore and discuss this subject in great detail with theologians, physicians, social scientists and laymen. The views espoused by these individuals were so divergent as to preclude any sense of unanimity. Suffice it to say that this is a topic on which reasonable men differ. Resolution of the question must depend on our own personal, ethical and moral judgments. Therefore, I believe that it would be inappropriate for my office - I am talking about Attorney General Hyland's office now - to comment on the desirability of this legislation. Rather, it was the Attorney General's thought that he might best serve the Committee by reviewing legislative efforts in other states and by observing what we perceive to be substantial deficiencies in the proposed bill.

First of all, we are struck by the fact that statutory proposals authorizing euthanasia and antidysthanasia have generally been rejected by the Legislatures of other jurisdictions. Attempts to enact such legislation seem to have commenced in Nebraska and England in the late 1930's. Both proposals were soundly defeated. Since then, similar legislation has been introduced and rejected elsewhere, including New York, Wisconsin and Florida.

In point of fact, legislation of this nature has been enacted only in California. On September 30, 1976, the California Legislature enacted a statute authorizing voluntary antidysthanasia. Euthanasia literally means "happy death." Voluntary euthanasia connotes the termination of an individual's life in accord with his wishes. In contrast, the failure to take positive action to prolong the life of an incurable patient is termed antidysthanasia. The California statute, which gives legal sanction to the concept of living wills, falls within the definition of antidysthanasia.

An exhaustive review of the California legislation appears in our statement. While the statute appears to be technically sufficient, it is too soon, of course, to evaluate its merits during a period of operation. However, it would appear reasonable that any antidysthanasia legislation should contain certain essential provisions. Among these requisites are:

1. Establishment of a highly-formalized, witnessed and memorialized document clearly manifesting the signor's intent (a "living will," with functional equivalents to the formalities that attend execution of a will).
  2. A general statement of the operative circumstances in which the document will be legally effective, terminology to be definite but sufficiently flexible to accommodate medical advances.
  3. Prior judicial permission to give effect to the will, as with probate of a will.
  4. Maximum flexibility with respect to revocation, either oral or written.
  5. Limited effective duration with stringent renewal requirements. Annual renewals are desirable.
  6. Removal of criminal and civil penalties for participation.
  7. Provision for effect on property rights, life insurance, etc.
  8. Imposition of criminal and civil liability for fraud or negligence.
- Measured against these criteria, the proposal before this Committee is

deficient in certain significant respects:

1. Extraordinary medical treatment is undefined.
2. There is no requirement that the witnesses be unrelated to, or financially disinterested in the death of the testator.
3. Revocation procedures are insufficiently flexible in so far as a conscious, competent patient would be unable to order that his life be maintained unless two adults were present at the time of his oral expression.
4. There is no provision limiting the time period during which the document or living will is effective and no concomitant provision for periodic reexecution.
5. There is no provision imposing civil or criminal liability for fraud or negligence regarding the destruction, or falsification, of a "living will."
6. There is no provision for rendering void a "living will" during a period of pregnancy.
7. There is no "probate" requirement.
8. There is no statement of the circumstances under which the document is to become legally effective.
9. There is no provision governing the effect of the living will on property rights other than life insurance policies.
10. The civil and criminal immunity conferred by the proposal is limited to the "physician" and does not extend to other medical personnel or facilities involved in the termination of the extraordinary treatment.

I might add also that the definition of "terminal illness" in my judgment leaves something to be desired and that that would have to be stiffened, along the lines perhaps set forth in the California legislation.

SENATOR FAY: Does the California legislation meet all of these criticisms?

MR. DEL TUFO: The California legislation on --- Are you talking about terminal illness?

SENATOR FAY: No, all of the faults that you found in this legislation.

MR. DEL TUFO: I think it meets generally most of them, except for the probate requirement.

These apparent deficiencies underscore the profound difficulties associated with any legislation in this ethically-fraught and medically-dynamic area. Judicial response to these developing problems has already occurred on a limited scale. However, the questions at issue concern the very heart of the assumptions upon which our society and our civilization is predicated. Only through careful and deliberate legislative activity can the full society participate in even beginning to formulate morally valid responses. A wide variety of comment and expertise must be consulted, and I believe that we should proceed with all due deliberation.

I might say in conclusion on this that I, personally, believe that legislation of this type would be socially desirable - this is my personal view - but that the types of safeguards, which have been mentioned briefly in my remarks and are set forth in greater length in the statement distributed to you, must be included in any legislative judgment to pursue that course of action.

SENATOR SCARDINO: Thank you very much, Mr. Del Tufo.

MR. DEL TUFO: Thank you.

SENATOR SCARDINO: And, Mr. Baime, thank you for joining us.

SENATOR SCARDINO: Now I would like to call on Donald Colleser, Morris County Prosecutor.

We had given ourselves until 12:30 for the morning session. Unfortunately, we don't have too much time left. What we are going to do is continue the hearing on this bill up until 1:00 o'clock and get as many speakers in as possible.

Having said that, welcome, Mr. Collester.

D O N A L D     G.     C O L L E S T E R,     J R.: Good morning, Senators.

I am also scheduled to speak on both sets of bills, the Brain Death Bills, as well as the bill dealing with the living will.

I also must apologize to the Committee for not having for you right now a copy of my remarks in writing. I am told that it will be forthcoming before the end of the day and I will submit it to you later on.

Dealing first with the issue of brain death, I have a sense of irony appearing before this body today. It was exactly one year ago to the day that the case of Karen Quinlan was argued upstairs before the Supreme Court. The issue of brain death was not treated in the Karen Quinlan Case. The court did not set forth any definition of death, although it appears, frankly, from a reading of that opinion that, if a case were presented with an adequate trial record, some formulation of a brain death standard would have been accepted by the court. Other state courts have accepted such a standard, notably in cases involving organ transplants.

However, it is my belief that this is an area which is more appropriate, in any event, for legislative action than for case-by-case judicial development. Reliance upon judicial decisions does not involve the public in the decision-making process and would not lead to the prompt and general statement that this subject demands. The courts must not speak in the abstract, but must await litigation; and litigation involves considerable delay and also expense to the detriment of the individual parties and to society.

As I indicated, I think the legislative process is best equipped to handle these problems.

Having determined in my own mind that legislative action is preferable to judicial case law development, it is also my opinion that legislative action is necessary on the subject of brain death from both a medical and from a moral standpoint. The necessity for a brain death standard of death is relatively new. Until recently, case law within the United States viewed the determination of death as an assessment of the manifestation of vital signs, particularly the cessation of respiratory and circulatory functions. However, the advance of medical technology has resulted in the fact that circulation and vital functions can be maintained artificially even after the cessation of all brain function. While we know that progress always has unfortunate side effects, it is still somewhat of a shock that medical science's struggle against death has resulted in its own peculiar horrors, the literal mechanical maintenance of human bodies without brain activity. Recognition of these horrors and also the futility of artificially maintaining vital signs have generated the concept of brain death.

There can be no argument, Senators, that physicians rely upon this concept and that they withdraw life-support apparatus upon brain-dead patients routinely and daily. This practice must be recognized and accepted by the law of our State, as it has been, in fact, enacted in statutory law in at least eight other states to my information.

Another reason why a brain death statute is necessary is to clarify a potential problem in our criminal law, which, of course, is the field of my expertise.



Absence of a brain death statute may even hinder prosecution in certain types of cases. Consider the case of a victim of a violent assault placed upon a respirator to save his or her life, but with an eventual deterioration of condition to the status of brain death. Removal of the respirator would constitute standard medical practice under these circumstances. However, it would also permit the assailant to raise a defense of intervening cause in a subsequent homicide prosecution. Moreover, there is a common law concept, which is called "the year and a day rule," which briefly provides that no person can be convicted of homicide unless the deceased dies within a year and a day from the date of the injury received. I might add that the "year and a day rule," I am told, is now being litigated before our Supreme Court.

Assuming that the "year and a day rule" were upheld, the assailant may argue that, but for the withdrawal of the treatment, the victim would have survived beyond the period of time and, therefore, he could not be prosecuted for homicide.

Cases have arisen in other jurisdictions, most notably, California, Oregon and Montana, involving these questions. And, as of this moment, there is a prosecution pending in the State of New York on that very issue. Those prosecutions which have resulted in convictions have been affirmed in the States of California, Oregon, and, I believe, also Montana, with or without a brain death statute. But I think our criminal law deserves finality in terms of resolving this issue.

The difficulty facing this body is that brain death is not an easily definable term. It is not a static concept. Medical science has developed certain criteria in this regard, the most common of which was developed by the Harvard Medical School Ad Hoc Committee Report on Irreversible Coma. In the course of that study, various criteria were set forth, including the lack of spontaneous respiration, the lack of any vital signs of reflex action, as well as a flat electroencephalogram. Even these criteria have been further defined. Therefore, I agree with members of the medical profession, including the witness who testified before you earlier, who believed that it is inappropriate to have a legislative definition of death in the sense of specified criteria, that there must be flexibility to allow for changes in criteria due to the advancement of medical technology.

In this connection, I do not believe that there should be a provision setting forth an exact time of death. Any such provision would ignore the fact that death is not really an event, but rather a process, and that the determination of death should be left with attending physicians. However, I do believe that a statute should be enacted setting forth certain standards. The standard which I suggest is that which was just enunciated a few moments ago by Director Del Tufo.

With respect to the two bills that you have before you, again I suggest the language that Director Del Tufo has put before this Committee. I also would point out that I have a preference toward Senator Greenberg's bill because Senator Russo's bill appears to adopt a dual standard of death, indicating that there are two separate phenomena of death, the cessation of natural respiratory and circulatory functions, as well as the cessation of brain functions. As I indicate, Senator Greenberg's standard is based upon a single phenomenon of death as the absence of any discernible central nervous activity, while leaving that determination to a physician acting in accordance with ordinary standards of medical practice. So that would be my preference with regard to the two bills you have before you on that subject.

SENATOR SCARDINO: Thank you, Mr. Collester.

MR. COLLESTER: Would you like me to go to the Living Will Bill or do you wish to break for lunch?

SENATOR SCARDINO: You are already scheduled for the afternoon.

MR. COLLESTER: Yes, I am.

SENATOR SCARDINO: Will you stay with us?

MR. COLLESTER: Sure.

SENATOR SCARDINO: Do you intend to have your comments typed?

MR. COLLESTER: Yes. As I say, they are being typed now. This is a draft. You will get that by the close of the day.

SENATOR SCARDINO: Great.

MR. COLLESTER: I apologize for that inconvenience.

SENATOR SCARDINO: That's okay. I appreciate your taking the time to come before us today.

MR. COLLESTER: Thank you.

SENATOR SCARDINO: Dr. James Delahunty, representing Doctors for Life.

D R. J A M E S M. D E L A H U N T Y: I think I should qualify that, first of all, by saying that I am no special physician. When you say I am a physician for life, I think all physicians are for life. But we have in recent years adopted a slightly different attitude as we have seen what we regard as a deterioration in the medical profession, a certain section of it, with respect to human life.

I would like to address Bills 992 and 1039, first of all.

My name is Dr. James Delahunty. I am a physician and a practicing obstetrician and gynaecologist in the State of New Jersey. The reason for my being here today is to testify on behalf of a group of physicians who call themselves "Physicians for Life," on the proposed standards for the determination of death as outlined by Senators Greenberg and McGahn in Senate, No. 1039, and Senator Russo in 992.

As an obstetrician, one is closely associated with human life, not alone from the moment of conception and through the nine months of development of the human infant, but also in taking care of the adult life of the mother.

As physicians, our knowledge of human embryology and physiology helps to instill into us a deep respect for human life. As medical doctors, we are pledged to protect and save human life, not to destroy it; albeit, we have always had the power and the knowledge to kill, and thus the medical profession could well become one of the most destructive forces in our society. How many of us four years ago would have imagined that the Supreme Court of the United States would have given to physicians the legal power to destroy the unborn child just because the mother no longer wished to be pregnant? For the unborn child, the physician has become the judge, the jury and the executioner.

In a carefully planned move, the advocates of euthanasia are now introducing into many states laws that will allow the physician to hasten the end to a patient's life, particularly if requested by the patient.

The bill before us this morning is the first step towards euthanasia. Standards are being set to allow us, as physicians, to pronounce death if in the announced opinion of a physician, based on ordinary standards of medical practice, he has undergone an irreversible cessation of spontaneous respiratory and circulatory functions. But, gentlemen, how do we define irreversibility?

All of us have attended at one time or another patients who were thought to have undergone irreversible cessation of spontaneous respiratory and circulatory functions. But because of rapid actions taken by the physician, the patient made a

dramatic recovery, often with little loss of normal function.

Ordinary standards of medical practice may have nothing to do with the physician's opinion, for in the light of modern thinking, where human life is measured in terms of productivity or usefulness to society, if it is considered that the patient may not make a full and eventful recovery, no effort would be used to help the patient, and he or she could well be pronounced dead. Anyone of us here this morning may today, tomorrow or next week be struck by some serious disease or have a serious accident, causing us to become unconscious. Our heart and lungs may fail. There is no way that we can verbally state our desire to live. And we are left in the hands of a physician whose philosophy is one of abandonment. It is a lot easier and cheaper - and we heard terms today as regards cost in the prolongation of human life - to do nothing than to institute complicated, expensive and prolonged methods of resuscitation to save one's life.

I am not at all surprised that the Medical Society of New Jersey has accepted these guidelines because they readily accepted the Supreme Court's decision in 1973. The acceptance by a section of the medical profession has been brought about by pressures put by society upon the medical profession and so-called changing moral values among society.

But let society beware, if this bill be passed and accepted, we will open the Pandora's box. We have heard several legal men talk today of the problems and complications that may arise from the passage of these bills. But if this is passed, none of us will be safe from that particular physician who has been ordained as a judge, jury and executioner.

Gentlemen, I would ask you, to coin a phrase, to "pull the plug" on this bill and do not recommend passage of the same in the interest of human society.

SENATOR SCARDINO: Thank you very much, Doctor.

I presume that you heard the testimony of Dr. Finley.

DR. DELAHUNTY: Yes, I did.

SENATOR SCARDINO: She gave a very personal, real-life example. How would you react to that and the reasons that Dr. Finley, herself, cited for the need for this type of legislation?

DR. DELAHUNTY: I disagree entirely with what Dr. Finley said as regards physicians who would force a patient to have excessive chemotherapy or surgery against his wishes. Every day all of us, including myself, who are involved with life and death decisions, will at times respect a patient's wish to withhold treatment. I recall two days ago a patient requesting no more chemotherapy in a carcinoma of the ovary. I said, "Right. It's your decision." I felt that the situation was serious, that the treatment I would give her may prolong her life possibly, but really I felt the situation was hopeless and I would just be grasping at straws in an effort perhaps to wonder if I could bring about some type of a miracle. But the patient made that decision. And we all let the patient make that decision. This is why I cannot see that a legislator has to be brought into the picture when we know what to do. Physicians know what to do. There is no ambiguity among physicians as regards handling a particular patient. It is the pressures put on by society and the fear of litigation. And, let's face it, we could be sued for being late doing our rounds in hospitals in the morning. So the fear of litigation is really an excuse rather than the reality of a physician generally feeling that he does not know what to do. If a physician does not know what to do,

I suggest he return to medical school.

SENATOR SCARDINO: I have to concur with one of your points, only on the basis of being ignorant of examples of litigation in terms of these situations. I think the question was raised earlier and I have yet to hear a concise delineation of various cases and situations where physicians have found themselves before the courts. I don't know if you know of any examples that you could cite.

DR. DELAHUNTY: In respect to death? No, I don't know any. But no doubt, even if this bill were passed, there would be so many loopholes in it that there would be litigation in any case. So I don't think the physician is off the hook anyway at all.

SENATOR SCARDINO: I indicated that apprehension myself in my earlier comments and I am still not quite convinced that it might not, in fact, open up Pandora's box.

Senator Fay.

SENATOR FAY: Doctor, I assume then that you and the doctors whom you are here representing feel there is no need for legislation with regard to medical practice.

DR. DELAHUNTY: Ten years ago we practiced medicine reasonably well. We knew what to do. Why suddenly in the past year or two years has this need arisen? We have had these resuscitative measures for many years and we have been using them. Why suddenly the last year or two has it been necessary to ask the law to step in for definitions? I can't explain it.

SENATOR FAY: We are always at such a terrible disadvantage trying to debate medical subjects when we are not doctors, and legal problems when we are not lawyers. As a layman, my answer to that would be that suddenly this has become a major problem. The medical profession has advanced and made spectacular breakthroughs on prolonging life, as was demonstrated in the Karen Quinlan Case, and people are living so much longer.

DR. DELAHUNTY: I think you made a very valuable point. We have fewer younger children. We have a reverse pyramid system. We have a great deal of elderly people now and they are developing more complicated conditions the older they get.

SENATOR FAY: Therefore, anymore 80- and 90-year-olds are not uncommon and, if they do have strokes, ---

DR. DELAHUNTY: But we still know what to do with them. We still know what to do because we are physicians. We know what to do. We don't have to have the law come along and say, "You can do this; you can't do that."

SENATOR FAY: So you feel that both these bills are completely ---

DR. DELAHUNTY: --- unnecessary.

SENATOR FAY: They are necessary?

DR. DELAHUNTY: Unnecessary.

SENATOR FAY: Thank you.

SENATOR SCARDINO: Thank you very much, Doctor.

Arthur Frakt. Thank you for joining us today, Arthur.

A R T H U R N. F R A K T: Thank you for inviting me.

Gentlemen, I want to thank you for the opportunity to present the position of the American Civil Liberties Union of New Jersey on these important matters.

We at the New Jersey Chapter of the ACLU had cause to consider some of the issues before the Committee at the time of the Karen Ann Quinlan controversy. Actually we were approached by both sides in the controversy.

In all candor, I must tell you that the members of the State Board of the ACLU had great difficulty in determining where the essential civil liberties interests reside when dealing with questions of preservation of life by artificial means: The rights of family members to determine to discontinue artificial means of life support, the rights of an individual to be protected against arbitrary decisions to end life-support treatment, and the rights of an individual to die with dignity should all be considered.

I am not here today to enter into the debate over the medical definition of death. We certainly have no objections to the bill introduced by Senators Greenberg and McGahn concerning the determination of death when an individual undergoes an irreversible cessation of vital brain functions. Legal definitions such as these must obviously keep pace with medical science.

Naturally our organization favors legislation such as that introduced by Senator Martindell, which you will consider later in the day, to permit individuals through "living testaments" to declare not to have extraordinary maintenance medical treatment utilized during a terminal illness in order that they may die with dignity. The ACLU recognizes that this is a highly-personal basic civil liberty which should be legislatively recognized.

Our principal concern is with the preservation of the rights of those whose conditions are such that they are unable to intelligently express themselves concerning whether or not support treatment should be continued. I have attached to the printed copies of my testimony a copy of the draft ACLU statement on the Karen Ann Quinlan case. (See page 2X for the statement.) The basic thrust of that statement is that although we recognize that under certain circumstances the continued maintenance of biological functions where there is no hope of a return to conscious life is socially and medically untenable and that the equipment and personnel used in the performance of such functions may often be better utilized in preserving and protecting the lives of those for whom there is some chance of continued existence, at the same time, we recognize the serious possibilities of abuse of the power to determine when such procedures should be discontinued.

None of the bills which we have seen that are being considered by your Committee appears to address itself to this problem of potential abuse. Although it may be a relatively simple procedure to determine when brain death has occurred, what of instances such as the Karen Ann Quinlan case in which not all brain functions have ceased, but in which treating physicians determine there are no hopes for individuals to return to anything more than a persistent vegetative state? Furthermore, in the instances of the "living wills," what protection is there for the individual who may have been influenced by family or friends to execute such a document or who may have executed such a document thoughtlessly, when the time comes for a determination that medical efforts to save their lives should be discontinued? In both of these situations, we believe that it is imperative that independent medical review by physicians not connected in any way with the family of the patient, the patient himself or herself, or with the prior treatment of the patient be afforded.

We want to avoid even the shadow of suspicion that these procedures would be utilized as a means of disposing of the senile, the mentally incompetent, the chronically ill and others who might be seen as a drain upon society and their families. The specter of the Nazi solution to problems of how to deal with the infirm and the unwanted still looms too large to discount these possibilities entirely.

In cases involving the living wills when the patient is conscious and

rational, protective procedures may be relatively minimal. An independent interview by neutral medical personnel may suffice to assure that the patient's desires are indeed being carried out. In cases where the individual is not conscious and not able to express his wishes, an independent review by a hospital committee may be appropriate. In cases such as the Quinlan Case in which there has not technically been brain death, but in the opinion of treating physicians, a chronic vegetative state has evolved, we believe that not only should there be independent medical review but, before final action is taken, a further review by a neutral legal officer such as the Public Advocate or the Public Defender may be appropriate. In such a case, the individual patient should have the protection of a law officer who will be capable if the situation demands of instituting proceedings on their behalf. We hasten to add that we do not mean this to be a particularly cumbersome or time-consuming process. We have no doubt that in most cases the good faith of treating physicians would be confirmed. We do not see this as necessarily an adversarial proceeding but merely one in which there is some safeguard against abuses.

In conclusion, we would simply commend the Committee for its consideration of these matters. We certainly believe the measures exemplified in the bills you are considering are important, but we do hope that the Committee will go on to consider some of the more difficult issues which do not appear to have been directly addressed.

SENATOR SCARDINO: Thank you very much, Mr. Frakt.

Senator Fay.

SENATOR FAY: I believe every point you made is very well taken. I think maybe we should have stressed before the enormous potential for abuse. Most certainly those of us our age and those of us who have lived history as well as read it are not about to treat this casually at all. It is most important. It is most serious. And I think you brought out very well the salient and vital points.

MR. FRAKT: Thank you very much, Senators.

SENATOR SCARDINO: Is there a representative of the New Jersey Hospital Association present?

MR. BAKER: Yes, Senator. I am Bill Baker. We had requested time before the Committee. In the interim, we have determined not to make a statement today. I would, however, like to cede my time slot to Mr. Leadem, representing the New Jersey Catholic Conference, with your permission. He has not requested time, but is here and would like to testify.

SENATOR SCARDINO: All right. Would Mr. Leadem like to come forward please.

E D W A R D J. L E A D E M: Mr. Chairman and members of the Senate Institutions, Health and Welfare Committee: I would like very much first to thank you for taking me out of turn, as it were. I will only speak this morning on S 992 and 1039. I am on the program this afternoon for 1751.

With your permission, I would like to read briefly the statement which we have prepared on behalf of the Catholic Conference.

My name is Edward J. Leadem, the Executive Director of the New Jersey Catholic Conference. The New Jersey Catholic Conference is an organization approved by the Bishops of New Jersey as an instrument in the promotion of inter-diocesan cooperation and coordination of Catholic representation on statewide issues in the State of New Jersey. As I said, I am grateful for the opportunity to address you this morning.

S 992 would define death by accepting the opinion of a physician, based on ordinary standards of medical practice, that a person has undergone an irreversible cessation of vital brain functions, accompanied by cessation of natural respiratory and circulatory functions.

S 1039 calls for the announced opinion of a physician, also based on ordinary standards, that a person has undergone an irreversible cessation of "spontaneous respiratory and circulatory functions," or if such cannot be determined because the person is receiving artificial means of support, which is the definition in the bill of "spontaneous," then if the person has undergone an irreversible cessation of vital brain functions, as defined.

Quite clearly both bills evidence an attempt to effect a legislative solution for a very complex social-medical problem -- an area of extremely vital sensitivity!

We feel that such an area is one that should be left untouched. We feel that there can be no real meaning to the language of either bill without the contribution of the medical profession.

The elements which these bills would codify are among the criteria which are employed today, and have for a long time been employed by the medical discipline - a discipline most competent to deal with the problem. The medical profession has always acknowledged the presence of religious and social values in discharging their professional responsibility, especially in questions of ordinary means and extraordinary means.

Much has been said these days of the focus upon the question as raised by the Quinlan case.

In a recent document entitled, "Declaration of Endorsement by State Agencies," proposed by the special committee established by the State to be promulgated by the Attorney General, President of the Board of Medical Examiners, and the Commissioner of Health, there appears, I submit, one of the clearest interpretations of the issues raised, and decided by the New Jersey Supreme Court in the Quinlan case.

In that document, it is declared that the Supreme Court "has placed the responsibility for making the most serious and awesome health care decisions in the hands of those directly associated with a patient. . ."

Those assigned both rights and responsibilities are the family, the attending physician and those responsible for the administration of health care institutions. In this diffusion of responsibility is a concept of health care with moral and scientific roots.

Further commenting on this diffusion of responsibility, the document states: "It is evident that the Court sought to resolve a medical and social dilemma by enunciating a new standard which protects physicians in their reasoned exercise of professional judgment and families in their exercise of moral determination, and privacy."

We submit that the words quoted above, as well as the entire document, while addressed to guidelines suggested for dealing with Quinlan type cases, have application to the legislation under consideration; that is, a problem beyond the scope of legislation alone.

Not one word can be found in either the Declaration of Endorsement or in the Guidelines that suggests the enactment of legislation such as is encompassed by these proposed bills.

A careful review of either bill fails to reveal any consideration of the



continuing process and progress of medical science which might well render any current efforts ineffective.

We feel, therefore, that the definition of death is properly one for the medical discipline diffused in moral and scientific roots and, as such, should not be invaded by legislation. We, therefore, urge that no legislation be enacted in this area.

Thank you very much.

SENATOR SCARDINO: Thank you very much.

Senator Fay.

SENATOR FAY: I don't know who did the research for Senator Russo, who is pretty big on death, and Senator Greenberg in preparing their bills.

Dr. Finley, just yesterday, with the Medical Society, with Dr. Albano and with the Attorney General's Office, has set forth guidelines for the hospitals and the nursing homes. And today we heard Dr. Todd speaking for the Medical Society.

Now I was under the impression that the great majority of the doctors in the medical profession did have a need for, if not these two particular bills, at least a need for a further definition in view of the advances in medicine and questions such as were raised in the Karen Quinlan case, which happens to have been the one recently on the front pages. I asked Dr. Finley how many people we are talking about in this category - how many doctors have been confronted with a particularly tragic case such as that one - how many have been threatened with malpractice suits and even with the charge of murder in some cases. I think she used that word.

I also listened to the statement presented by the Attorney General which I haven't yet had time to study. He certainly didn't try to make an emotional appeal in stating his views on this matter.

Then to hear that the status quo is all right and that there is no need for any further definition was a shock to me. Up to now, I have just read the bills before us and some casual research that our staff has done. But this is the first opportunity that we have had to go into this. The major point that you made and the young lawyer just before you made was that this is a complex and serious problem. And I sincerely feel it is, and that it obviously calls for a debate or a hearing, even if the conclusion is that no legislation is needed.

MR. LEADEM: I certainly, Senator, do not dispute the right of a Committee to consider a bill nor the right of a legislator to submit a bill.

I would like to make just a couple of comments. I think the testimony this morning shows that it is very broad and very complex. My position, as I have stated, is that I don't think it can be addressed adequately by the Legislature.

A couple of real quick comments: I noted Dr. Todd used that famous expression, "Medicine is inexact." We know that. I tried to emphasize the words, "based on ordinary standards of medical practice." They are the foundations for all that follows. To me as a lawyer - and I am not a doctor - there is your house of cards. What is ordinary? There is nothing in the statute and the Legislature, at least by these bills, is not about to define what is ordinary. The whole concept of ordinary versus extraordinary care was raised and, I think, quite well litigated in the Quinlan matter. But we had that before legislation, and it works.

I have one final comment as a lawyer. I have been away from the trial practice for quite some time now. But I always think of malpractice as founded in negligence. Negligence is rooted in the obligation or the denial of an obligation

or a duty that is created. What is the duty? Has there been a duty, first of all; and, if there is a duty, has it been breached? The duty, I submit here, is the fundamental duty of the physician, as all of them, I think, have agreed, to exercise ordinary care. So when you call for statistics as to whether or not there has been a prosecution criminally or a malpractice suit, I know of none. I can be corrected, if I am wrong, but I know of none. Again, whether there has been a suit started as opposed to a judgment rendered from a suit, I don't know that there has been.

Again, I say I don't profess to have exhausted the area in that field. That's the end of my comments.

SENATOR SCARDINO: Thank you very much for your statement today, Mr. Leadem. We appreciate your coming.

Can I assume, having ceded your time to Mr. Leadem, that the Hospital Association agrees with his statement.

MR. BAKER: Perhaps I had better go on the record for a second if I may.

SENATOR SCARDINO: All right.

W I L L I A M H. B A K E R: I am William H. Baker, New Jersey Hospital Association.

First of all, I would like to say that the views just presented by Mr. Leadem do not represent the views of the New Jersey Hospital Association, as such. We do agree in part with what Mr. Leadem has said.

The reason we did not testify this morning was because we have studied the bills before the Committee thoroughly and have come down almost squarely in the middle, not being convinced, one, that there is a need for legislation in this area; and, two, if there is, it really, as Mr. Leadem said, is a broad, complex issue, which we, frankly, are not prepared to address in depth today.

We do come down slightly on the side of feeling it really is a medical determination to be made by the physician, the patient, the patient's family, and those others that are involved directly in the process, and is not an institutional question, as represented by the hospital.

SENATOR SCARDINO: That you very much. I am pleased that you did come forward and express your point of view. Thank you.

Dr. Herbert Kohn, Chief, Neurodiagnostic Section, Rutgers Mental Health Center, representing the New Jersey Psychological Association.

D R. H E R B E R T K O H N: I would like to first say that what I am going to address myself to is really a narrower issue than what you have been talking about till now. I am talking about a patient in a specific set of circumstances, as opposed to a general case that you have been addressing till now. I think that will be made clear in the course of my statement.

My name is Dr. Herbert Kohn and I am a psychologist trained in assessment of the nervous system in man, including electroencephalography. I am an Associate Professor of Psychiatry at the College of Medicine and Dentistry of New Jersey, Rutgers Medical School and am Chief of the Neurodiagnostic Unit of the Rutgers Mental Health Center. I have been asked to testify on the bills before you by the New Jersey Psychological Association.

My experience germane to the issues at hand has been in assessment of electroencephalograms (EEG) of comatose patients who have shown signs of "brain death" or what has come to be known as "electrocerebral silence." That has a specific

technical meaning. If you would like, I can explain it; if not, we can just let it pass. But one of the gentlemen who testified previously, I think, from Mr. Hyland's office suggested that there were some differences in assessment techniques. I can tell you this is a noninvasive technique and EEG is done by a recording from the scalp. There are definitive ways of recording such EEG's in the case of questionable electrocerebral silence. There is a lot of technical stuff that I have tried to avoid in my statement. However, should you like, I would be happy to expand on it at any time.

SENATOR SCARDINO: Suppose you continue with your statement and then we will get to that later.

DR. KOHN: My experience in such cases is virtually identical to the results reported in what is now an extensive clinical literature. Comatose patients who must be artificially respirated following a variety of insults and, in particular, closed head injuries are routinely assessed for neurological signs and EEG activity according to the Harvard activity. When such patients show no EEG activity over a thirty-minute period on two occasions, separated by twenty-four hours, and the Harvard signs are positive, cessation of heart beat is inevitable within three weeks for all such patients. In two-thirds of such cases this occurs within three days. The exceptions are when drugs or other toxic metabolic states are present or when low body temperatures are present. In the interim between the EEG and neurological findings and cessation of heart beat no improvement in the patient's condition occurs.

Electrocerebral silence is only one of a variety of clinical signs that occur in such patients and if one follows good clinical practice, the so-called Harvard criteria will be tested for and echoencephalograms, brain scans, or arteriography of the blood vessels supplying the brain may be performed. Decisions on the clinical tests to be performed are dictated by the nature of the insult and the subsequent clinical course. Thus all cases will not require the same array of clinical testing to determine that the patient's condition is hopeless over a very short term and maintenance of heart beat will not alter the clinical course.

Why must we concern ourselves with this issue of assessing death at a stage earlier than the time-honored cessation of heart beat and spontaneous respiration, if, at most, only a few weeks are involved and, at least, a few hours? I believe there are three major reasons. The first of these is concern for the patient as a person. One has only to visit a patient in such a comatose state to recognize the indignity heaped upon the individual when his plight is hopeless. Joseph Heller has described this in his novel "Catch 22" for those who might not bear up well in the real event. It is not a service to so dehumanize the body that in the process one's personhood is devastated and not recoverable. The second reason is a direct outgrowth of this devastation. The family, and, in particular, those members who must see the patient may be subjected to inordinate stresses when viewing a spouse, parent, child, etc. in such conditions. This is often heightened by the ultimate loss of heart beat after a period of days or weeks and the family attempts to justify its heroic stance under such circumstances. Lastly, there is a social argument addressed to the needs of people outside the family in need of transplant organs. Organs from these patients tend to be more viable for purposes of transplant than from bodies where the heart no longer beats. In some cases, the time, place, and recipient of the organ can be more propitiously arranged for successful transplant.

There is, however, another side to each of these points. In the first instance, it is well known that even in the case of insurmountable odds and horror,

people choose to persevere, witness the survivors of concentration camps. If we had fifteen million cases, we might indeed find some small percentage of patients surviving irrespective of their ultimate clinical condition. In the second instance, many families will have psychological needs which make it necessary that all steps must be taken until the cessation of heart beat, the time-honored criterion of death, occurs. The third point relates to the previous two. If either the person or his family have indicated that only a cessation of heart beat is acceptable as a death criterion, then the giving of organs must be considered the giving of one's life for another. We would term this heroic and expect such behavior from few individuals and then only on their own decision.

What then are my conclusions following considerable and serious thought on this matter? Our society has sought to maintain the rights of the individual through a body of law, but it is incumbent upon the individual to provide guidance in personal matters as in the case of a will. I would argue that the situation is analagous. A law should be written, based on clinical experience, defining the instance of "brain death" and equating that with heart beat death. The law should recognize that, if an individual has given written notice prior to the event as to when he wishes to be considered dead, the attending physician must act in accord with such wishes. Similarly, if such a written notice is not found on reasonable search, written notice of the next of kin will serve to guide the physician's actions. In the case where neither of these guides are available within reasonable time and search, the physician should be empowered to act on his own responsibility. In all cases, the criteria of "brain death" must be present in order to disconnect heart-beat supporting equipment.

In order to make such a law most useful, public education in these matters should be undertaken.

Finally, I would like to say that while the electroencephalogram, if used as indicated, is an important clinical adjunct in determining cerebral or brain death, its utility is ultimately dependent on other clinical findings, in other words, in a total clinical context. I would like to thank the Committee for this opportunity to testify and the New Jersey Psychological Association for requesting me to do so.

SENATOR SCARDINO: Thank you very much, Dr. Kohn.

SENATOR FAY: Thank you, Doctor. You have been very helpful.

DR. KOHN: I hope that you understand that I am addressing a very narrow issue. I am not talking about the general case of people like Miss Quinlan and others of that ilk.

SENATOR FAY: It is an aspect that is certainly, I think, an absolute part of the whole picture that hasn't been presented thus far.

DR. KOHN: And this is very narrow. I will tell you what provoked my coming here. When I was asked by the Association, I felt, well, since I would only talk about such a narrow thing, why should I testify? But I have been privvy to such cases. In fact, in one particular case, a physician was charged with murder. Well, not really charged by the State, but charged by the defending attorney with murder because he had transplanted an organ vital to life prior to the cessation of spontaneous heart beat in a patient who had no brain left whatsoever. His head was entirely filled up with soup. You understand what I am saying. Hence, I decided to come.

SENATOR SCARDINO: Thank you very much.

Rev. William Smith, Professor of Moral Theology, St. Joseph's Seminary, representing New Jersey Right to Life.

REV. WILLIAM B. SMITH: First, I do want to thank you for the opportunity of appearing before you and apologize for putting down the wrong name for your committee. On my statement, I have before the Committee on Judiciary. But my name is easy to pronounce. If you found yourself in a squeeze when they muffed Scardino and decided to be Senator Smith, maybe I should be Father Scardino, at least for a few moments.

I do testify in behalf of the New Jersey Right to Life Committee. The Right to Life is interested in the civil rights of all human beings from conception until natural death.

I have provided you with copies of what I am going to say, so I would like to capsulize, if I could, because I would really like to come back to the question of need that you have raised several times, and also things that Senator Fay has said that I think are very pertinent, if not the heart of what I am trying to say.

The question before this Committee is really whether or not there is a need for a statutory determination of death. In my judgment, it is very important that we understand clearly the question that is being asked because often the answers we get in life depend on the questions we ask.

This is not a hearing on transplantation - the ethics thereof or the lack thereof - although transplants have been mentioned a lot. This is not a hearing on the advisability of continuing or discontinuing treatment for the living but moribund patients. That's a separate question; both of them are separate questions, as editorials in the Journal of the American Medical Association point out. This is a hearing on the need for a statutory determination of death.

Nobody will deny that the transplant discussion is really the stimulus of a lot of discussion in this area. But the criteria for pronouncing another human being dead must be made independent of the needs of others. Whether those are exemplary or very laudable needs, the definition of death has to rest on its own merits because I fear that the medical profession cannot retain trust if it does otherwise or even if the public suspects that it does otherwise.

My own religious tradition, which is Roman Catholic, does address the point under discussion; in Number 31 of the Ethical and Religious Directives for Catholic Health Facilities, which are the chartered purposes of most of our institutions, it says: "The determination of the time of death must be made in accordance with responsible and commonly accepted scientific criteria." In that, the Church is not saying that she defines death - she doesn't. Theological death, yes, when the soul leaves the body, but you can't photograph that one. What we are saying here is the "commonly accepted scientific criteria." That statement is understood to represent and incorporate the teaching of the late Pope Pious XII. However, often this teaching is cited and it is cited all over the place - it is cited in those Harvard criteria - it was cited by all sides in the Karen Quinlan case - and I don't think any one of them ever quoted the right paragraph -- but every time it is cited, some things are missed, particularly the needed nuance on the definition of death, where the Holy Father said: "In case of insoluble doubt, one can resort to presumptions of law and of fact. In general, it will be necessary to presume that life remains, because there is involved here a fundamental right received from the Creator, and it is necessary to prove with certainty that it has been lost."

So, while there may be some questions here resolvable only in philosophical terms, certain moral principles and presumptions do pertain. But they pertain to established medical facts. The verification of clinical death today depends upon the responsible and commonly accepted scientific criteria of today.

Therefore, when the commonly accepted scientific criteria are accepted and endorsed by the whole medical profession - and not just interested parts of that profession - I think then would be the time to consider pertinent legislation. Perhaps even then, given a future endorsement and support of the whole medical profession, one could rightly question the necessity for legislation there, because all they would have to do is "canonize" what is standard and accepted by everybody.

I think we should easily agree that a living body turns into a corpse by and because of biological reasons only. You might change the law, but a changed law will not change biology. And if the biology of this matter has changed, we should be able to establish that with certainty.

Thus, it strikes me as odd, if not strange, that any Legislature, including my own in New York, seems willing to legislate as law what the American Medical Association is unwilling to certify as fact in this area. The AMA has not neglected the question before this Committee this morning on the need for a statutory determination of death; rather, and recently, and repeatedly, the AMA has responded to this very question in the negative.

I put down there for you their policy statement of 1973, which they have repeated time and time again:

1. A statutory definition is neither desirable or necessary.
2. State medical associations should postpone enactment of such legislation.
3. Death shall be determined by the clinical judgment of the physician using the necessary available and currently accepted criteria.

Prior to this hearing, I wrote to the Judicial Council of the AMA in Chicago just to make sure whether or not there had been any change in their policy. I attach at the end of my statement a letter I received from the Director of the Judicial Council of the AMA who said, no, there have been many requests to change the policy on the part of some, but in each instance these attempts have been voted down. In particular, the 124th annual convention of the AMA, which took place in this State at Atlantic City, in June '75, and, then again in Texas this last year, in June of '76, both rejected proposals to change existing policy in this regard and reaffirmed their stand that a statutory definition of death is "neither desirable or necessary." (See page 1X for letter from the AMA.)

You can see as well as I in that little policy statement that there is no mention of so-called "brain death" or the "irreversible cessation of (total) brain function" as "determinative of death." But the AMA did not overlook that question either. At that annual convention that took place in Atlantic City, the AMA House of Delegates rejected the proposal of its Tennessee delegation that - and I would like to read this one very carefully - "it is currently medically established that irreversible cessation of total brain function is determinative of death." That was the proposal. They voted it down. Therefore, according to the AMA, it is not currently medically established that irreversible cessation of total brain function is determinative of death.

It might also be good to include the reasons that came along with that

Tennessee proposal. They said on the one hand, it would be in the public well-being to be able to cease all artificial life support systems for so-called brain death patients; and, on the other hand, it would facilitate the transplantation of organs in their best conditions. As at the AMA convention and also here, your hearing is not really on either of those things - discontinuing means or facilitating organ transplants. This is a hearing about the statutory determination of death and it must rest on its own merits.

My basic point then is --- As Senator Fay said several times, you are a layman in the medical area; and I am a layman. I am sure when it comes to doctors, they dazzle you and me and others right out of our pants. I think the thing to do is to have them go back to the AMA and dazzle the AMA on their grounds and on those criteria. Then have them come back to you to talk about pertinent legislation if it is deemed necessary.

I would also like to add that Dr. Edward G. Kilroy, who just stepped down as the President of the National Federation of Catholic Physicians Guilds, in his presidential editorial entitled "Definition of Death" in the Linacre Quarterly, which is their official publication, has opposed a statutory definition of death.

In February of '76, the Connecticut General Assembly defeated a similar effort. I would like to ask: Will my neighbors in Connecticut be pronounced dead by one set of standards, and my neighbors in New Jersey be pronounced dead by a different set of standards? I don't say that to be facetious. This raises a point about what is generally considered to be the trend-setting article in this regard: the Capron-Kass article, which appeared in the University of Pennsylvania Law Review. One of their aims was to have uniformity in law. The direct opposite has happened. Eight states, as someone mentioned, already have statutory definitions. No two of them read the same way. They were looking for uniformity and they ended up with diversity.

The need for certitude, together with the resulting lack of clarity, is one of the reasons why Dr. Harold L. Hirsh, who is both a lawyer and a physician - he teaches in Law School and in Medical School - has published his opposition to a statutory definition of death. I point out to Senator Scardino that that second article, in the "Medical Trial Technique Quarterly," discusses those three stages in the brain and brings out that the recordable is only the highest. The absence of recordable activity tells you that there is no recordable activity. It does not tell you everything you might have to know.

Along the same lines, in January of 1976, the Board of Directors of the National Right to Life Committee, meeting in Washington, unanimously adopted the resolution of their legal-medical advisory committee on the "Definition of Death," that they are unalterably opposed to a strict definition based on the absence of brain waves. Logically, every inclusion is also an exclusion. We should be seeking the widest spectrum of clinical factors rather than limiting it, as most of these bills do, to fewer or, perhaps, to only one criterion.

Some of the advocates of redefined death either choose very poor words to express themselves or reveal a bit more than they had intended to. A transplant specialist at London's Hammersmith Hospital is quoted as saying that the decision to switch off life-support systems for "brain dead" patients is made several times a day in British hospitals. I quote from the London Daily Express: "It is only when some poor fellow starts blinking his eyes as he is being prepared to have his organs



removed that there is a fuss. With death redefined, there need be no fuss at all."

Can we not agree that the determination of death must be made on its own merits? Also, I think we should be able to agree that the motives of some, even very generous and other-serving motives, should not be mixed up with nor confused with the merits of this point. Matters of fact should not be confused with the motives of some faction.

To date, there is no new definition of death that is commonly accepted by the whole medical profession. Thus, it seems to me, without absolute clarity and documented certainty, I submit that it is premature and unwise for a Legislature to legislate as law what is not established and endorsed as medical fact by the whole medical profession. I submit that the common law practice on the determination of death should remain unchanged, because it is medically, legally and morally adequate; whereas, the proposal before you in either form is not adequate on any of those counts - medical, legal or moral.

SENATOR SCARDINO: Thank you very much, Father Smith. You make your points very well and very clearly. I think you certainly defined the dilemma that the Committee faces and that the Legislature obviously will face in making a determination as to whether or not these bills should, in fact, become law. Quite frankly, I think you have touched on a number of the questions that I have been wrestling with in my mind and on which I have been unable to come to a satisfactory conclusion, nor am I prepared to come to one now. I suppose it is going to take a thorough review of the testimony given here today plus whatever else is going to be added to this. It would certainly be interesting, for example, to obtain a response from the representatives of the Medical Association in the State in terms of the AMA's position, based on your description and your supporting document.

REV. SMITH: Some of them will anticipate that by saying that the AMA opposes any laws that in any way restrict doctors. And they will say that it is political. But the AMA did ask them not to do it. They did it - they did it in my home state too.

There is one thing I don't want to be misunderstood on, and you can come on like Attila, the Hun, if you are coming on, say, against transplants. I am not arguing against transplants. Someone mentioned that. But if you want to donate or I want to donate, the understanding is postmortem. Just don't play games with "postmortem."

SENATOR SCARDINO: Let me react to that, a minute, as one layman to another in this case. From some of the testimony I have heard so far, it is indicated that transplants do go on today. They do exist in the State of New Jersey. So, obviously, there is some system or understanding that apparently is followed by both the physician of the patient who dies as well as the physician who accepts the organs for transplant.

REV. SMITH: Right.

SENATOR SCARDINO: So, in terms of dealing with that aspect of the subject, it is apparently clear that it does exist and that really there are no obstacles, as far as I can see, existing to prevent that from continuing under the common law setup.

REV. SMITH: I agree.

SENATOR SCARDINO: The other points that you raised concerning the social aspect of it and the effect and impact it has on the family members specifically,

financial and emotional, are something that is obviously dealt with presently. I think the question we are dealing with is whether or not it is adequate and definitive enough. That is something that we have to make a judgment on ultimately.

REV. SMITH: Right. There are connections there. I think the presumption, say, in transplanting a vital organ is always postmortem. In the vast majority of cases, there is no difficulty in a doctor declaring someone dead. There can be, because of the use of some super-duper machinery, a clouded issue in some instances perhaps. But, if that is the case - and I presume you are a lawyer.

SENATOR SCARDINO: I am not.

REV. SMITH: Neither am I. The lawyers I do think have a little maxim that heart cases make bad law. And it seems to me that this legislation is geared for an infinitesimally small amount. Dr. Finley was talking about it making a difference in 50 more transplants. That is interesting. I am not against it. I favor it. Good luck to them! God bless them! Good health! But it has nothing to do with the definition of death, which must be defined on its own merits.

SENATOR SCARDINO: I think you made that very clear.

SENATOR FAY: Father, you spoke of the AMA's last two national conventions when they voted on this. Were these close votes? So many doctors, at least in the last few years, are saying they don't speak for them and they are not really the final word as far as the medical profession is concerned. But was it a close vote by the members of the AMA who went to these conventions? Was there any change from one year to the next when they put this issue on the floor?

REV. SMITH: That's a good question, Senator. I came across these things in the paper. Then I wrote to the Judicial Council of the AMA in Chicago and asked them for a fuller statement and they keep sending back the policy one.

A couple of times there would be a little bit of a nuance in the question that was being asked. I think the one that is right on the target is the one that the Tennessee delegation proposed when they met at Atlantic City. This year in Dallas, actually I believe it was the New Jersey delegation that spoke of a proposal of dying in dignity or death in dignity, or something, which was tangential and really wasn't on the old target. But they still reaffirmed the same policy.

As to the specific number of "yeas" and "nays," I do not know. I don't know that they told me that.

SENATOR FAY: Before this year is over, I would want this Committee and all the people of New Jersey to have an opportunity to have the facts concerning the AMA brought out. It is the first time that has been mentioned today. Usually something like that is mentioned immediately when doctors are ---

REV. SMITH: That is what strikes me as being odd. I just took a couple of hours to go to a nearby Catholic Hospital and I went in their library. In three hours, I came across what I consider a rather basic objection, which is rarely, if ever, mentioned.

SENATOR FAY: Father, you talk of the "whole" medical profession. Outside of not making house calls, I don't know how we are going to get any kind of a consensus.

REV. SMITH: Only priests and politicians make house calls.

SENATOR FAY: --- on Wednesdays.

REV. SMITH: I guess I was trying to be nonspecific. I realize that a good portion of the transplant sector of the medical community is in favor of this. And I am not questioning motives. They do good work; I want them to do better

work. But I would consider, perhaps wrongly, that the AMA would be kind of the major spokesman for the broader medical community, by which I would mean the whole medical profession. Now that may not be true. I don't know the ins and outs of medical politics, if that is the proper word.

SENATOR SCARDINO: Father, we appreciate your testimony and your taking the time to be with us today.

REV. SMITH: Thank you.

SENATOR SCARDINO: Are you going to be with us here this afternoon?

REV. SMITH: Yes.

SENATOR SCARDINO: Is Eleanor Bates with us? Eleanor, may I beg your indulgence for something. Do you intend to stay with us?

MS. BATES: Yes.

SENATOR SCARDINO: Is it all right with you if we break for lunch now for 45 minutes and then at two o'clock sharp we will put you on?

MS. BATES: All right.

SENATOR SCARDINO: Thank you very much. We will now break for lunch and resume at 2:00 P.M.

(Recess for Lunch)



AFTER LUNCH

SENATOR SCARDINO: I would like to resume the hearing on Senate Bill 992, sponsored by Senator John Russo and Senate Bill 1039, sponsored by Senator Greenberg. We have one more person who has indicated an interest in testifying. Her name is Eleanor Bates. She is a registered nurse, representing Nurses for Life.

As Eleanor is approaching the speaker's seat, I would like to suggest that if we do have time before we close the hearing today, we will hear testimony from those who have not written in beforehand and who are not part of today's list. So, if you would care to do that, we would welcome your testimony. We will stay as long as we can for you.

Proceed Eleanor.

E L E A N O R B A T E S: Thank you, Mr. Chairman. My name is Eleanor Bates. I am a registered nurse and a nurse educator. At the present time I am an Associate Professor in Nursing Education, Middlesex County College and in my - much to my chagrin - almost 20 years in Nursing Education, I have had the opportunity to serve as Director of Nursing in an institution for retarded children and to work for two years in a cancer research unit in the city of Washington, D. C.

I rise to speak in opposition to the bill proproting to define death. Philosophically, the major flaw in the bill is that it presumes that death is a phenomenon that can be legislated. In fact, death is a natural phenomenon which occurs as the last stage of living. Therefore, when we look to legislation to control and define death, we are in fact beginning to legislate and control life.

Perhaps more critical is that the bill speaks to criteria which are vague and not always sure indications that irreversible damage has occurred and that death has now occurred as a certainty.

The notion of brain death as indicated as a criteria for defining death has been considered now for more than ten years. Still controversy rages within the medical profession as to the validity of the EEG as an indicator of death. Any person working within the nursing profession or the medical profession for any length of time could speak to experiences when a patient, from whatever cause - a stroke, drug overdose, hypothermia, or head injury, to name a few - appeared to have irreversible loss of "vital brain function" only to have the patient recover and go on to live a full and productive life.

When we speak of cessation of spontaneous respiration, the same problem appears. Patients with temporary problems of a critical nature, such as a severe electrolyte imbalance could present with loss of respiration. However, with assisted breathing until the medical problem is corrected, the patient can again live a normal productive life.

When we speak of cessation of spontaneous cardiac activity, I daresay that everyone in this room has heard of or has experienced, first hand, a patient who as a result of a massive coronary has appeared to die, only to be shocked "back to life" and to go on to live for many more years.

Even placing all three of these categories together, we cannot use these criteria to assure that death has occurred. Each person's response to the dying process is different and each person's method of dying is unique to the individual. Therefore, drafting legislation to legally define death could, in fact, cause the denial of life to individuals who do not fit your definition. Is this not a violation of the Constitution?

I would like to share with you a case study. The question was raised this morning as to whether these three factors can occur and have life continue.

About 12 years ago, a nine-year-old boy was admitted to a hospital where I was teaching. He had been hit with an automobile and on admission to the hospital had a severe brain laceration, was unconscious with no spontaneous respiration or heartbeat. He was resuscitated and heart activity reestablished. He remained on a respirator for several weeks with no return to consciousness and no response to pain. Support care such as nutrition and active physical exercises were provided and six weeks after admission he was transferred from intensive care in a "vegetative state" with little hope for recovery. However, twelve weeks later, after much work, a lot of faith, and the cooperation of the entire health team, he was discharged home, ambulatory, with verbal communication although with paralysis of one side of his body. Six months later, he had completely compensated for his paralysis and was back in school. He is today an A-B student soon to be going on his own as a man. Using your criteria, he would not be alive.

Miss Patricia Neal is another example, perhaps better known, of the same type of circumstance, except that in her case efforts paid a double indemnity since she delivered a normal healthy child soon after her stroke - a child she carried at the time that she might have been declared dead.

Another important point is that taking the time to assess the patient and to apply these criteria in an emergent situation could, in fact, cost valuable time resulting in the death of a patient who might otherwise be saved.

Death like life is uncertain and unpredictable. While we know that we all will die at the conclusion of our individual lives, I fear that this type of legislation will serve to hasten death for some of our citizens.

Since the medical profession has as yet not been able to conclusively determine criteria for death, based on scientific data and ethical data, I think we presume too much when we think that one page of language by a State Legislative Body can accurately and without fear of error purport to accomplish the task.

I respectfully request the Committee to refrain from releasing this potentially damaging piece of legislation from Committee, and to seriously reconsider whether it should be a matter of law at this time or for that matter at any time.

There were two points that were raised this morning and if possible I would like to respond to them. One is that we have continuously referred to the Karen Quinlan case as a basis on which other decisions are going to be made. In fact, the Karen Quinlan case has settled nothing. If anything, it has raised more questions. The notion was that if Karen was removed from her respirator she would die. Almost 9 months later, she is alive and her status has improved although she remains unconscious at this point.

I think it is also important at this point to mention, for those of you who are lay people, that we have this great fear - a growing fear - of the misuse of equipment which has become a monster in itself. The respirator was never intended to prolong death, nor should it be used for that purpose. The respirator was intended to support life until the person was able to support life again on his or her own, spontaneously. So, to use a respirator for nine months or a year is unconscionable and good medical practice would not recommend continuation of such activity.

The other point I would like to respond to was, the question was raised this morning as to when neurological life begins. I don't think we have gotten a correct answer as of yet. There is not a medical college in the country, or a school of nursing which does not teach the concepts of fetus circulation and fetal brain development, and that begins and is well established as young as 12 weeks of gestation.

So, there are indications that we have circulatory function, which is recordable, as young as 12 weeks of gestation. Thank you very much.

SENATOR SCARDINO: Thank you and I appreciate your adding to your written statement the comments you just made, particularly answering the question I asked this morning. I guess maybe I didn't make it clear to the speaker at that time. From your answer, you obviously picked up the meaning I had behind my question. Thank you.

MS. BATES: Thank you.

SENATOR SCARDINO: We will now go into the portion of this public hearing wherein we will be dealing with Senate Bill 1751, sponsored by Senator Martindell. Senator Anne Martindell is with us today and wishes to speak before this Body at this time. Anne, would you kindly come forward?

SENATOR ANNE MARTINDELL: Thank you, Senator. Thank you for allowing me to testify. I think this is a very worthwhile enterprise.

Before I go into my formal remarks, I would like to say that this all comes up because of a personal experience. In the days before these machines were invented, people died in a natural way. They died at home. They died surrounded by their loving relatives and friends. I think a recent and very important story was about Colonel Lindbergh. When he knew he was terminally ill, he said, "Take me out of the hospital and take me to Maui." He spent the last month of his life in his favorite surroundings. I think that is what we would all like to do. Sometimes we can't.

My experience was with my mother, who died a little over a year ago. She made me promise not to use any extraordinary means, nor to let the doctors use any extraordinary means. She was 83. She had cancer. She had heart trouble. She had emphysema and she developed kidney failure. The doctor said, "I can take her to the hospital and put her on a kidney dialysis machine and she may live for six months in intensive care." My brother and I talked it over. She was semi conscious. We decided that was absolutely not what she wanted to do. The big question then came up as to whether the doctor would be subject to a malpractice suit by us or by other relatives. Therefore, I got interested in this.

I speak to you this afternoon about a simple issue which has grown complex, about a basic right which has been circumscribed by social change and modern technology.

This is the right of a person to decide while in a competent, rational state of mind, the time and manner in which he wishes to die should he become comatose due to an accident or terminal illness from which there is no hope of recovery.

This is a right we now exercise in determining whether or not we should see a physician for the normal ills that plague us, whether we follow his instructions or take the medicine he prescribes. Today we are discussing expanding that right through legislation to include the right to reject treatment if it unnecessarily prolongs the dying process, which is often very painful.

It is not that unusual an occurrence for a person to be told by his physician that a certain treatment or surgery is essential to his health. That person is free to leave his physician's office and never return. A series of court cases in the 1960's established to some degree the patient's control over decision-making in his health care, most importantly the right of informed consent and the right to refuse treatment.

I think -- Am I not correct, Senator, when I say that we now have Patients' Rights legislation in effect?

SENATOR SCARDINO: That is correct.

The major area of conflict is the situation of a moribund patient whose condition prevents his consent to or refusal of treatment. This is the situation which my bill attempts to cover - preserving the right of persons who wish to do so, in advance of illness or accident, to make a determination how they wish to be treated if they should ever be in such a condition.

The specific condition my bill refers to is the artificial prolongation of life beyond natural limits which is now a reality due to modern medical technology.

There are a few of us who have escaped the experience of seeing a friend or relative linger on when all hope of recovery is gone. Unless that person has specifically made known his wishes as to how he would like to die, we are placed in an emotional bind. We would spare him unnecessary pain, suffering, and loss of dignity but our love for that person leads us to feelings of guilt which implicitly tell us that no treatment should be spared to keep that person alive, however long.

This is a bind for the physician as well, instructed to preserve life at all cost, but whose personal knowledge of his patient and his or her family as well as fear of liability pulls him in a different direction.

The Death with Dignity, or Living Will concept, is not without precedent. One of the earliest proposals was made to the House of Lords in England in 1936. Legislation was proposed in this country in 1937. There has been a steady growth of interest with 16 bills introduced in various state legislatures last year and 12 introduced so far at sessions this year.

The first enactment was one in California, with the Natural Death Act on January 1st. We now have a precedent for the states to legislate in this area.

I have a great admiration for the California legislators who grappled with this legislation. As one reads their law, the agony and the deliberation which went into the wording of each section is clearly apparent.

I am in some agreement with those who believe this is a perilous area to legislate in. However, it is a necessary one which we must address. Although prior expressions can now be made and are frequently honored by physicians, these instructions are not binding.

The California law, I believe, is in some ways unnecessarily restrictive. I am fearful that the more restrictions we put on the bill, the more we will defeat the very purpose we sought - which is to make this right to self-determination more widely available.

We have an additional problem today in that only 25% of American families have what is considered to be a family physician - they go to clinics and hospital emergency rooms - a physician who has some intimate knowledge of the persons involved, their financial resources and the ability of the family to make decisions that are best for all involved.

As I have read and discussed legislation in this area, I have become aware that my bill, as introduced, does not include all the safeguards that may be necessary and I am certainly willing to add any after they have been discussed. These are points that I raise with you today and I plan to propose amendments to the bill. I welcome your comments.

The provisions regarding witnesses to a Living Will should exclude, very likely, those who are related to or have a financial interest in the estate of the declarant.

A section dealing with violations and penalties for those who destroy, forge, falsify, or cause life sustaining procedures to be withdrawn without the knowledge of the declarant is necessary.



I feel there should be some provision for directing physicians who, for personal reasons, will not carry out the patient's wishes to transfer that patient to another physician who will implement the directive.

As a member of the Nursing Home Commission, I have given considerable thought to the dilemma of our nursing home patients, many of whom have no living relatives - that would also include many who are in mental hospitals - and who await death, as we all do, but with the additional fear that they will have no control over their treatment.

It is essential that the rights and dignity of these persons be protected. I would very much favor inclusion of a section dealing with this situation and propose the assignment of a specific person in the Division of Aging or Department of Health to serve as an official witness to a Living Will and who would see that these patients are informed so that they can make their own determination about their own treatment. It could be sort of an ombudsman, out of the Public Advocate's office, for example.

There is a final point that must be made about death with dignity. It is a fact of life and of death in this instance. This is the cost of maintaining a terminally ill person, a cost that is not easily borne by the family of average means, and I can think of a dozen families - and I am sure you can too - including members of my own, where their entire life savings were wiped out by a long and expensive illness. Other members of the family had to, if they were able, help pick up the expense. Life savings are depleted, debt is incurred and surviving relatives may suffer financial deprivation that the patient would never knowingly have imposed upon them.

I believe there is widespread support for this bill. Public opinion polls consistently indicate that physicians and the public support the concept of termination of treatment when death is imminent. I consider myself a religious person and I have no difficulty with this view. To get back to my mother, she was very religious and when we did bring her back after a very bad heart attack, she said, "Why? I would like to go on to the next life. It will be happier."

Pope Pious XII expressed the sentiment that normally individuals are only held to the use of ordinary medical means to preserve life.

With this legislation, we are providing the means by which a person may guarantee in advance that his own death will not be delayed beyond natural limits.

SENATOR SCARDINO: Thank you, Senator. You said you have had an opportunity to look at Director Del Tufo's comments?

SENATOR MARTINDELL: Yes.

SENATOR SCARDINO: He has a series of recommendations for additions.

SENATOR MARTINDELL: Some of them I agree with.

SENATOR SCARDINO: Okay. If I may -- I don't know whether you are willing or able to comment on it now, because I realize you have just seen it, but does it appear as though some of the comments the Attorney General's office has put forth would add substantially to the intended purpose of your bill?

SENATOR MARTINDELL: I think several of them would. Some of them I have questions on.

SENATOR SCARDINO: Okay. So you will--

SENATOR MARTINDELL: I think it is a valid comment, that there should be more definition of extraordinary medical means.

SENATOR SCARDINO: What I am asking, Anne, if I may, is that in your review of these, perhaps you might forward your comments on each or collectively to the Committee

so that we will have an opportunity to know what your reaction is to these recommendations.

SENATOR MARTINDELL: I would be happy to. I would be happy to sit down and discuss it further with the Committee.

SENATOR SCARDINO: There are still several things that puzzle me, Anne. Can I ask you, outright, the reason for your sponsoring this type of legislation?

SENATOR MARTINDELL: It was because of my mother's experience. It was also because friends of mine had signed a Living Will, but then I realized it wasn't legal in New Jersey. I signed one myself.

SENATOR SCARDINO: You had a personal experience. I am just wondering whether or not you are familiar with any instances, other than your own personal situation, where the prolongation of life has, in fact, created the problems that you enunciated?

SENATOR MARTINDELL: You could go on all day giving examples. There are many.

SENATOR SCARDINO: Because as a legislator, I can quite frankly tell you that I have not received one letter or one comment, directly or indirectly, in all the time I have been in public service, on this particular subject.

SENATOR MARTINDELL: I am surprised, but I think now with the people reading about it, you might.

SENATOR SCARDINO: Well, again, even in light of the fact that we publicized these hearings, I can say that I don't recall seeing any mail in terms of people who have faced the situation and who said as a result, "My mother or father" - or whoever it was - "had to suffer unnecessarily." It seems to me that is really the basis of your reason for the legislation, in addition to the financial, social factor. I just wonder about that.

Going back to the example that you cited - your own personal example - I appreciate your bringing this before this Committee, as difficult as it is for you to do that. Am I to understand by what you said that you had no problem as a result of following your mother's wishes?

SENATOR MARTINDELL: No, I felt that we did what she wanted us to do.

SENATOR SCARDINO: So, in light of that, isn't it clear that the system, as it now exists, presents no obstacles in terms of fulfilling the request of a person in that same situation?

SENATOR MARTINDELL: It is true with a family physician that you know and trust, and who trusts you. They have been doing it for years, there is no question about that. But, the problem is all these people who do not have a family physician. Seventy-five percent of the population does not have a family physician.

SENATOR SCARDINO: Well, again, just to reemphasize - I am not directing this towards you, but am stating it as a matter of record - I would certainly like to hear from these people, because, to date, I have not. I would certainly like to have some documentation on that subject. I think you can appreciate my questioning this.

SENATOR MARTINDELL: Yes, I do. The fact that it has been introduced in so many states must mean that someone must have been writing to somebody.

SENATOR SCARDINO: Is there anything else, Anne, that you would like to add at this time?

SENATOR MARTINDELL: No. I would love to stay and listen. May I join you up there? There might be a question or two that I would like to ask.

SENATOR SCARDINO: I would be honored if you did. I welcome your presence and I welcome your joining me up here. You are certainly welcome to ask any questions you may wish to as well.

Now, obviously, the restrictions set forth in the bill are far broader than those in California. Since many illnesses will, in all reasonable medical probability, result in the natural expiration of life many years hence, this bill constitutes a significant step toward acceptance of euthanasia, especially in light of the language of "extraordinary treatment."

By virtue of the bill, as it is presently written, patients suffering from diseases that eventually will result in death many years hence may have their lives cut short because of misunderstanding or, more probably, a decision made in the depths of depression without adequate protection afforded to those least able to protect themselves.

Moreover, the bill does not provide a specified form of a Living Will. Rather, it would permit such wills, broadly drawn, subject to vagueness and differing interpretations. On the contrary, the California legislation provides for a specific will, which is included in the Act itself. It is denoted as a Directive to Physicians.

Among the provisions of the written Directive, which, as I say, is the only form of Living Will acceptable in the State of California and, to my knowledge, the only Living Will acceptable in the United States, there are the following: In the Directive, it provides that an individual asks that his life not be artificially prolonged in a terminal condition where death is imminent. In order to carry out the directive, the physician must consult with at least one other physician who must concur in the diagnosis of a terminal condition. The bill before you does not have such an additional safeguard requiring physician consultation in the diagnosis of a terminal condition.

Under the California legislation, moreover, a terminally ill patient must wait two weeks after receiving a diagnosis of a terminal condition to sign a Directive and the Directive requires that the name and address of the physician be supplied by the patient.

There are obvious reasons for this two week delay period. One is to provide a period within which the patient may weigh all considerations, including that of continued life for whatever short period of time, as opposed to an immediate death. Many physicians and eminent writers on this subject, such as Elizabeth Cugler Ross, have indicated that the initial reaction of a patient when advised of a terminal illness is a desire to end life quickly, a desire that may be altered with the passage of some time for reflection. The bill as originally drafted, contains no such period for reflection and, indeed, may be executed by persons in the fullness of life who cannot reasonably be expected to consider weighing a life reaching its termination due to disease as against the immediacy of death.

Many persons have indicated that life has certain qualities without which it is not worth living. I think that such an approach for the purposes of legislation is terribly dangerous. To ascribe certain qualities to life, such as the capacity to communicate, to love, to love one's family and one's children, those things that to us right now in the fullness of life seem worth living for, to set that forth or have that be a policy basis for terminal action seems to me to be terribly dangerous.

We have also seen persons who desire to hang on to life when faced with the ultimate determination. While I do not wish to indicate in any way that a patient should be over treated to last and their dying prolonged, I think the distinction must be made between the hastening of death and the prolonging of dying.

The California legislation also provides that only mechanical or other artificial means to sustain, restore, and supplant a vital function may be withheld

SENATOR MARTINDELL: Thank you.

SENATOR SCARDINO: Donald Colleser is next on the list. He is the Morris County Prosecutor. Thank you for staying with us. You were with us this morning. We are sharing this long day, but it is a very interesting day.

DONALD COLLESTER: Good afternoon, Senator. Once again, I have to apologize for the lack of your having a prepared text in front of you. I called my office and was advised that it was coming. However, so is Christmas and if it is not here in time for the termination of these proceedings today, I will see that it be delivered to you forthwith.

With respect to Senator Martindell's bill, I think I should start out by indicating that the case of Karen Quinlan brought about a public consciousness to the terrible problems of the dying and resulted in the judicial recognition of a constitutional right to die, exercisable by proxy.

Other courts also have concluded that there exists a right of a competent patient to refuse treatment even if that rejection results in the patient's death. There are also conflicting decisions, but the weight of modern authority appears to be along the lines of recognizing the wishes of the patient with respect to his or her own self-determination.

In this connection, the concept of a Living Will is nothing new. The Euthanasia Educational Council has distributed many, many thousands of Living Wills, which are unfortunately vague and fortunately, to my mind, unenforceable in any state.

Within the last year, and due in no small part to the Quinlan decision, the State of California has enacted a statute, termed the Natural Death Act, which is based upon - generally based upon - the concept of the Living Will. It is my opinion - and I must emphasize that this is strictly a personal opinion - that the Living Will concept merits consideration by our Legislature. I believe that the individual has the right to assert his wishes against the prolongation of his dying through the maintenance of mechanical means where death is imminent, whether or not such procedures are utilized or continued.

Where death is imminent, radical surgery, respirators, and similar apparatus are, to my mind, neither medically nor morally indicated since they would only prolong death.

Another reason why I believe that the Senate should give serious consideration to legislation involving a Living Will is due to the opinion of our State Supreme Court in Quinlan. The authorization of a right to die by proxy, under circumstances where death is not imminent, presents a situation where, I submit, safeguards are called for.

Therefore, I believe that some legislation would be appropriate. However, with all deference to the Senator, I believe that Senate Bill 1751 does not provide sufficient safeguards and, indeed, presents some significant dangers.

I would like to compare, in some respects, the bill, against the existing California legislation. I will try not to go over some of the ground the Senator just went over, indicating there may be room for possible amendment of her bill.

The most significant difference between the California legislation and this bill is that there is a restriction in California with respect to a Living Will to instances where in the judgment of attending physicians, death is imminent, whether or not such life-sustaining procedures are utilized.

The bill before you speaks only in terms of terminal illness, which is defined to mean an illness which, in all medical probability, will result in the natural expiration of life, regardless of the use or discontinuance of medical treatment. That is quoting from the bill.

Will. Notification by the patient to the attending physician alone is apparently insufficient. I would suggest that under those circumstances, the bill - if it is to go forward - be amended in that particular as well.

Also - as I believe has been previously indicated by the Senator and by others who testified on the subject this morning - there is no provision with respect to the fraudulent use of a Directive or a concealment of a revocation, resulting in the hastening of someone's death. While the bill provides for immunity from civil prosecution or immunity from civil liability for a physician acting in reasonable professional care, it is silent with respect to penalizing someone who falsifies or forges a Directive of another. While some may believe that such an action would be subject to present homicide statutes, I suggest that spelling it out further may be necessary.

SENATOR SCARDINO: Do you have any more recommendations to follow?

MR. COLLESTER: Very few.

SENATOR SCARDINO: Okay, because I was just going to suggest -- Okay, why don't you just complete them since there are only a few.

MR. COLLESTER: Yes, there are only a few more.

SENATOR SCARDINO: Because they will be incorporated as part of the transcript anyhow.

MR. COLLESTER: Yes. And I will also, as I indicated, submit this in writing to you.

There is also the provision, which has been mentioned earlier, with respect to providing that no physician, health facility, or other health service plan, welfare benefit plan, or the like, shall require any person to execute a Directive. It would seem that such a clause would be very necessary. No one wishes to believe that Living Wills will be misused or subtly coerced in the name of allocation of health care resources, or the like. Nonetheless, I believe it wise to specifically prohibit such a practice.

There are other provisions with respect to the two statutes and I will not take up much more of your time except to say that I think the California Statute is a tighter drawn statute. I have contrasted the two not for the purpose, I might add, of stating that New Jersey should adopt the same legislation as California - total, part, parcel, and everything. Certainly, a detailed study of its provisions would be required by you. There are some aspects of that legislation, by the way, that I do not agree with. For example, there is a requirement that the attending physician act, or provide a substitute physician to act, upon pain of professional discipline of the physician. Moreover, the factor of the California legislation that I like the best - the restriction to situations where death is imminent - may, in individual cases, admittedly be subject to dispute and certainly is imprecise with respect to a definite time. It also omits as to the remote possibility of error in instances where error is absolutely irretrievable.

On the other hand, restrictive Living Will legislation, such as provided in California, does set forth some safeguards and does permit an expression by the patient not to prolong his dying. In light of the potential far-reaching effect of Quinlan and the legitimate concerns of the dying, that in and of itself is some accomplishment.

In closing my statement, I wish to add that I fervently hope that your Committee will not be swayed or misled in some fashion by some popular catch phrases, the most common one being "death with dignity", since I believe those words miss the issue. We all, the living and the dying, want and deserve dignity, but dignity for

or withdrawn and only when death is imminent, whether or not such procedures are used.

Once again, I must stress that the California legislation is based on the imminency of death. Moreover, the reference to mechanical or other artificial means distinguishes, to my mind, the ordinary routine administering of antibiotics for infection from the use of such super apparatus as a respirator employed to keep alive a terminal cancer patient on the brink of death.

I do not believe that the bill you have before you sufficiently distinguishes those two cases.

Senator Martindell has made reference to the problem of witnesses. I would concur that it would be necessary to provide that witnesses not be members of the family, heirs, creditors, attending physicians, employees of the health care facility, or the like. The California Statute, indeed, makes such a distinction. The reason for such an exclusion, insofar as witnesses are concerned, is, it is obviously designed to insure that this ultimate step is taken without suggestion or prompting by those who may well have an economic interest, or some other interest, in the death of the patient.

The California legislation also provides that a Directive to Physicians, as set forth in the Act, will have no force in effect even if the declarant is a patient in a nursing home. I think Senator Martindell has already treated that matter and has indicated that she thinks an amendment may well be appropriate.

Under the California law the Directive is also only valid for five years and may be reexecuted in the same manner as often as necessary. There is a caveat that if a patient becomes comatose or is rendered incapable of communicating with the attending physician, the Directive shall remain in effect for the duration of the comatose condition, or until such time as the condition renders the patient unable to communicate with the attending physician.

By way of contrast, the bill before you provides for a Living Will governing an individual's destiny throughout his entire life, no matter how long ago executed. Such a provision, as in California, requiring reexecution every five years, leaves the individual once again to focus upon the problem in instances where terminal illness has been made subject to a remission.

The California statute also provides that if a patient is competent, the physician must determine that the Directive is in accord with his wishes and verify that the Directive has been executed in accordance with the Statute. In this connection, the physician is not limited to the Directive. He is not solely bound by it. He may also give weight to other factors, such as the nature of the patient's illness, the information received from the patient's family, in determining whether or not the Directive should be carried forth in instances where death is imminent.

By way of contrast, the bill before you does not indicate that the physician may consider any other factors, including the nature of the patient's illness, as well as his conflicting information from his family in making the determination to terminate or withdraw treatment. Rather, the legislation appears to indicate to me that the Living Will would govern without recourse to conflicting evidence, absent an effort to revoke the document by the declarant.

With respect to the matter of revocation, I believe there is an unfortunate loophole in the bill you have before you. The bill provides that revocation may be accomplished by destroying the document or by contrary indication, which apparently is oral or written - there is no specification - but it must be expressed in the presence of two witnesses, 18 years of age or older, in order to revoke the Living

these proposals. In particular I wish to thank the distinguished California Assemblyman, the Honorable Barry M. Keene, author of the California Natural Death Act, for his wise and perceptive, analytical missive dealing with the subject matter of this hearing. A copy of this letter, as well as copies of the California Natural Death Act, Guidelines and Directives for California Physicians and a relevant memorandum of the California Hospital Association are attached also.

The following opinions are advanced within the context of the Judeo-Christian principle of the sacredness of human life, for it is only by faithful adherence to this universal axiom that the moral and just resolution of the myriad dilemmas of this epoch of unparalleled scientific and technical invention will be resolved.

A further guiding principle in drafting legislation providing practical procedures for implementing these fundamental rights is to unequivocally preclude euthanasia, while at the same time to avoid the undue fettering of the exercise of individual autonomy and integrity.

I turn the Committee's attention to the statutory standards for an individual's Living Will. It is the opinion of this witness that Senate Bill No. 1751, in its present form, fails to merit enactment and that the interests of the citizens of the State of New Jersey would be better served by the legislative adoption of a bill modeled after the recently enacted California Natural Death Act. The reasons for this opinion are manifold and are premised on the attached analysis selflessly provided by Assemblyman Keene of California in response to my request for the application of his critical acumen and experience to the present issues confronting the Committee.

I pointed out, Senators, to Mr. Bruinooge, that Assemblyman Keene had done this at my request. I would like, with your permission, to read some of the comments that Assemblyman Keene has advanced with reference to these issues. I refer you to his letter of January 18, 1977 and will commence reading after the salutation.

These are the words of Assemblyman Keene. "I appreciated the opportunity of reviewing the New Jersey legislative proposals on brain death and right to die. As I have greater familiarity with the latter, I will largely confine my remarks to Senator Martindell's measure to validate the living will. With respect to the 'brain death' proposals, I will only briefly comment on the applicable California law on this subject.

"At the outset, let me offer some insight regarding legislating in the field of terminal illness. I would admonish any legislator inclined to pursue such a course of action with a simple but emphatic caution: GO SLOW. I can personally attest to the tortuous labyrinth of political, legal, moral, medical, theological, and ethical dilemmas that confront the lawmaker who resolves to achieve a solution through the statutory law.

"My own lessons would include:

"Any proposal should reflect the medical-legal consensus regarding the ethical parameters of professional practice in using life-support systems on a terminally ill patient. Similarly, the proposal should reflect contemporary societal thinking and substantially adhere to the moral teachings of the Judeo-Christian tradition. Legislation which is beyond the professional consensus or the societally acceptable will not only increase the strength of the opposition, but also render useless any likelihood that the medical profession would honor such a law.

"Any proposal must be drafted with precision and clarity. Definitions, formalities, and statutory procedures should be, to the extent feasible, precise in order to minimize confusion that might result from the law. The tighter the definitions and provisions are, the easier it is to convince legislators and the public that such a measure does not open any doors for euthanasia, mercy killing, or any



the dying doesn't come from placing hemlock at the bedside, but from an understanding of the dying and sympathy toward them, as persons such as Elizabeth Cugler Ross, in her writings, and Paul Ramsey of Princeton, have taught us, and also as shown by the Hospice Movement, which is taking root in our state.

Finally, I wish to add that while I personally oppose this bill, I applaud its sponsor. The bill, like the Quinlan case, is another step toward bringing death and the problems of the dying out of our psychic closet and calls for some form of action. I believe that action is necessary. After all, the dying is the one minority to which we will all belong.

SENATOR SCARDINO: Thank you very much, Mr. Collester. Are there any questions?

(no questions)

Excuse me, Mr. Collester, just one point of clarification. You indicated that you oppose this legislation, S-1751.

MR. COLLESTER: Yes, I do.

SENATOR SCARDINO: I think if I understood your comments correctly, if this legislation were to be enacted you would recommend points that you raised be included in your bill and that it coincide, obviously, as much as possible to the California law.

MR. COLLESTER: Yes, I think that is a correct statement.

SENATOR SCARDINO: But, if that were the case - assuming it were the California law, with the modifications you suggested - would you support the concept and the approach?

MR. COLLESTER: I would support the concept. I don't, as I said, swallow wholeheartedly, the California legislation. There are problems there. Senator, as I am sure you are aware, we are dealing in an area which is comparatively dark.

SENATOR SCARDINO: Would you prefer no legislation?

MR. COLLESTER: I would prefer some form of legislation.

SENATOR SCARDINO: But it is questionable as to just what the right form is, obviously.

MR. COLLESTER: Yes.

SENATOR SCARDINO: You raised that, I think, with every question.

MR. COLLESTER: Yes. I think something along the lines of the California legislation would be the most appropriate action this Body could take. I think some form of legislation is desirable.

As to some of the precise language, I would have to submit that to you in writing.

SENATOR SCARDINO: Thank you. Paul Armstrong will be our next witness.

P A U L A R M S T R O N G: In preface, let me extend a sentiment of gratitude for the privilege of this opportunity to share in the exemplary labors of your profound deliberations.

While my representation of the Quinlan family at this point precludes me from fully exploring the various aspects of the proposed legislation, it is the purpose of this appearance and testimony to briefly set forth an opinion concerning the proposed Senate Bill, No. 1751, providing for an individual's Living Will, as well as Senate Bills No. 992, and 1039, establishing a standard for the determination of human death.

Before proceeding to that end, I would like to generally acknowledge the selfless aid, counsel and advice of numerous physicians, scholars, and lawyers throughout the State and the nation, to whom I have turned for guidance in reviewing



medical societies, hospital associations, legislators, scholars and lawyers throughout the State and the Nation reveals a uniform consensus that Senate Bill No. 1039 incorporates the most widely accepted and acknowledged legislative standard for the determination of human death. I then footnote to the article which was referred to by Father Smith, which is Capron and Kass. It is therefore the opinion of this witness that the statutory definition introduced by Senator Greenberg and Senator McGahn merits enactment.

I again wish to thank the members of the Committee for the privilege of presenting testimony and hope that it serves as an aid in the legislative resolution of these most significant issues. (See page 5X for material submitted by Mr. Armstrong.)

SENATOR SCARDINO: We thank you for taking the time to appear before us and presenting us with your comments and also for having gone to the extent of writing to the sponsor of the legislation which was enacted in California and making, as a matter of record, his comments and recommendations as well. I know that is going to be extremely helpful to us in making a judgment on this issue.

MR. ARMSTRONG: Thank you, Senator.

SENATOR SCARDINO: Are there any questions from the members of the Committee?

SENATOR MARTINDELL: As a matter of record I want to thank both you and Mr. Colleser. I want to state that I did not know about the California bill when we originally drafted this, which is quite some time ago.

I agree with many of your comments. I think we will incorporate them into the bill. Assemblyman Keene was further down the road than we are. One of the beauties of the legislative process is that we can discuss and have hearings on legislation and that we do get input from many places, which aids us in improving legislation. I couldn't agree more about going slow.

MR. ARMSTRONG: I would also like to echo the sentiments of Mr. Colleser with reference to your sponsorship of this bill, Senator.

SENATOR MARTINDELL: I wanted to get the concept started.

MR. ARMSTRONG: Yes.

SENATOR SCARDINO: Chris Smith, Executive Director of the New Jersey Right to Life.

MR. SMITH: Mr. Chairman, with your permission I would like to have Mr. Frank Niemeyer, who is the Middlesex County Right to Life Chairman, speak in my behalf.

SENATOR SCARDINO: We welcome you, Mr. Niemeyer, and your comments.

F R A N K N I E M E Y E R: Thank you very much, Senator. To begin, I would like to thank you and all the members of this Committee for the opportunity to appear before you to give testimony on Bill 1751.

Bills such as 1751 direct a physician to withhold maximum effort in treating those patients whom he considers terminally ill and who have executed a Living Will. Dr. Laurance V. Foye, Director of Educational Services at the Veterans Administration commented on the effects of such actions:

"If a physician withholds maximum effort from patients he considers hopelessly ill, he will unavoidably withhold maximum effort from an occasional patient who could have been saved. Patients will die because of the physician's decision not to treat actively. This approach...cannot be fostered or condoned, legally or otherwise." That is a quote that came from "Constant Crisis of Conscience."

SENATOR SCARDINO: Excuse me, Mr. Niemeyer, are you reading from the statement?

MR. NIEMEYER: I will highlight the statement. I have given you a copy of the statement also.

SENATOR SCARDINO: Are you reading from the statement now?

other act that might cheapen the quality of life.

"With these caveats in mind, I would express my personal reservation as to the wisdom of enacting S-1751 by Senator Martindell. This measure is not patterned on the Natural Death Act. Instead, it is the legislative proposal prepared by the Society for the Right to Die. In drafting the California law, previous drafts of the Society's model law were reviewed and found largely unacceptable.

"Turning to the provisions of S-1751:

"1. Definition of 'maintenance medical treatment:' Section 1(a) attempts to define 'maintenance medical treatment' with a breadth similar to our definition of 'life-sustaining procedure.' However, I believe that the use of the term 'extraordinary' is a grievous error, one that I learned from the personal experience of defending its inclusion in Assembly Bill 3060. Such a term has greater acceptance in the theological literature than in the medical books or in judicial decisions. It places the physician in an uncomfortable position of determining at his or her peril, what is extraordinary and what is ordinary, a distinction that largely depends on the patient's prognosis and the purpose of the medical intervention.

"Instead, I would recommend that the definition of 'maintenance medical treatment' should be drafted with respect to the context within which medical care is rendered. You might note our definition of 'life-sustaining procedure' in the Natural Death Act which states that the procedure must serve only to artificially postpone the moment of death and when death is imminent whether or not such procedure is used. Although this formulation is narrow, it is fairly precise and avoids conferring excessive latitude to the physician to withdraw medical treatment.

"2. Definition of 'terminal illness:' I have no disagreement with the definition of terminal illness in Senate Bill 1751 except to recommend that 'illness' be expanded to explicitly include an 'injury' and a 'disease.' In the strictest sense, an automobile accident might not be construed as an 'illness.'

"3. The document: One of the critical decisions in drafting 'right to die' legislation is deciding whether the measure should contain a specifically-worded document - like Assembly Bill 3060 - or whether the declarant should be free to execute a statement in his or her own words", as is provided in Senate Bill 1751. "Although choosing the latter course of action is more consonant with our values of individual freedom, I opted for the statutorily-worded document solely on the grounds that it is more workable and avoids confusion. If the physician is obligated to honor the patient's instructions, only a uniform directive will satisfy his concern for certainty and clarity of expression.

"Without a legally prescribed document, the patient could decide to use his own terms, not those in Senate Bill 1751."

SENATOR SCARDINO: Excuse me, Mr. Armstrong, I will ask the stenographers to make all of this a matter of record. If you could just maybe highlight each point that the Assemblyman made and then add your own comment, that would help in expediting this hearing.

MR. ARMSTRONG: To that end, Senator, what I would do is, I would endorse the analysis set forth by Assemblyman Keene in that essentially Senator Martindell herself and Director Del Tufo and Mr. Colleser have advanced additions to this bill. Therefore, again, to expedite the hearing on the matter, I would adopt that which was selflessly provided by Assemblyman Keene.

I will simply turn your attention to a brief statement concerning the statutory standards for human death.

With respect to Senate Bills 992 and 1039, consultations with physicians,

dignity." She said, "It won't be long before it becomes economically sound to do away with our sick old people and the hopelessly insane...Life has lost its value. There is evidence", she says, "that our society takes death very casually and that the nation is showing the same sociological symptoms Germany experienced before Hitler came along with his final solution to the Jewish problem." That was a quote, again, from "Private Practice Magazine," August 1973.

The bill before you, S-1751, has many deficiencies. But I believe the greatest deficiency that is here is, once the physician makes the judgment of terminal illness, he is not required to tell the patient. The assumption is that if a patient has executed this Living Will at a time in which he is, say, in the bloom of life, his desires at that time will be the same as when he is confronted with the actual situation of death. I don't believe that this type of assumption can be warranted and I believe that many behavioral studies have proven that it does not hold.

As this document literally deals with life and death, it is of utmost importance that it is enacted with a truly informed consent. This informed consent could only be given in some period of time after the patient is told by the physician that he or she is terminally ill.

Bill 1751 also does not mention any provisions for the pregnant patient. The California Bill which was mentioned before does. Our New Jersey Supreme Court in another case held that a woman had to undergo a blood transfusion, even though this was against her religious principles, because she was pregnant and it would have an effect on the unborn.

Death penalties that are enacted in states always state that it cannot be carried out on a pregnant woman.

We are here, again, talking about a document that deals with life and death. Gentlemen, this bill is not needed. Doctors have always determined the best course of action to be followed concerning patients. The decisions are based upon their professional training, as applied to the circumstances at hand.

Physicians currently withhold treatment for those patients whom they consider, based upon circumstances, terminally ill and for whom treatment would not in any way help. Enactment of this type of legislation limits the action of the physician and implies that the patient, not the physician, knows what is best. That is an implication which is not founded in fact and I ask this Committee, "Why put it into law?"

This type of legislation also - this was alluded to before - comes about now when, as the Senator has said, "I really haven't received a letter saying that we need this type of legislation, or that people were unduly imposed upon." The patient always has the right to switch physicians, if he determines that the physician's actions were not in his best interest. He has always had the right to refuse medical treatment.

There was a case recently that was decided upon in the New York Court. The man had gangrene and the doctor said, "We must amputate." He had the right to refuse and he did refuse.

Legislation of this type, I believe gentlemen, is unnecessary and can have the potential to be very dangerous. Thank you very much.

SENATOR SCARDINO: Thank you very much, Mr. Neimeyer. Are there any questions? Senator Fay?

SENATOR FAY: No.

SENATOR SCARDINO: Senator Martindell?

SENATOR MARTINDELL: Just an observation. As I stated before, only 25% of the population have their own physician and a strange physician doesn't have

MR. NIEMEYER: On the quote, I definitely am.

SENATOR SCARDINO: Okay.

MR. NIEMEYER: That quote would be on page 1, in the middle.

SENATOR SCARDINO: Are your comments directed towards the two bills that we discussed this morning?

MR. NIEMEYER: No, they are not. They are directed specifically to the Living Will.

SENATOR SCARDINO: Did you submit two statements to the Committee?

MR. NIEMEYER: I submitted written testimony on the bills under discussion this morning, yes.

SENATOR SCARDINO: I see. Okay. I am looking at the wrong statement. I think my colleagues are as well. Please proceed, Mr. Niemeyer.

MR. NIEMEYER: With Dr. Foye's statement in mind, I think this Committee has to realize that in dealing with the Living Will we are not only dealing with an individual's right to enact a document, but we are also dealing with the consequences that such a document could have and would have on those of us in society who wish to have the physician treat us with maximum effort.

As was stated before, the Death with Dignity Bills, the Living Will Bills, and the Right to Die Bills have as their emphasis a certain quality of life. When you put the emphasis on the quality of life as opposed to the innate, infinite value of life, the consequences can be horrendous.

Dr. Leo Alexander in an article entitled "Medicine Under the Nazis" stated - this is quoted from Private Practice Magazine, December 1975 - "Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. At first, there was merely a subtle shift in emphasis in the basic attitude of the physician. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as a life not worthy to be lived."

I think in viewing the situation in the United States today -- Certainly, we have heard testimony here today that we are not the only State considering the Living Wills. If you take a look at Doctor Alexander's statement and say, "Does it apply to the United States today?", I believe it does. I believe that the subtle shift that Dr. Alexander spoke about has its beginning here with the Living Will.

Senator Martindell may be familiar with the efforts of a Dr. Walter W. Sackett, a Florida Representative, who has consistently introduced bills dealing with Death With Dignity and the Living Will. I would like to quote a statement that he made before the United States Senate Committee on the Aging: "I think instead of stressing the prolongation of life...medicine ought to stop that and increase the quality of the expected life today", Dr. Sackett said, pointing to 1,500 severely mentally retarded in Florida institutions who, he said, will cost the state an estimated five billion dollars over the next 50 years. Dr. Sackett recalled that if we were back in the 1930's that these people would have died from pneumonia at the age of twelve or thirteen; now they can, through the use of antibiotics, continue to live through age fifty or sixty.

I think one must again ask, "Is the Living Will, and will the Living Will be the end or does it have further criteria which can be stretched out into active euthanasia?"

Dr. Lois Lobb, Director of Mental Illness Research at California's Patton State Hospital stated:

"I imagine our mercy killing laws will begin by legalizing death with

because they were what the local draftsmen conceived them to be. They were active bills, passive bills, bills that provide that anyone could sign it, irrespective of age, the definitions were far-flung. For that reason, the Society for the Right to Die first published a Legislative Manual bringing all of these bills together and presenting a model bill. The model bill was attempted to be the simplest type of bill to act as the springboard from which members of legislatures could work in dealing with the problem.

Now, you have the perfect example of that here where Senator Martindell has introduced a bill based on her own experience. It is for that reason that the second edition of the Legislative Manual contains bills that were introduced in the States of Alabama, Alaska, Arizona, Delaware, Florida, Georgia, Hawaii, Kentucky, Massachusetts, Missouri, New Jersey, New York, Ohio, Pennsylvania, Tennessee, and Virginia.

So, in a sense I envy you, not having felt the need, because the need has resulted in the introduction of these bills and, unfortunately, the need is one which tears at the heart.

I would next like to deal with this question of comparing the bill that was introduced with the California bill. That is very interesting because it gives you the impression that the California bill is the beginning and the end and to the extent that it varies, perhaps we should look askance at our bill.

The California bill that was first introduced was a very simple bill, Representative Keene introduced a very simple bill. The bill was then subject to all of the pressures - the political pressures, the pressures from the various groups in Sacramento. I appeared in Sacramento at a conference and I was able to observe this because when I was there the bill was very simple and I was told that the various hospital groups would not approve it. It was only approved after the bill was so conditioned and restricted that those who decried the concept, fearing that the bill would pass, were able to get their restrictions put in the bill and then they said, "We will go along with it." It was the give and take of the legislative procedure at its best. But, that is not to say that we should follow that pattern here.

For example, the document is only good for five years. What purpose does that serve? You prepare a will of your property. The will of your property is good until you either destroy the old will or prepare a new will. We all know how we procrastinate with things of that nature. You think about something. You consider it. You prepare a document. That document should remain your document until it is revoked.

The bill, in effect, provides it can be revoked by destruction, by writing, or orally. It goes far further than revoking wills. Therefore, there is a restriction which really serves no purpose. It also provides that the bill is only legally effective if you say, "I was told 14 days ago, by Doctor 'So and So' that I have a terminal condition." What about the individuals who are not informed that they have terminal conditions where the doctor says, "Well, you have a type of cancer but it has responded to treatment in the past and you have a good chance?" This makes an individual have to state, "I was told by Doctor 'So and So' 14 days ago that I have a terminal condition." The only purpose something like that serves is a restriction because there was a study made at a high school in the New York area and the high school students concluded after some consideration that a document like this should be executed when you are well, when you have thought about the problem, when you have a chance to consider the pros and the cons, and when you are able to take a stand with

quite the same rapport with the patient or his family.

The other thing is, in a malpractice question they used to, always - I said it and you said it - stop treatment when they thought it was useless - or a great many of them did. Now they would hesitate to do this because of the question of malpractice.

MR. NIEMEYER: If malpractice is the issue, then let us design legislation for malpractice. In the legislation which is before me, there is no mention of malpractice.

SENATOR MARTINDELL: Well, maybe there should be.

SENATOR SCARDINO: Thank you very much, Mr. Niemeyer.

Mr. Sidney Rosoff, representing the Society for the Right to Die. Welcome, Mr. Rosoff. Thank you for joining us today and for giving us a packet of material as well.

S I D N E Y R O S O F F: Thank you very much. I commend the Senate of the State of New Jersey for holding this hearing in order to enable us to freely exchange our various viewpoints which are evident today. If I may, I would like to depart from my prepared remarks, which you have before you, and rather deal with some of the things that have been discussed up to this point.

SENATOR SCARDINO: Yes. On that - and perhaps this is a bit repetitive on my part - I would just like to make the point that Mr. Niemeyer, in his comments, presented testimony on all of the bills and I would expect that all of the testimony that he presented to us will become part of the transcript. So, it will be included, as well as the entirety of your transcript.

MR. ROSOFF: Thank you very much. The question is do we need a bill like this and why are these bills introduced? At the point in time that I first became aware that numerous bills were being introduced I was counsel to the Society. You would have thought that the Society, being the legislative arm of this movement, would have been a moving force for the introduction of these bills. Yet, I found that bills were being introduced in as far away places as Wisconsin, West Virginia, the States of Washington, Montana, Oregon, Delaware, Florida, Idaho, and Massachusetts. So, I thought, "Why don't we find out why these bills are being introduced?" I would obtain a bill and I found out, for example, that in Wisconsin the bill was introduced by a Senator Soyke so I called the Capitol and I asked to speak to Senator Soyke. Senator Soyke was no longer a Senator; he was selling farm implements in a little town in Northern Wisconsin. So, I asked him on the telephone, "Why did you introduce the bill?" He said, "Well, a friend of mine is a physician in Green Bay. He was fishing in Northern Michigan. His wife was driving up to see him one weekend and her car was hit and smashed by a drunk. Her car was a complete wreck. She had terrible brain injury. She was maintained on machines. Her husband wished the machines to be disconnected. The sisters said why don't we leave it up to God. The machines kept her up to 48 hours when she expired." He said, "My friend came to me and said, 'Introduce a bill.'" I said, "Well, what did you do then?" He said, "Then I went to the Legislative Service and I said, 'Make me a bill' and they prepared a bill and I introduced it."

I then followed the same track with the Representative who introduced the bill in the State of Washington and I received substantially the same form of answer: "I had a family member in this condition. We could do nothing about it. Therefore, when I got back to the Legislature I asked the Legislative Service to prepare a bill for me."

For that reason, the first bills that were introduced varied tremendously

Supreme Court, someone stood up and said, "If you have an income tax, the next step, or the final step, will be confiscation of property." Justice Holmes said, "We are deciding on the constitutionality of the income tax. When it comes to the confiscation of property...."

SENATOR SCARDINO: You could lead into a very interesting response if you keep talking like that.

MR. ROSOFF: You think we are getting there, I know. I have hope that with this new Administration that we can get our \$50.00 and start from there.

SENATOR SCARDINO: You may continue.

MR. ROSOFF: I would rather answer any questions if you have some you would like to ask me regarding something I haven't dealt with.

SENATOR SCARDINO: Okay. Am I to deduce from all you have said that you don't feel there is any active legislation anywhere in the United States today that satisfies what you feel ought to be done before a legislative body enacts a law, in essence, on this matter?

MR. ROSOFF: I think that the enactment of the Claifornia law was a truly wonderful thing because it placed a law on the books that we can improve upon and work on from there. I think that Senator Martindell's bill speaks for itself.

SENATOR SCARDINO: It speaks for itself but it does not do, obviously, what you feel it ought to do?

MR. ROSOFF: Oh, it does what I think it ought to do. But I recognize there are those who feel some provisions and safeguards are necessary. I would not be adverse to that. I don't seek a bill just for the sake of the passage of a bill. However, I think those safeguards and those measures should be purposeful in order to make the bill a better bill, not to restrict its use.

SENATOR SCARDINO: You were here, I believe, when I made some observations earlier. I do that deliberately, kind of thinking out loud because I don't feel it is fair for me to restrain my thinking on this subject, particularly if I have to make a decision on it. I would like you to know just how I feel, pro and con, at any given moment. It is not that I have made up my mind decisively at this point. I want to make that clear.

I still don't understand and no one to this point has really elaborated sufficiently on this in terms of where the shortfalls, if you will, exist under the present method that is used now between the physician and the patient or the physician and the family of the patient. In essence, why the bill? Why the law?

MR. ROSOFF: The present shortfall exists because of certain conditions with respect to our society, or training. First of all, the training and inclination of the physician is to regard death as the enemy to be defeated at all cost and to forget that death can be a friend. One need only go into the intensive care units or into some of the nursing homes and spend time there and see the physicians practicing their art for no purpose, really, other than to extend the period of dying.

What am I talking about? I am talking about an 86 year old woman with severe cancer, with kidney failure, who develops pneumonia and is then put in an oxygen tent and given every conceivable antibiotic to defeat that pneumonia. For what purpose? I am also talking about the problem that exists where you have the patient who says, "let me go" and one or both offspring have a sense of guilt - it is their mother or father and perhaps they should do something. They are torn with guilt. Can they say it is right to let the person go? It is a terrible responsibility to place upon people. Yet, we should recognize the right of the individual who feels he or she should



respect to living and dying in the abstract. When you have the immediacy of death thrust upon you, that is the time when you are least able to think through the problem clearly.

Finally, if you do - in Claifornia - execute the document when you are well, the physician need only give it consideration along with considering a lot of other factors. In effect, your wishes, expressed when you are well, count for nothing, really. That, I decry, thrusts you right back into the Karen Ann Quinlan situation if you had a document, because it leaves it up to a stranger. You know how you wish to be treated and you know how you wish to be treated when you are well.

SENATOR SCARDINO: On that point, isn't it indicated in the bill that if a person makes out a will within 14 days after learning that he has this illness, it becomes binding at that point?

MR. ROSOFF: Well, if it were that simple -- But, even there the document requires you to insert a paragraph that reads as follows: "I have been diagnosed and notified at least 14 days ago as having a terminal condition by \_\_\_\_\_ M.D. whose address is \_\_\_\_\_, whose telephone number is \_\_\_\_\_. I understand that if I have not filled in the physician's name and address, it will be presumed that I did not have a terminal condition when I made out this directive." That type of legislative drafting I decry because rather than simply saying, "We refuse to support the bill" we say, "We will support the bill, but why don't you just put in this paragraph."

SENATOR SCARDINO: Okay. Your point is well taken.

MR. ROSOFF: I would like to deal with several other aspects of the discussion. First of all, is it true that if your wishes are known they will be observed? Do you need a document like this? Won't physicians follow through with what they know your wishes to be?

An individual in Texas sent his living will to the hospital, a very distinguished hospital in Houston. I recite this in my paper - in my formal presentation. The hospital told him, "After consultation with our legal counsel, it is necessary to advise you that we will not be able to honor such a will. In the opinion of our counsel such a document does not constitute a valid commitment on the part of the hospital. Therefore, in the event you are hospitalized as a patient here, every measure will be taken to see that your life is sustained to the best ability of our staff." What they were saying to him is, "No matter how you wish to be treated, we will treat you as we see fit to treat you." It is that, really, that we are doing now.

What we are seeking to do is to give the individual the right to exercise some prerogative over the way he lives and dies. The bill here does not provide active steps to terminate life; it provides for termination of treatment which extends the dying period. It should be welcomed by the medical profession since it provides guidelines for the physician, the hospital, the nurses, and others involved, in order for them to know that they can obey the wishes of the patient without fear of liability.

One of the strongest arguments against what we are doing here now is the slippery slope argument. Once you embark upon this course of conduct, who knows where you will end? Now, I am old enough to remember the first days of the Roosevelt Administration when they were introducing bills which took children out of the mines, which cut back child labor and which did other amazing things with respect to the business rights of the country. Everyone decried this. They said, "If you start here, who knows where you will end?"

When the first law providing for the income tax was argued before the



and giving us your comments.

Edward Leadem, Executive Director of the New Jersey Catholic Conference.

E D W A R D L E A D E M: Senator Scardino, members of the Committee, Senator Martindell, by way of preface to my written remarks, I would like to share two of what I consider very personal things, two things I have never shared in public before but which I feel really compelled to do today. I am somewhat encouraged by virtue of what Dr. Finley said this morning and by what Senator Martindell, herself, said this morning.

I think I comment from very personal experience on two aspects of this. On July 8, 1961 my mother called us at home and told us that our father, who had had prostate cancer and who was at home peacefully, was experiencing shortness of breath and that he had blueness in his lips. My mother's background was that of a teacher. She called my wife, who is a nurse and my wife said, I think he is suffering from lack of oxygen. We called the doctor and the doctor said send him to the hospital right away. We sent him to the hospital right away and in the time that it took me to get from our home out to the hospital we saw my father-- I went to the house first and they took him in the ambulance and then in the time that it took me to go through the paper work - that you just referred to - he was taken to his room. We got up to his room and there he was in an oxygen tent. He looked very comfortable. He looked at us. He had an I.V. going. In about five minutes the doctor came in and took a look at him and removed the I.V. In about five minutes my father was dead.

Do I have guilt feelings? No. I think that we experienced something. We abided in the judgment of the doctor. We took that judgment and accepted it. To get very personal about it, I am the oldest of eight boys and not one of my brothers objected to this procedure. My mother was there and she had no objection. And I don't think we could, for one minute, ever be accused of not having the appropriate love that one should have for his father. Now, it is not easy to make this statement here.

The second incident I lived myself. This happened in November of 1973. At the age of 48 I was slammed by two coronaries and I woke up on the Coronary Care Unit at St. Francis Hospital and from what I could see even in that dazed state, I had tubes out of every part of my body. But I am here today. So, I offer these as two personal experiences to show you what I think are the extremes between what is the ordinary situation - the use of ordinary care - and the use of extraordinary care. Maybe because of the emotion of the presentation this loses some sense to you but I lived it.

With that, I would like to go into my statement. I have introduced myself at your meeting this morning.

I should like to commend the Committee, its staff, and the Law Revision and Legislative Services Commission for what I consider excellent background papers on the issues to be considered at this public hearing.

Time does not permit this speaker to comment on each and every point raised in these background papers. I respectfully submit, however, that careful scrutiny of those documents can lead only to an inescapable conclusion: The concepts embraced by the proposed death and dying legislation are far too broad to be adequately addressed by our Legislature.

Last month at a Committee hearing conducted by the Assembly Judiciary, Law, Public Safety and Defense Committee, we presented a position paper on A-1973, the "Death With Dignity Bill." We should like to express a few of those thoughts here. We said, "However altruistic this legislation may be in concept, it must be remembered that this type of legislation has a very strong tendency to diminish the value of human life and relieve society, as well as the law, of its responsibility to provide adequate

be let go.

Finally, we keep talking about the right of the patient to state that he doesn't want further treatment. That is often muted by circumstances. The individual who is plugged, connected, hosed, is in no condition to make a decision. She feels at one point that maybe all of these people know what they are doing; maybe they recognize that it is only tomorrow and "I will wake up and will be able to step out of bed and walk down the hall." This is a terrible thing.

So, for these reasons the bill is needed.

SENATOR SCARDINO: Going back to your description of the geriatric care given to patients - elderly patients, obviously - suppose that patient was in a home, a hospital, or a nursing home and they had no immediate family - no one - and a judgment was made that they were terminally ill, what would your recommendation be in that case?

MR. ROSOFF: If the patient had executed the document, I would observe that patient's wishes.

SENATOR SCARDINO: How would that patient execute a document within 14 days of having been told they were terminally ill?

MR. ROSOFF: I don't believe that provision is reconcilable with what we are sitting here discussing. But, suppose you had a law like Senator Martindell's law. And suppose the individual was conversant with the law and executed the document. That document would speak for the patient's wishes. If you do not have the document and if the patient suffers from irremediable conditions, then you have the guidelines described in today's papers that have been issued.

SENATOR SCARDINO: Have you ever admitted a patient into a geriatric hospital?

MR. ROSOFF: I beg your pardon?

SENATOR SCARDINO: Have you ever admitted a patient into a hospital for geriatric care? Have you ever had that experience?

MR. ROSOFF: Yes.

SENATOR SCARDINO: You have seen the forms that have to be filled out and signed upon admission?

MR. ROSOFF: Yes.

SENATOR SCARDINO: Were you familiar, totally, with all of the forms that were signed upon admission?

MR. ROSOFF: No.

SENATOR SCARDINO: Neither was I. I can't help but think of the time we admitted my grandfather who was 86 and who really had no control over himself whatsoever. He was senile, that was the diagnosis. He had swelling in the legs. He was turning blue - the whole thing. The doctor came up to us and told us on the side that it was just a matter of time. So, in essence, I would suggest that meant he was terminally ill. He lived for some 10 or 12 years afterwards. He came out of it and gave us a great deal of joy for those 10 years. I just wonder about that.

MR. ROSOFF: Well, you see there are the chronic diseases of old age where you bring the patient to the home and the doctor says, "We can do nothing. This is aging." Neither this bill nor our society believes we play any part in that situation. That is the aging problem and the Lord takes at appointed time.

What we are talking about is the terminal illness situation. And I would not, for one moment, condone shortening the lives of the patients in nursing homes simply because their life lacks quality.

SENATOR SCARDINO: I appreciate your comment on that. Thank you. Are there any further questions? (no questions) Thank you very much for being with us today

'terminal', 'natural', 'usual', and so on?

"There is fear of the implications relative to society itself. Legislation supposedly designed to protect rights and insure mercy can move very quickly from voluntary discontinuing of life to involuntary and direct taking of life. A society which routinely allows persons to die creates a social climate in which laws to permit suicide or the direct killing of the terminally ill can be accepted. As we have seen with the abortion issue, law affects public attitude and behavior. A consideration of possible consequences and developments, no matter how unintended, is not irrelevant in the field of legislation. Once we begin to legislate in the specifics of ethics, we are led irrevocably to additional legislation that opens up the whole question of positive euthanasia. The proposed legislation eventually raises the question of direct taking of human life." End of quote.

By way of conclusion, we feel that S-1751 authorizes a document comporting with the formalities of a will that can be looked upon as a mechanism to condition public opinion to accept positive termination of life in cases of senility or incurable illness.

Further, it is our opinion that there is no need for legislation in this area and in the absence of documentation of such a need, we feel the reasons against such enactment of such legislation far outweigh those in favor of such legislation.

Thank you very much.

SENATOR SCARDINO: Senator Martindell has one question.

SENATOR MARTINDELL: Mr. Leadem, you didn't see anywhere in the bill that anybody had to do that?

MR. LEADEM: I beg your pardon.

SENATOR MARTINDELL: You didn't see anywhere in the bill that anybody had to sign a Living Will?

MR. LEADEM: No, of course not.

SENATOR MARTINDELL: It is purely permissive.

MR. LEADEM: Yes.

SENATOR MARTINDELL: Doesn't that make a difference?

MR. LEADEM: I don't think so. I think we are talking concept, Senator. Nobody has to have an abortion. That is the argument raised there. But, what is it doing to our society? We have an objection to that. I think there is a moral consideration here that has to be registered.

SENATOR SCARDINO: Thank you very much, Mr. Leadem, for testifying both this morning and this afternoon.

Reverend William Smith, representing the New Jersey Right to Life.

REVEREND WILLIAM SMITH: Senator, I would like to thank you again for this opportunity. I am sorry Senator Martindell stepped out because, for her benefit, I would like to point out that I aim to disagree strongly with the ideas, the words and the concepts of her bill, but I don't intend or infer disagreement with her person.

SENATOR SCARDINO: I think, knowing Senator Martindell, that she understands that completely. Unfortunately, she is suffering with a cold and she doesn't feel quite that well at this point, so she had to leave.

REVEREND SMITH: Very good. Senate, No. 1751 is a so-called "Living Will" modeled on a bill prepared, I am told, by the Society for the Right to Die, Inc., of 250 West 57th Street, New York, New York. It differs in wording but not in logic from a "Living Will", prepared by the Euthanasia Education Council of the same address.

The same model bill you have - somewhat rearranged - was the subject of

legal protection for human life at every stage of its existence and in every circumstance, even if the enjoyment of life is limited or qualified."

We submit that legislation such as the subject bill most certainly paves the way toward euthanasia and gives rise to the valid question, "Will the same rationale of euthanasia be invoked against the terminally ill or the victims of accidents or violence or the senile?"

We submit that the concept of S-1751 in attempting to define, statutorily, words such as "maintenance medical treatment", as extraordinary medical treatment, or "terminal illness" as founded in "all reasonable medical probability", is a futile attempt to use the precision of the law in an issue far too complex. There is no magic in the words "maintenance medical treatment" that alters our understanding of extraordinary medical treatment. So also, "terminal illness" rooted in "reasonable medical probability", clearly shows this to be a medical concept. One must ask: What is medical probability? Certainly, such concept escapes legislative definition.

We submit that the decision here must be left with the patient and his doctor, with the counsel of his relatives and advisers.

The "Living Will", the document referred to in S-1751, is a unilateral document -- that of the testator. Let us not be confused into thinking that since the document must be written, signed, acknowledged, and declared, by the testator, all in the presence of two witnesses, such witnesses can exercise any adversary influence over the testator. This statutory language is identical to the present law regarding wills in our state. Thus, the subscribing witnesses need not, indeed in the practice for wills should not, have any knowledge of the contents of the document. The legal function of the witnesses is just that - two witnessing the publication of the document, no more, no less.

There is abundant legal scholarship on this issue today. Permit me to quote a colleague, Charles J. Tobin, Esquire, Executive Secretary of the State Catholic Conference of New York, speaking on the undesirability of the statutory process in this area. I quote: "There is a fear of the effect on the doctor/patient relationship. A 'Living Will' statute would compel a physician to seek to conform his actions to its provisions, not necessarily to his own medical judgment. In that sense, he would become a servant of the statute and lose his ability to be an advocate for his patient.

"There is a fear of the willingness or ability of a doctor to respond to a patient's needs or wishes in the absence of a signed and formal 'Living Will'. The right of the patient might be seriously jeopardized if physicians, seeking the security of the statute, refuse to discontinue 'extraordinary means'.

"There is a fear of the effects upon the patient/family relationship. It seems reasonable to anticipate that some, perhaps many, patients could be 'pressured' into signing a 'Living Will' in advance of their personal commitment to such a decision. In reverse, in the absence of a signed and formal 'Living Will', would the family of a comatose patient be compelled to conclude that the patient wishes that 'extraordinary means' not be withdrawn or withheld?

"There is a fear of the ability of any statute to use terminology which is not subject to change, because the issue relates more closely to the social and human aspects of the decision making than to the practice of medicine. For example, how can any statute be sensitive to the various basic aspects which form the context of such difficult decisions; the spiritual, physical, emotional and mental condition of the patient; the judgment of a particular physician; the attitude of the family; from situation to situation, the specific nature and meaning of 'extraordinary means',

have already pointed out, that no one is really talking about euthanasia yet. But, if the discussion is limited to active euthanasia that may be superficially true. However, the problem is with and in the inherently ambiguous term "passive euthanasia", here, "discontinuance of medical treatment."

The critical point, really, in "passive euthanasia" concerns the "nonuse" or "discontinuance" of treatment. Whereas on the one hand the discontinuance of extraordinary means is not euthanasia and should not be so called, the discontinuance of ordinary means is euthanasia and should be so called. That needed distinction is absent here. "Discontinuance" is inherently ambiguous until and unless you spell out just what is being discontinued.

Discontinuance of extraordinary means - that is, those that do not offer a reasonable hope or benefit to this patient in his or her circumstances - already is a patient's legal, moral, and medical right. One has the ability, now, to use or to forego such means. However, discontinuance of ordinary means is no mere omission but rather serious neglect. When chosen by oneself, we call it suicide; when others help it along, it is known as assisted suicide. But, in either case, that is passive euthanasia.

Furthermore, the terminology "terminal illness" like "incurable illness" promises a kind of certitude of judgment that you simply cannot deliver. No one is more aware of the misleading code words in this area than the medical profession. I make a few short quotes: "...incurability of a disease is never more than an estimate based upon experience, and how fallacious experience may be in medicine only those who have had a great deal of experience fully realize." I am sure the scale of expertise in the medical profession is somewhat like the scale of expertise in the legal profession, and the same in the ministerial profession - that is pretty wide.

Dr. Haven Emerson, a former President of the American Public Health Association, goes as far as saying: "To be at all accurate we must drop altogether the term 'incurables' and substitute for it some such term as 'chronic illness'."

The renown pediatric surgeon, Dr. C. Everett Koop, surgeon-in-chief at Children's Hospital of Philadelphia - he is the man who just accomplished the separation of the Siamese twins recently - has made the same point in his book: "...it should be medically stated that although death seems imminent to a physician and although he knows it is impossible to turn it away with the armamentarium at his disposal, death can never be exactly predicted as to time. The earlier in the death process one attempts to make this prediction, the less accurate are his prophecies."

Thus, in my judgment, the wording of the bill before you - its definitions and terminology - is purposely vague and dangerously misleading. It does not lead to a first step, it is a first step on the euthanasia trail. Here, it is cleverly disguised as either compassion and efficiency but it is a form of "passive euthanasia", properly defined.

That much for wording, I would like, secondly, to look at the bill's logic and, in particular, its religious association.

The so-called "Living Will" is prepared and presented as if it were in line with conventional Judeo-Christian morality and, in particular, as if it reflected the "sentiment" and teaching of the late Pope Pius XII. In fact, it does not reflect conventional morality accurately and, it is particularly at odds with the teaching of Pope Pius XII as an examination of his teaching in English translation or in the official French original will reveal. I say that for the following reasons:

First of all, the presumption in Catholic morality is that the patient is spiritually prepared for death, that is, his or her spiritual and practical affairs are

public hearings before the Subcommittee on Health Care of the New York State Assembly last November. We had hearings on this in New York City, Albany, and Rochester.

Thus, what is before this Committee is not a novelty, I don't think, but a carefully chiseled piece of social engineering, part of the "death package" now being marketed throughout the country by the Euthanasia Education Council. Different items in the "death package" presently include, or at least are presently presented as: Death redefined; so-called Death with Dignity bills; so-called Right to Die bills; and, the so-called "Living Will."

I was listening closely to Mr. Rosoff. I don't think it was an accident that he was in California when they were discussing legislation, as he is in Trenton when you are discussing legislation, and as he is in New York when we were discussing legislation.

The "Living Will" before this Committee, I think, fails in its wording, in its logic, and its loose association here with the incredible - or what I take to be incredible - religious insult that it is "intended to encompass the sentiment of the late Pope Pius XII."

First, as to wording: The so-called "Living Will" is, of course, a misnomer; it doesn't have to do with "living", it has to do with "dying." It should be called a "Dying Will", or perhaps more appropriately "A Death Wish."

As to wording, if you will notice the definition of the words -- First of all, "l.a., 'Maintenance Medical Treatment' means extraordinary medical treatment used or continued solely to sustain life processes." While this terminology is novel, I take it to be misleading.

Medical treatment is offered to patients, it is not offered to life processes. Thus, the terminology chosen is both slippery and dehumanizing, I think. I say it is slippery because it slips by and leaves undefined "extraordinary medical treatment" and thus effectively begs the question of whether a treatment, operation, medication, or procedure does offer a reasonable hope of benefit to a patient or does not. I call it dehumanizing because of its radical reductionism. It reduces the human being to mere "life processes."

Could not basic nourishment and even drinking water be so construed by someone as "treatment used or continued solely to sustain life processes"? Surely, an oxygen tent or intravenous feeding could be so described by someone as treatment used or continued solely to sustain life processes.

This description of "maintenance medical treatment" is, I believe, purposely vague. It does not define medical treatment but it encapsulates a conclusion and a value judgment: That is, any treatment or procedure which in the judgment of someone is "used or continued solely to sustain life processes." I know of no treatment, procedure, or instrument solely so defined in itself. Theoretically, while the definition sounds somewhat limited in its statement, it really has no limits in its applications; it could be any treatment, procedure, or medication which is judged by someone "solely to sustain life processes." I might note that previous speakers have also had trouble with l.a. and, I think, with l.b.

This definition also fails to define the one in l.c., which I really shouldn't read back to you - the one on "terminal illness." I say it fails to define it because the second half of the definition repeats the vagueness and all the problems inherent in the mention of "maintenance medical treatment" in l.a. The definition presented completes an almost perfect circular argument since the qualification of l.c. rests largely on l.a. which is vague and undefined and not properly qualified in the first place.

Now, the advocates of this bill will be quick to point out, and I note some

Seven, any Living Will can be read as a subtle document of self-rejection, I think especially by our elderly folks. The elderly are guided to fashion an image of themselves as not being useful and to think of themselves as a burden, such as, "My illness is preventing the kids from paying the mortgage." The unspoken pressure here is to go along with the trend under the guise of improving the lives of others and the effort is to invest death with a bogus dignity that is nothing more than a cover-up, in fact a hindrance, to the proper care of the dying.

Practically, should a Catholic sign a Living Will? They would have to be out of their mind. In my judgment, no. First, there is no medical, moral, or legal need to sign one. Second, it would be most unwise to contribute, even unwittingly, to the present push for voluntary euthanasia in this country. They say a stream is always purest at its source and one known source here is the Euthanasia Education Council.

Finally, the Roman Catholic Bishops of the State of Connecticut issued a pastoral "On Death and Dying", September, 1976, opposing this legislation. Also, the Roman Catholic Bishops of the State of New York, speaking through their Executive Director of the New York State Catholic Committee who testified in Rochester, New York on the 30th of November, opposed the very same legislation. Since July of 1974, the Catholic Hospital Association of the United States has been distributing its "Christian Affirmation of Life" to counter the spread and distribution of the so-called Living Will. Now, while this Affirmation is an improvement over the so-called Living Will, it meets some of the objections in part but none of it, and no part of it, is meant to be the object of legislation.

I do not mention these final elements to introduce a sectarian component into this discussion. I mention them only because of the erroneous and offensive remark included on page 3 before you. The quote reads: "The bill is intended to encompass the sentiment of the late Pope Pius XII." Nothing could be further from the truth, nor could anything be a worse distortion of the truth. It is standard procedure with the euthanasia crowd to constantly quote or mention Pope Pius XII. In all due respect for our past Pontiff, he doesn't need these rave notices.

I would like to close, as I began, testifying in support of the Right to Life - that is, the right to life even for the dying. We support the Right to Life, and especially the Right to Life of the Dying.

SENATOR SCARDINO: Thank you very much, Father. I would like to find out what the purpose was for putting in that sentence that you referred to. You know, I respect your authority in refuting it.

REVEREND SMITH: Well, it is even misstated. The statement is incorrect.

SENATOR SCARDINO: Well, it would be interesting to see how it came about.

REVEREND SMITH: This familiar expression that normally individuals are held to use ordinary medical means is inaccurate. We are always held to use ordinary means, usually one is free or not free to forego extraordinary means.

Like the example you gave before, I don't know the facilities too well in the State of New Jersey but at home we have several institutions just for terminal care. Calvary Hospital in the Bronx is only for people who have cancer. Rosary Hill in Horthorn, New York is run by an order of Dominican Sisters who are dedicated to nothing else; they only treat people who have cancer. There are no alumni of these institutions but all ordinary means of care are offered. We always keep someone clean. We always relieve pain. We always provide food and relieve hunger. Radical extraordinary procedures are not done. You already have this right now. What I am trying to say is, there is no law that says a doctor has to use all means



in order. The Living Will has no such qualification.

Second, the "extraordinariness" of "extraordinary means" is determined by specific situations, actual conditions, measured according to the patient's real, factual and unique circumstances, not all of which are medical. This Living Will converts this option about the future into an actual choice here in the present long before those actual circumstances have even been faced, much less studied.

Three, forms vary, but the expression "terminal illness" is just too broad to be helpful and just vague enough to be dangerous. The Living Will of the Euthanasia Education Council speaks of "my recovery from physical or mental disability." Well, the Report of the Judicial Council of the American Medical Association, "On the Physician and the Dying Patient" was correct in noting the lack of clarity in these terms. They point out things that we all know - "A patient well adjusted to kidney dialysis, lives with 'a physical disability from which he will never recover.' A mentally retarded infant suffers from a 'mental disability from which he will never recover'. In fact, a diabetic is irreversibly ill."

In such a serious matter as here, where judgment, by definition, is made by those other than the patient, I think every term involved demands scrutiny, clear understanding, and complete explanation.

Four, the so-called Living Will is being pushed by the Euthanasia Education Council which is trying to "educate" the public to their point of view. Voluntary euthanasia is now the stated goal, but simple logic tells you that there is no way to advance involuntary euthanasia without first "educating" the public to "accept" voluntary euthanasia. There is a sense in which I think the Society for the Right to Die really doesn't care what these bills say the first time, because the next time they will improve them.

Five, the Living Will is signed when someone is not concerned with death. It becomes operative, of course, in terms of consent, when you are 100% concerned with death. The Living Will of the Euthanasia Education Council makes no provision to cancel out. This bill of the Society for the Right to Die does make some provision but I would ask you to look at it because I think it is very curious. It says in the bill before us, "Revocation may be accomplished by destroying such a document or by contrary indication expressed in the presence of two witnesses 18 years of age or older."

To destroy such a document, I think you would have to be well enough, first of all to find it, get your hands on it, and get rid of it. Doesn't this really presume a kind of mobility that just may not be available? Why does it talk about two witnesses? Is this because hospital rules normally limit Intensive Care visits to one person at a time? And, on the last point of canceling out, I would want to bring to your attention that a Living Will bill was proposed in the State of Montana, in their Legislature, in 1975 - House Bill No. 256 - which could only be revoked once.

Six, the reasoning behind the Living Will is materialistic and mercenary. They serve as an excuse for the caring services and a pretext to limit rather than improve care of the dying. One of the best examples of this comes from one of the best known advocates of euthanasia in this country, Representative Walter Sackett of the Florida State Legislature. One August 7, 1972 he testified before that U. S. Committee on Aging, which was mentioned before. He testified before Senators Percy, Church and Fong. Sackett said that the State of Florida could save \$5 billion by withdrawing support from some 1,500 severely retarded residents of that State over the next 50 years.



SENATOR SCARDINO: Pat Grosso, New Jersey State Nurses Association. Welcome. It is nice to have you with us. I appreciate your taking the time to come here today.

PATRICIA GROSSO: I am Patricia Grosso, a member of the faculty of the College of Nursing, Rutgers University. I am also a psychotherapist. I have a private practice of patients who are dying. I have for the past two years only worked with dying patients and their families. The testimony I am about to give is in support of the legislation that is proposed by Senator Martindell.

Nursing represents at least, if not more than, 75% of the people who give health care in this state. Nurses are the largest members of that group. We are the people who are there twenty-four hours a day. The doctors come in for five minutes and leave. The dieticians come in; the families come in, but we are there all the time. We are very much a part of the patient's drama.

SENATOR SCARDINO: Do you make house calls also?

MS. GROSSO: Yes. I do. I only work with dying patients and most dying people don't need a therapist until three o'clock in the morning, their lonely time. Besides working only with dying patients, prior to going on to graduate school I spent six years in an intensive care unit as a staff nurse, so I guess I have been there.

The legislation that is proposed we support in principle. Specifically a lot of the safeguards that were mentioned this morning probably would need to be included, so it is not that we blatantly support the legislation as it is, there are more provisions needed.

You asked the question before, "Why do we need this bill." Well, if everything was like Camelot, we wouldn't need it, but it is not that way. To doctors, death is the enemy and it must be avoided at all costs, and this is what we have to deal with day in and day out in nursing. The doctors are the curing people and we are the caring people and sometimes in giving that care, it goes against what the patient wants, what the family wants; it goes against everything but what the doctors want, and we are the ones that have to provide that care. Twenty-five years ago, the determination of death was not hard at all. The patient's heart stopped beating and he stopped breathing and he was dead, and that was all there was to it. But now people in hospitals no longer die. They go to intensive care units, and there beneath the tubes and the tents they are made dead. If your heart goes out, they can put in a pacemaker. If your lungs give out, they can hook you up to a respirator and that will breathe for you. In fact, they have come up with a new ingenious method called hyperalimentation. They can directly inject into your vein nutrients that will keep you alive. They have had cases up to eight years of never having to eat and never being awake, yet you can be fed through hyperalimentation. So it is not such an easy job any more and I believe some of that was spoken to this morning with the definition of death.

American medicine has become most clearly eminent in providing intensive technically elaborate and modern treatments for patients. The result is that patients no longer die; they go to hospitals. Gone are the days when we fall peacefully into never-ending sleep in our own beds at home with those we love nearby. Eighty percent of all deaths now take place in hospitals where life extending heroics are second nature to the hospital staff.

The hospitalized patient is surrounded by nursing personnel 24 hours a day. It is nurses who create the atmosphere in which most of you will die. Nurses make many decisions that directly affect what happens to other people's lives. In practice, nurses face many problems in which the dying patient's rights are very much

at all times. There is a law that says doctors can't kill those they can't cure. In the first case we don't need a law. In the second case that is a good law. Just because we can't cure doesn't mean that care should end. Sometimes the only care is to hold someone's hand, but that is care.

SENATOR SCARDINO: Thank you. You made your point very clear. I would like to thank you for staying with us all day and presenting your testimony both this morning and this afternoon. We appreciate your presence.

REVEREND SMITH: Thank you very much.

SENATOR SCARDINO: Pardon me?

MS. GROSSO: Do you know what a code 99 is, or what a resuscitation effort is?

SENATOR SCARDINO: Yes.

MS. GROSSO: Okay, if someone should stop breathing, they immediately start resuscitation. Some hospitals mandate or require this for every patient in the hospital, even the 91 year old terminal cancer patient. So you call a code on that person, and then they shove a tube down his throat, and they put him on a respirator, and maybe it takes 14 days for him to die. Even if on the shift before he had said, "Please, I know it is my time, and I am ready, let me go," they mandate that there be a code called.

SENATOR SCARDINO: Have you experienced any situation where they didn't die?

MS. GROSSO: Yes, and at that time it was the best thing that ever happened. Someone may have a cardiac arrest and you defibrillate them, you give them a shock to their heart, and they go home and they are fine. That is very, very different from being terminally ill.

SENATOR SCARDINO: You have answered the question. You made a point about the nurses. I think it is a valid point. I share it with you. The nurses should be more represented on these groups or bodies that make determinations of one kind or another that affect the profession or the patient.

Were you by any chance referring to the recent announcements concerning the decision of the Commissioner of Health and the Attorney General's office? Because quite frankly, I didn't recognize that the nursing profession was not represented on that group until you mentioned it.

MS. GROSSO: They are not represented.

SENATOR SCARDINO: Just to be specific and make it a matter of record, would you be disposed to having representation on a committee like that?

MS. GROSSO: Very much so, yes.

SENATOR SCARDINO: I appreciate your comments. Thank you for coming today.

MS. GROSSO: Thank you.

SENATOR SCARDINO: Is Dr. Delahunty here? I suppose he will not return. Did Dr. Gross arrive? This concludes all of those who have signed up for testimony. If there is anyone who did not sign up for testimony, I am now referring to the two bills of this morning, because obviously these are people who have been here all day, is there anyone who would like to speak to Senate Bill 992 and Senate Bill 1039 at this time that did not speak this morning? (No response.)

MEMBER OF THE AUDIENCE: I would like to speak on this afternoon's bill.

SENATOR SCARDINO: On this afternoon's bill, Senate bill 1751, is there anyone who did not sign up that would like to speak to this bill. Okay, suppose we have you come up first, and then we will have you conclude.

Would you like to speak to the bill, sir?

MEMBER OF THE AUDIENCE: Yes, Mr. Chairman, please. I spoke to Mr. Bruinooge yesterday, I believe, and he said he would get me on sometime today.

SENATOR SCARDINO: We will get you on right after Mrs. Bates.

E L E A N O R     B A T E S: Thank you. My name is Eleanor Bates. I spoke to you earlier. I would like to respond to the statements that were made this afternoon on the living will bill. I echo Pat Grosso's statements and concerns about the way in which some terminally ill patients are handled in some hospitals. However, I think

at stake, and nurses make decisions that confirm or negate these rights.

The majority of the people in the medical profession have a very paternalistic attitude. What happens is I am the doctor; I know what is best for you. Therefore, if the patient's rights are respected, we wouldn't need legislation like this, because the patient would be aware of what they had and they would be able to make the decision not to go to the hospital or not to go to that doctor.

When the legislature mandates the formation of a committee within a hospital to explore the ethical and moral issues surrounding a dying patient, it is imperative that nursing be represented. On a number of prognosis committees nurses are not represented on those committees, and we need to be, because we can offer valuable input.

Everyday nurses witness the human suffering and indignity that occurs in institutions that provide care, and eventually, the nursing profession will be forced to question the prolongation of the agony that they witness. Perhaps nurses are the logical people to ask the questions, because they provide continuous care and enter into the patient's drama of illness as no other member of the health care team can. The nurse is the best member of the team to act as the patient's advocate at all times.

Law is the major tool by which society translates its ethical value structure into action. Life is the good thing and the precondition of all good things. Any decision to end it in any context for self or for another must be slow and deliberate. The life that is good also bears the mark of the tragic. There are times when the ending of life is the best that life offers. Dying is a human response to physical disease. No one ever died from dying; you die from illness. In death more than ever Americans are finding themselves in the hands of medical authorities dedicated to keeping him or her alive at any cost; too often that cost is suffering, indignity, and alienation. Isn't it time we gave that decision back to the one whose life it is?

I did have one comment about the bill specifically and that is on page 2, lines 7 and 8. The bill contains a provision of immunity for only the physician. It is not just the physician who carries out the patient's wishes; it is other health care providers. I also have a comment for the Reverend who was before me. If we had more Calvary Hospitals, we wouldn't need legislation like this. If we had more care for the dying at home, legislation like this wouldn't be necessary, because if you had a family physician and you and he or she had worked out your arrangements, we wouldn't need this legislation. It is for the person who comes in who is a clinic patient. It won't be carried out unless you say you have written it. They will never know it.

SENATOR SCARDINO: I don't know whether I quite follow the logic in what you have just said, in light of your position in favor of this type of legislation. I have been asking all day for actual factual experiences, and I have gotten very few. As a matter of fact, those that I have gotten were from people whose experiences - or not necessarily their experiences - or final conclusion on this legislation is that it is not necessary. Now you come here today, and you have almost hinted at, and you are in the position to announce situations where legislation like this would be vital. I wonder if you could be more specific.

MS. GROSSO: In my six years in intensive care, I could stay here all day and tell you about some of them, certainly.

SENATOR SCARDINO: Well, you can be specific.

MS. GROSSO: Do you know what a code is?

T H O M A S     P.     C O O K: Mr. Chairman, my name is Thomas P. Cook, and I live in Princeton. I have been practicing law there for about 28 years. Now, I am not appearing on behalf of any organization or group. I am just appearing as one individual lawyer who has had a good deal of experience with clients who have wanted to sign these living wills. I just want to add some very brief personal testimony in support of the statement already presented by Mr. Rosoff, and also Senator Martindell.

A considerable amount of my practice now consists of drawing wills and handling decedents' estates. In the course of my practice I have discussed with many older people the subject of prolonging by medical means the suffering of persons who would otherwise expire naturally. I have also visited many clients who were in terminal stages of cancer or other incurable illness.

Every one of my acquaintances who has faced the prospect of having his or her life prolonged in its final stages by tubes and machines has emphatically rejected the prospect and has expressed a preference for the right to die with dignity - and I will use that word dignity for want of a better term. I know of not one instance of a person expressing to me a desire to be kept alive as long as possible, regardless of what kind of shape the person was in.

Dozens of my clients have signed what is usually known as a living will with which the Committee is undoubtedly familiar, since it has been under discussion here a good part of today. The one document that I am familiar with, produced by the Society for the Right to Die, says, among other things, "I do not fear death as much as I fear the indignity of deterioration, dependence and hopeless pain." Whenever I mention to a client the existence of these forms of a living will, the client invariably asks to sign one. Now, from my study of the Quinlan case, I am convinced that a terminally ill patient has a constitutional right to choose not to have his process of dying prolonged by medical devices. Chief Justice Hughes said for the court in one point in his opinion, "Although the constitution does not explicitly mention the right of privacy, Supreme Court decisions have recognized a right of personal privacy exists, and that certain areas of privacy are guaranteed under the constitution. Presumably this right is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances."

I believe it is essential for all concerned that the legislature implement this constitutional right of an individual to decline medical treatment where he is competent to make the decision and his attending physicians certify that he is terminally ill. We need a bill such as Senate 1751 in order to give official sanction and legal efficacy to a document such as the living will for at least two reasons. I think they have already been mentioned here today. First, it would give far greater assurance to each individual that his wishes will be carried out, so that if he has a stroke and is paralyzed and can't talk and so forth, he will in the meantime have already expressed his wishes and then it will be on the record so that his wishes can be carried out. Secondly, this bill will provide a clear protection from liability for an attending physician or, I think, a nurse - I agree with the nurse that was here. I think this bill should include nurses as well as physicians in this liability section, if they comply with the patient's wishes.

Now, of course this law wouldn't be a cure-all, but it would remove some of the present impediments to an individual's freedom of choice with respect to the process of dying. Now, I think the last speaker rather dramatically pointed out that the need for this legislation increases really with every passing year because

we are dealing with more than one issue this afternoon. When we speak to the notion of the living will, if what we are saying is that we need legislation that speaks to patient's rights, then let's say that. Because under current law the patient has the right to refute the physician's choice of treatment; the patient has the right to select another hospital; the patient has the right to refuse treatment; the patient has the right to say he wants to go home and die with his family. If we are saying that hospitals are precluding humanization of death, then let's speak to that question. But what we are talking about in terms of the living will is something that is different in concept from that.

What we are hearing, and Dr. Finley said it, Senator Martindell said it, and Pat Grosso said it herself, we are talking also about costs. My fear is that we are beginning to put a dollar and cents value on the question of life.

We also have said at least four times this afternoon a statement that equates aging with the "okayness" of death. I am very, very much concerned that what we are saying is that if one is over a certain age, it is okay for them to die, but if someone is younger, then perhaps we ought to use more life saving measures to keep them alive. I would support the notion that in some hospitals and some facilities we use in the medical profession - and Pat is right in that nurses have been excluded from the decision making processes there - extraordinary means to keep patients alive, where perhaps extraordinary means should not be used. On the other hand, to preclude the use of extraordinary means would exclude using them where you are going to keep the patient alive who can go on to survive in a normal, healthy position.

We also are assuming in the right to die bill - and I would prefer to call it that instead of a living will - that there is quality to life. My concern - and I have worked with cancer patients for two years also - would be that I have never in my experience with the dying patient had a patient who wanted to die. They may have wanted to not cause the family pain; they may not have wanted to remain in the hospital; they may not have wanted to run up extraordinary bills, but they did not want to die. So if we are talking about the need to support the dying patient, or if we are talking about the need to look to the Hospice notion of care, if we are talking to the statement of keeping a patient who is dying comfortable and with their family until death occurs, then let's address that issue. I don't believe this bill speaks to that question at all.

I am very, very much concerned because I heard our Commissioner of Health say this morning we must be concerned about cost. The Senator this afternoon alluded to the idea that perhaps someone from the state health facility could serve as a witness to the living will. Well, the state pays the bills when no one else can pay them; therefore, the person paying the bills would be the person who might be considered to be the witness. That certainly is not an uninterested party. There are some very, very real concerns with the notion.

If we are talking about death and its dignity and its last stage of living, then let's address that question. For myself, I would be most interested in being involved in legislation of this type, to be assured that the patient's rights are not violated. Perhaps we need a patient's rights bill. Pennsylvania has one and it has worked well for them, but I am not sure that we need this, nor are we ready for it. Thank you very much.

SENATOR SCARDINO: I thank you very much, Eleanor, for coming back and giving us your opinion on Senate Bill 1751. Mr. Cook.

terminally ill patient to choose the way he is going to meet his Maker. It is simply a freedom of choice and saying that you don't want all the techniques of modern medicine used to keep you needlessly alive to no useful purpose.

We read in the book of Ecclesiastes ~~that~~ there is a time to be born and a time to die. Now, when nature has determined that a person's body should return to the elements and his soul to God who gave it, the dying person must have the right to choose freedom from interference as he departs this life.

SENATOR SCARDINO: Thank you very much, Mr. Cook. I want to thank everyone who participated in today's hearings on Senate Bill 992, Senate Bill 1039, and Senate Bill 1751.

I want to also take this opportunity to thank Mike Bruinooge from Legislative Services staff of the Senate Institutions, Health and Welfare Committee for putting this hearing together today with the help of Steve Robbins, also a member of the staff and his putting together of background information, and Betty Fecak, Secretary to the Institutions, Health and Welfare Committee, and I also want to thank the stenographers for their perserverance, Barbara Smith and Virginia Floyd, and our recorder Therese Doll. Thank you everyone, and good evening.

\* \* \* \*

(Hearing concluded)

of advances in medical techniques for prolonging life processes, even though meaningful life may have already terminated. Now, the logical conclusion of this as medical science progresses is that after awhile by putting people on machines and inserting food into them and everything else, you are going to have a heap of remains going on for years; and as more and more people get to this stage, where is it going to end? I think it is completely unrealistic and absolutely senseless to keep people in that stage going to the extent that medical science is not able to do.

Now, one of the speakers said---

SENATOR SCARDINO: You even say this in light of any possibility that the illness may be reversible, that the condition with which the person is suffering might in fact disappear and be cured?

MR. COOK: No, I think that this is where the practice of medicine comes in.

SENATOR SCARDINO: The reason I raise the point is because I am sure there is documentation. It has been indicated even through personal experience that it has happened.

MR. COOK: Oh, yes, it has happened. But all you can go on is the very best medical knowledge of the time, and of course as medicine gets to know more, they will be able to cure things in the future that can't be cured now, but this is a matter of medical practice.

They were saying that the main motivation of this kind of legislation is an economic one to save costs. Well, for one thing, I would be very happy to sign my living will, as I have done, in order to save my own family from spending thousands of dollars a month for nurses around the clock and hospitalization to just keep me going when it is perfectly fruitless to do so. But I think the main motivation of all this is really to prevent the prolongation of suffering, needless suffering of people who are in final stages who would otherwise die normally and naturally when medicine now is able to keep them alive.

SENATOR SCARDINO: Wouldn't you feel equally as satisfied with a decision like that if you had confided such an interest with your physician in terms of making it known to him or her that this is your wish?

MR. COOK: Oh, definitely. In fact, I have talked this over with my physician, and I wanted to make sure he was the kind of physician who would let me die, or I would want to get someone else. I think that is a very important decision for everyone to make.

Now, I think we need safeguards against abuse by those who would want to hasten somebody's end. I think some additional safeguards are needed in the bill as has already been testified to. I think Mr. Collester and the gentleman from California made some helpful suggestions and I am sure Senator Martindell may want to consider some of those amendments. But I think the main point is that we need some legislation of this kind for the reasons already mentioned.

I want to emphasize in closing that this legislation has nothing to do with actively putting somebody to death. Now, the view is that, oh, gee, if you go this far, then you are going to take the next step and the next step. That isn't so at all. All the time in human affairs we try to cure a problem by legislation or other appropriate action, and it doesn't mean that you are going to go any further than curing that particular problem. So I think that this scare tactic that has been thrown up, that this is just the first step towards active euthanasia, is simply a wholly invalid argument. All this bill is going to do is to allow a



DRAFT

A.C.L.U. POLICY STATEMENT ON THE RIGHTS OF THE UNCONSCIOUS  
OR INCOMPETENT TO LIFE SUSTAINING PROCEDURES

The case of Karen Ann Quinlan has been brought to the attention of the New Jersey Civil Liberties Union by interested persons in the matter. The following is a general statement of principle concerning individuals who are unconscious or otherwise unable to protect their own interests as a result of injuries or illness and with regard to whom relatives, guardians, doctors or other responsible officials have determined to cease life-sustaining procedures. This statement does not deal with such issues as an adult's conscious decision to end his or her life or to refuse life-sustaining medical treatment; nor does it deal with the state's interest in protecting children against parental decisions to reject medical treatment for them on religious or other grounds. In fact, the law appears to be well established that adults who are conscious and informed may and should have the right to reject extraordinary life-sustaining procedures and to die with dignity and that the state may intervene to preserve a child's right to continued life when that is threatened by parental refusal to permit recommended medical procedures such as transfusions.

The question of the medical definition of death is also not the concern of this statement. Certainly where there is a cessation of all brain activity with no medical possibility of renewal, the preservation of minimal bodily functioning by extraordinary medical processes would seem degrading to the recipient, and both cruel and unconscionably expensive to the family. Rather, our concern is directed to the threat that



## AMERICAN MEDICAL ASSOCIATION

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### JUDICIAL COUNCIL

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Rev. William B. Smith, S.T.D.  
Saint Joseph's Seminary  
Dunwoodie  
Yonkers, New York 10704

Dear Rev. Smith:

This letter is in reply to your letter of October 27, 1976. You wrote for information on "dignity in death" and recent AMA actions.

Newspaper reports being what they are, I am afraid that the article you mentioned was somewhat less than clear. What really happened was that the AMA House of Delegates reaffirmed existing policy on this matter and on the definition of death. Whether this is "liberalized" or "regressive," in journalists' terms, I do not know. Such labels often seem to have little meaning these days, especially in areas such as this.

In any event, I am enclosing copies of previous Reports of the Judicial Council of the AMA on death and on the physician and the dying patient. Although these matters have been subsequently considered by the AMA House of Delegates, AMA policy remains as indicated in these enclosures.

Very truly yours,

  
Bruce Nortell

BN/lrs

Encs.

initial determination of whether serious questions are raised by the report; and if there are, to take appropriate judicial or administrative action. If, in fact, it is determined that there is either meaningful conscious life, or some reasonable possibility of a return of meaningful conscious life, then the life ending measure must not be taken.

There are, of course, many other important issues related to a determination to begin or to continue life preserving measures. The right to continued life should not depend upon an individual's financial resources, but the appropriate manner of financing treatment is beyond the scope of this statement.

Other questions too complex to be treated here are the issues of proper allocation of limited medical resources. For example: What criteria shall be applied to determine who shall receive the life-preserving treatment if there are not enough facilities to provide it to all who may require it? The exact definition of what constitutes a "meaningful" level of consciousness also is something which requires considerable legislative study, and, may in fact require continued scrutiny as new medical procedures develop. The A.C.L.U. does believe that in order to avoid the possibility of development of tacit approval of euthanasia or involuntary terminations of the lives of those society may look upon as "defective" there must be a heavy presumption that where there is any substantial degree of consciousness it is "meaningful."

individuals who have some reasonable hope of regaining conscious life functioning may be prevented from doing so by decisions of family and doctors based upon economic, emotional or other considerations including the desire to have organs available for transplant. Even more dangerous is the possibility that if too great a discretion is given to family members and the medical personnel who directly serve them, an overly broad definition of "extraordinary means of sustaining vital processes" might result in decisions to end the lives of seriously ill, aged or mentally incompetent individuals by denying them appropriate treatment. Certainly a fundamental principle underlying all of our constitutionally protected civil liberties is that every individual has a basic right to continued life regardless of the fact that society may place little value on that life. We have seen in Nazi Germany where rejection of such a principle may lead.

On a pragmatic level we believe that the preservation of such a principle requires that legislative action be taken to ensure that in any case in which the family or guardian of an individual determines that life preserving processes should cease and that the individual should be permitted to die, prior to any such action being taken an independent evaluation of the matter should be undertaken by a committee of disinterested physicians who have no connection with the case. A report of their evaluation should be forwarded to an appropriate official, perhaps the public defender or public advocate, who shall be charged with the responsibility of making an

like to generally acknowledge the selfless aid, counsel and advice of numerous physicians, scholars and lawyers throughout the State and the Nation to whom I have turned for guidance in reviewing these proposals. In particular, I wish to thank the distinguished California Assemblyman, the Honorable Barry M. Keene, author of the California Natural Death Act, for his wise and perceptive analytical missive dealing with the subject matter of this Hearing. (A copy of this letter as well as copies of the California Natural Death Act, Guidelines and Directives for California Physicians, and the relevant memorandum of the California Hospital Association are attached hereto.)

The following opinions are advanced within the context of the Judeo-Christian principle of the sacredness of human life. For it is only by faithful adherence to this universal axiom that the moral and just resolution of the myraid dilemmas of this epoch of unparalleled scientific and technical invention will be resolved.

A further guiding principle in drafting legislation providing practical procedures for implementing these fundamental rights is to unequivocally preclude euthanasia while at the same time to avoid the undue fettering of the exercise of individual autonomy and integrity.

PAUL W. ARMSTRONG

COUNSELLOR AT LAW

MAIN STREET

BEDMINSTER, NEW JERSEY

07921

(201) 234-2664

January 26, 1977

Re: New Jersey Senate Bills  
No.992, No.1039, and No.1751

Honorable Members of the Senate Institutions, Health  
and Welfare Committee:

In preface, let me extend the sentiment  
of gratitude for the privilege of this opportunity to  
share in the exemplary labors of your profound  
deliberations.

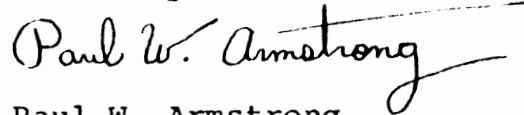
While my representation of the Quinlan  
family at this point precludes me from fully exploring  
the various aspects of the proposed legislation, it  
is the purpose of this appearance and testimony to  
briefly set forth an opinion concerning the proposed  
Senate Bill No.1751, providing for an individual's  
"living will", as well as Senate Bills No.992 and  
No.1039, establishing a standard for the determination  
of human death.

Before proceeding to that end, I would

this witness that the statutory definition introduced by Senator Greenburg and Senator McGhan merits enactment.

I again wish to thank the members of the Committee for the privilege of presenting testimony and hope that it serves as an aid in the legislative resolution of these most significant issues.

Sincerely,

A handwritten signature in cursive script that reads "Paul W. Armstrong". The signature is written in dark ink and has a long, sweeping horizontal line extending from the end of the name.

Paul W. Armstrong

PWA:mla

Statutory Standards For An Individual's Living Will

It is the opinion of this witness that Senate Bill No.1751, in its present form, fails to merit enactment and that the interests of the citizens of the State of New Jersey would be better served by the legislative adoption of a bill modeled after the recently enacted California Natural Death Act.

The reasons for this opinion are manifold and are premised upon the attached analysis selflessly provided by Assemblyman Keene of California in response to my request for the application of his critical acumen and experience to the present issues confronting the Committee.

Statutory Standards For Human Death

With respect to Senate Bills No.992 and No.1039, consultation with physicians, medical societies, hospital associations, legislators, scholars and lawyers throughout the State and the Nation reveals a uniform consensus that Senate Bill No.1039 incorporates the most widely accepted and acknowledged legislative standard for the determination of human death.<sup>1</sup> It is therefore the opinion of

1. See Capron & Kass, A Statutory Definition Of The Standards For Determining Human Death: An Appraisal And A Proposal, 121 U. Pa. L. Rev. 87 (1972).



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professional consensus or the societally acceptable will not only increase the strength of the opposition, but also render useless any likelihood that the medical profession would honor such a law.

2. Any proposal must be drafted with precision and clarity. Definitions, formalities, and statutory procedures should be, to the extent feasible, precise in order to minimize confusion that might result from the law. The tighter the definitions and provisions are, the easier it is to convince legislators and the public that such a measure does not open any doors for euthanasia, mercy killing, or any other act that might cheapen the quality of life.

With these caveats in mind, I would express my personal reservation as to the wisdom of enacting S-1751 by Senator Martindell. This measure is not patterned on the Natural Death Act. Instead, it is the legislative proposal prepared by the Society for the Right to Die. In drafting the California law, previous drafts of the Society's model law were reviewed and found largely unacceptable.

Turning to the provisions of S-1751:

1. Definition of "maintenance medical treatment:" Section 1(a) attempts to define "maintenance medical treatment" with a breadth similar to our definition of "life-sustaining procedure." However, I believe that the use of the term "extraordinary" is a grievous error (one that I learned from the personal experience of defending its inclusion in AB 3060). Such a term has greater acceptance in the theological literature than in the medical books or in judicial decisions. It places the physician in an uncomfortable position of determining, at his or her peril, what is extraordinary and what is ordinary, a distinction that largely depends on the patient's prognosis and the purpose of the medical intervention.

Instead, I would recommend that the definition of "maintenance medical treatment" should be drafted with respect to the context within which medical care is rendered. You might note our definition of "life-sustaining procedure" in the Natural Death Act which states that the procedure must serve only to artificially postpone the moment of death and when death is imminent whether or not such procedure is used. Although this formulation is narrow, it is fairly precise and avoids conferring excessive latitude to the physician to withdraw medical treatment.

2. Definition of "terminal illness:" I have no disagreement with the definition of terminal illness in S-1751 except to recommend that "illness" be expanded to explicitly include an

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# California Legislature

## Assembly Committee on Health

STATE CAPITOL  
445-1770

BARRY KEENE  
CHAIRMAN

January 18, 1977

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Paul W. Armstrong  
Counsellor at Law  
Main Street  
Bedminster, New Jersey 07921

Dear Mr. Armstrong:

Please accept my warmest greetings and felicitations for the new year. For both of us, the legal achievements of 1976 impose special burdens in 1977.

I appreciated the opportunity of reviewing the New Jersey legislative proposals on brain death and right to die. As I have greater familiarity with the latter, I will largely confine my remarks to Senator Martindell's measure to validate the living will. With respect to the "brain death" proposals, I will only briefly comment on the applicable California law on this subject.

At the outset, let me offer some insight regarding legislating in the field of terminal illness. I would admonish any legislator inclined to pursue such a course of action with a simple but emphatic caution: GO SLOW. I can personally attest to the tortuous labyrinth of political, legal, moral, medical, theological, and ethical dilemmas that confront the lawmaker who resolves to achieve a solution through the statutory law.

My own lessons would include:

1. Any proposal should reflect the medical-legal consensus regarding the ethical parameters of professional practice in using life-support systems on a terminally ill patient. Similarly, the proposal should reflect contemporary societal thinking and substantially adhere to the moral teachings of the Judao-Christian tradition. Legislation which is beyond the

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to S-1751, I would recommend clarifying Section 4 to permit revocation without regard to the mental state of the patient. I would also question the necessity of witnesses; although my legislation originally contained such a provision, I felt that the requirement might inhibit easy revocation. If there is any doubt as to the patient's desire, then the document should not be relied on.

5. Effectuation and liability: Initially, I would note that Section 5 does not require a physician attending a mentally competent patient to verify all steps with the patient. Such a requirement should be added, even if it may be viewed as window-dressing, in order to remind the physician that he must secure an informed consent from the patient so long as the latter remains possessed of his mental faculties.

One of the more curious omissions from S-1751 is language specifying the sanction when a physician fails to honor a directive. Although the absence of such a provision would imply the imposition of liability, I believe that it is appropriate to delineate specifically the scope of liability and protect the physician who cannot in good conscience effectuate a directive. In contrast to S-1751, the Natural Death Act does not impose criminal or civil liability. However, it does subject a physician to a finding of unprofessional conduct (a violation of the Medical Practice Act) for failing to honor a directive of a terminally ill declarant, or for failing to transfer the patient to a second physician if he cannot in good conscience carry out the directive.

Finally, I have two technical comments regarding Section 5. First, I note the absence of an exculpation clause for the hospital or the nursing staff. This is important since the nurse may well be the one to actually withhold or withdraw maintenance medical treatment pursuant to a physician's order. Secondly, I would suggest including the words "or withdrawing" after each reference to "withholding" of maintenance medical treatment.

6. Miscellaneous comments: I would recommend the inclusion of the following provisions similar to language contained in the Natural Death Act:

A. A provision clarifying that withholding or withdrawing maintenance medical treatment shall in no way constitute a suicide for any purpose.

B. A provision prohibiting any physician, hospital, health insurance company, or health plan from requiring a patient to execute a directive as a condition of receiving health care.

C. Language setting forth criminal penalties for forging a directive, for concealing a revocation, or for destroying

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"injury" and a "disease." In the strictest sense, an automobile accident might not be construed as an "illness."

3. The document: One of the critical decisions in drafting "right to die" legislation is deciding whether the measure should contain a specifically-worded document (like AB 3060) or whether the declarant should be free to execute a statement in his or her own words (like S-1751). Although choosing the latter course of action is more consonant with our values of individual freedom, I opted for the statutorily-worded document solely on the grounds that it is more workable and avoids confusion. If the physician is obligated to honor the patient's instructions, only a uniform directive will satisfy his concern for certainty and clarity of expression.

Without a legally prescribed document, the patient could decide to use his own terms, not those in S-1751. He may simply instruct the physician to discontinue "heroic measures," a term similar to "extraordinary" in lacking acceptance in the medical community. The declarant could likewise order the physician to act in a manner beyond the scope of the legislation or designate a family member or friend to give consent to discontinuing medical treatment. The possibilities are endless and they would require the physician to either ignore the instructions or seek judicial construction of the document. Needless to say, both options are unacceptable.

Even if this reasoning is rejected, a further question regarding the document is the voluntariness with which it is executed. In California, legislators, senior citizen groups, and the clergy were reluctant to permit potentially interested witnesses to attest the document and the declarant's state of mind. By the time AB 3060 had passed the Senate, family members, creditors, physicians, hospital employees, and beneficiaries were held unqualified to witness the directive. A special provision was inserted for nursing home patients as they were deemed insulated from a voluntary decision-making process. Although legislators in New Jersey might not view all these classes of potential witnesses to be inherently suspect, I would recommend a review of whether witnesses to the document should be disinterested parties.

Finally, many California legislators felt that such documents should terminate by operation of law after a prescribed period of time. Although AB 3060 places a five-year limitation on the effect of a directive, this limit was a compromise and is without mystical wisdom that I could impart to you.

4. Revocation: In drafting the Natural Death Act, every effort was made to insure easy revocation. Applying this principle

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to you and the New Jersey Legislature. Please feel free to quote or otherwise use my comments in any manner you deem appropriate, including submitting it as written testimony to the Senate Committee on Institutions, Health, and Welfare.

Best personal regards.

Sincerely,

A handwritten signature in black ink, appearing to read "Barry Keene", with a long, sweeping horizontal stroke extending to the left.

BARRY KEENE

BK:sld

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a validly executed document.

D. A provision clarifying that the rights conferred in S-1751 are in addition to other rights to legally refuse health care. This language is intended to prevent a determination that the process outlined in S-1751 would be the exclusive means to legally withhold medical treatment, a potential violation of the right of privacy.

If the legislature opts for a statutorily-prescribed directive, I would also recommend consideration of a method for distributing the forms to the thousands of citizens who will request them. In the absence of such a provision in the Natural Death Act, my staff convened a task force with members of the Los Angeles County Bar Association's Committee on Bioethics and the legal counsels to the California Hospital and Medical Associations to write guidelines for signers and physicians. In the interim between the Governor's signature and the measure's effective date, my office received thousands of requests for the forms. With a resurgence of media attention to the law since January 1 (its effective date), I expect to receive even more requests. Thus, I strongly recommend that if the legislature requires a specifically worded directive, they should consider how such forms should be distributed.

With respect to the "brain death proposals," I would not hold myself out as an expert. However, the applicable California law on this subject (enacted in 1974) is the following:

1. A person must be pronounced dead if a physician determines that the person has suffered "a total and irreversible cessation of brain function." The determination must be confirmed by a second physician.
2. A physician may still rely on other usual and customary procedures for determining death (e.g., cessation of heartbeat).
3. If the decedent is to be a donor for a transplant, neither physician determining or confirming death shall be involved in the transplantation.
4. The health facility must maintain complete patient medical records when a person is pronounced dead under the "brain death" statute.

I trust that this exploration of S-1751 and my brief recitation of California's brain death statute will be of assistance

## LEGISLATIVE COUNSEL'S DIGEST

AB 3060, as amended, Keene (Health). Cessation of medical care for terminal patients.

No existing statute prescribes a procedure whereby a person may provide in advance for the withholding or withdrawal of medical care in the event the person should suffer a terminal illness or mortal injury.

This bill would expressly authorize the withholding or withdrawal of life-sustaining procedures, as defined, from adult patients afflicted with a terminal condition, as defined, where the patient has executed a directive in the form and manner prescribed by the bill. Such a directive would generally be effective for 5 years from the date of execution unless sooner revoked in a specified manner. This bill would relieve physicians, licensed health professionals acting under the direction of a physician, and health facilities from civil liability, and would relieve physicians and licensed health professionals acting under the direction of a physician from criminal prosecution or charges of unprofessional conduct, for withholding or withdrawing life-sustaining procedures in accordance with the provisions of the bill.

The bill would provide that such a withholding or withdrawal of life-sustaining procedures shall not constitute a suicide nor impair or invalidate life insurance, and the bill would specify that the making of such a directive shall not restrict, inhibit, or impair the sale, procurement, or issuance of life insurance or modify existing life insurance. The bill would provide that health insurance carriers, as prescribed, could not require execution of a directive as a condition for being insured for, or receiving, health care services.

The bill would make it a misdemeanor to willfully conceal, cancel, deface, obliterate, or damage the directive of another without the declarant's consent. Any person, not justified or excused by law, who falsifies or forges the directive of another or willfully conceals or withholds personal knowledge of a prescribed revocation with the intent to cause a withholding or withdrawal of life-sustaining procedures contrary to the wishes of the declarant and thereby causes life-sustaining procedures to be withheld or withdrawn, and death to thereby be hastened, would be subject to prosecution for unlawful

homicide.

This bill would also provide that, notwithstanding Section 2231 of the Revenue and Taxation Code, there shall be no reimbursement nor appropriation made by this bill for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: yes.

*The people of the State of California do enact as follows:*

1 SECTION 1. Chapter 3.9 (commencing with Section  
2 7185) is added to Part 1 of Division 7 of the Health and  
3 Safety Code, to read:

4  
5 CHAPTER 3.9. NATURAL DEATH ACT  
6

7 7185. This act shall be known and may be cited as the  
8 Natural Death Act.

9 7186. The Legislature finds that adult persons have  
10 the fundamental right to control the decisions relating to  
11 the rendering of their own medical care, including the  
12 decision to have life-sustaining procedures withheld or  
13 withdrawn in instances of a terminal condition.

14 The Legislature further finds that modern medical  
15 technology has made possible the artificial prolongation  
16 of human life beyond natural limits.

17 The Legislature further finds that, *in the interest of*  
18 *protecting individual autonomy*, such prolongation of life  
19 for persons with a terminal condition may cause loss of  
20 patient dignity; *and unnecessary pain and suffering, and*  
21 *an unreasonable emotional and financial hardship on the*  
22 *patient's family*; while providing nothing medically  
23 necessary or beneficial to the patient.

24 The Legislature further finds that there exists  
25 considerable uncertainty in the medical and legal  
26 professions as to the legality of terminating the use or  
27 application of life-sustaining procedures where the  
28 patient has voluntarily and in sound mind evidenced a  
29 desire that such procedures be withheld or withdrawn.

30 In recognition of the dignity and privacy which



AMENDED IN SENATE AUGUST 24, 1976

AMENDED IN SENATE AUGUST 18, 1976

AMENDED IN SENATE AUGUST 13, 1976

AMENDED IN SENATE JUNE 24, 1976

AMENDED IN ASSEMBLY JUNE 16, 1976

AMENDED IN ASSEMBLY MAY 27, 1976

AMENDED IN ASSEMBLY MAY 24, 1976

AMENDED IN ASSEMBLY MAY 3, 1976

AMENDED IN ASSEMBLY APRIL 8, 1976

CALIFORNIA LEGISLATURE -1975-76 REGULAR SESSION

**ASSEMBLY BILL**

**No. 3060**

Introduced by Assemblymen Keene, Alatorre, Berman,  
Goggin, Kapiloff, Keysor, MacDonald, McLennan,  
Thurman, and Wornum

(Coauthors: Senators Behr and Gregorio)

February 13, 1976

REFERRED TO COMMITTEE ON HEALTH

An act to add Chapter 3.9 (commencing with Section 7185)  
to Part 1 of Division 7 of the Health and Safety Code, relating  
to medical care.

2 3060 15 14



x81

1 right to refuse medical or surgical treatment and accept  
2 the consequences from such refusal.

3 3. If I have been diagnosed as pregnant and that  
4 diagnosis is known to my physician, this directive shall  
5 have no force or effect during the course of my  
6 pregnancy.

7 4. I have been diagnosed and notified at least 14 days  
8 ago as having a terminal condition by \_\_\_\_\_, M.D.,  
9 whose address is \_\_\_\_\_, and whose telephone number  
10 is \_\_\_\_\_. I understand that if I have not filled in the  
11 physician's name and address, it shall be presumed that  
12 I did not have a terminal condition when I made out this  
13 directive.

14 5. This directive shall have no force or effect five years  
15 from the date filled in above.

16 6. I understand the full import of this directive and I  
17 am emotionally and mentally competent to make this  
18 directive.

19 Signed \_\_\_\_\_  
20 City, County and State of Residence \_\_\_\_\_  
21

22 The declarant has been personally known to me and I  
23 believe him or her to be of sound mind.

24 Witness \_\_\_\_\_  
25 Witness \_\_\_\_\_  
26

27 7188.5. A directive shall have no force or effect if the  
28 declarant is a patient in a skilled nursing facility as  
29 defined in subdivision (c) of Section 1250 at the time the  
30 directive is executed unless one of the two witnesses to  
31 the directive is a patient advocate or ombudsman as may  
32 be designated by the State Department of Aging for this  
33 purpose pursuant to any other applicable provision of  
34 law. The patient advocate or ombudsman shall have the  
35 same qualifications as a witness under Section 7188.

36 The intent of this section is to recognize that some  
37 patients in skilled nursing facilities may be so insulated  
38 from a voluntary decisionmaking role, by virtue of the  
39 custodial nature of their care, as to require special  
40 assurance that they are capable of willfully and

1 voluntarily executing a directive.

2 7189. (a) A directive may be revoked at any time by  
3 the declarant, without regard to his mental state or  
4 competency, by any of the following methods:

5 (1) By being canceled, defaced, obliterated, or burnt,  
6 torn, or otherwise destroyed by the declarant or by some  
7 person in his presence and by his direction.

8 (2) By a written revocation of the declarant expressing  
9 his intent to revoke, signed and dated by the declarant.  
10 Such revocation shall become effective only upon  
11 communication to the attending physician by the  
12 declarant or by a person acting on behalf of the declarant.  
13 The attending physician shall record in the patient's  
14 medical record the time and date when he received  
15 notification of the written revocation.

16 (3) By a verbal expression by the declarant of his  
17 intent to revoke the directive. Such revocation shall  
18 become effective only upon communication to the  
19 attending physician by the declarant or by a person  
20 acting on behalf of the declarant. The attending  
21 physician shall record in the patient's medical record the  
22 time, date, and place of the revocation and the time, date,  
23 and place, if different, of when he received notification  
24 of the revocation.

25 (b) There shall be no criminal or civil liability on the  
26 part of any person for failure to act upon a revocation  
27 made pursuant to this section unless that person has  
28 actual knowledge of the revocation.

29 7189.5. A directive shall be effective for five years  
30 from the date of execution thereof unless sooner revoked  
31 in a manner prescribed in Section 7189. Nothing in this  
32 chapter shall be construed to prevent a declarant from  
33 reexecuting a directive at any time in accordance with  
34 the formalities of Section 7188, including reexecution  
35 subsequent to a diagnosis of a terminal condition. If the  
36 declarant has executed more than one directive, such  
37 time shall be determined from the date of execution of  
38 the last directive known to the attending physician. If the  
39 declarant becomes comatose or is rendered incapable of  
40 communicating with the attending physician, the

1 any person may have to effect the withholding or  
2 withdrawal of life-sustaining procedures in any lawful  
3 manner. In such respect the provisions of this chapter are  
4 cumulative.

5 7194. Any person who willfully conceals, cancels,  
6 defaces, obliterates, or damages the directive of another  
7 without such declarant's consent shall be guilty of a  
8 misdemeanor. Any person who, except where justified or  
9 excused by law, falsifies or forges the directive of another,  
10 or willfully conceals or withholds personal knowledge of  
11 a revocation as provided in Section 7189, with the intent  
12 to cause a withholding or withdrawal of life-sustaining  
13 procedures contrary to the wishes of the declarant, and  
14 thereby, because of any such act, directly causes  
15 life-sustaining procedures to be withheld or withdrawn  
16 and death to thereby be hastened, shall be subject to  
17 prosecution for unlawful homicide as provided in  
18 Chapter 1 (commencing with Section 187) of Title 8 of  
19 Part 1 of the Penal Code.

20 7195. Nothing in this chapter shall be construed to  
21 condone, authorize, or approve mercy killing, or to  
22 permit any affirmative or deliberate act or omission to  
23 end life other than to permit the natural process of dying  
24 as provided in this chapter.

25 SEC. 2. If any provision of this act or the application  
26 thereof to any person or circumstances is held invalid,  
27 such invalidity shall not affect other provisions or  
28 applications of the act which can be given effect without  
29 the invalid provision or application, and to this end the  
30 provisions of this act are severable.

31 SEC. 3. Notwithstanding Section 2231 of the  
32 Revenue and Taxation Code, there shall be no  
33 reimbursement pursuant to this section nor shall there be  
34 any appropriation made by this act because the  
35 Legislature recognizes that during any legislative session  
36 a variety of changes to laws relating to crimes and  
37 infractions may cause both increased and decreased costs  
38 to local government entities and school districts which, in  
39 the aggregate, do not result in significant identifiable cost  
40 changes.

# Directive to Physicians

Directive made this \_\_\_\_\_ day of \_\_\_\_\_ (month, year).

I \_\_\_\_\_, being of sound mind, willfully, and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

1. If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.
2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.
3. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.
4. I have been diagnosed and notified at least 14 days ago as having a terminal condition by \_\_\_\_\_, M.D., whose address is \_\_\_\_\_, and whose telephone number is \_\_\_\_\_.  
I understand that if I have not filled in the physician's name and address, it shall be presumed that I did not have a terminal condition when I made out this directive.
5. This directive shall have no force or effect five years from the date filled in above.
6. I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

Signed \_\_\_\_\_

City, County and State of Residence \_\_\_\_\_

The declarant has been personally known to me and I believe him or her to be of sound mind.

Witness \_\_\_\_\_

Witness \_\_\_\_\_

This Directive complies in form with the "Natural Death Act" California Health and Safety Code, Section 7188, Assembly Bill 3060 (Keene).

## REVOCATION

A patient may revoke the DIRECTIVE at any time by (1) destroying it, (2) signing a written statement or (3) communicating to the attending physician his/her wish to revoke the DIRECTIVE. Should you receive such revocation from or on behalf of a patient who has previously signed a DIRECTIVE, enter that information promptly and prominently in the patient's current medical record.

## OTHER RIGHTS

No person may be forced to sign a DIRECTIVE. A person who has not signed a DIRECTIVE may not be denied health care or health insurance. The DIRECTIVE has no effect on any insurance policy and does not limit a person's right to accept or reject health care of any kind.

## PRECAUTIONS

A person who knowingly conceals or destroys a valid DIRECTIVE is guilty of a misdemeanor. A person who forges or falsifies a DIRECTIVE, or who withholds knowledge of a revocation of a DIRECTIVE may be guilty of unlawful homicide.

## SUMMARY

Withholding "life-sustaining procedures" in compliance with a DIRECTIVE is not euthanasia or "mercy killing." The DIRECTIVE is not a "Living Will." The DIRECTIVE is merely a method, recognized under California law, by which a physician may respect a patient's instruction to permit an imminent death to proceed naturally.

nursing facility at the time of signing, a "patient advocate" or "ombudsman" (designated by the State Department of Aging) must be a witness.

4. A health facility which, acting in accordance with the requirements of the Act, causes the withholding or withdrawal of life-sustaining procedures from a qualified patient, is protected from civil liability.
5. Furthermore, the Act specifically provides that no licensed health professional, when acting under the direction of a physician, who participates in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of the Act shall be subject to civil liability.
6. The Act does not cover documentation in the hospital record. CHA recommends that each hospital implement a policy which will assure such documentation at such time as a member of medical staff decides to withhold or withdraw life-sustaining procedures in compliance with a patient's valid directive. It is recommended that a copy of the patient directive be placed in the patient's hospital record and, in addition, that the physician's signed order based on the patient directive be recorded in the patient's hospital record.
7. Inasmuch as a patient may revoke a directive at any time, it is essential that any hospital personnel who has reason to believe that the patient wishes to revoke the directive make certain that the attending physician is notified immediately so that the physician may meet his/her statutory obligation to record in the patient's medical record the time, date and place of the revocation and, if different, the time, date and place when the physician received notice of the revocation.

Under the Act, there is no criminal or civil liability on the part of any person for failure to act upon a revocation unless the person has actual knowledge of the revocation.

8. The Act assigns no public agency responsibility for making copies of the Directive available to the public. Indeed, no state monies were appropriated for this purpose. Consequently, it can be expected that many physicians and hospitals will receive requests for copies of the Directive. Whether or not individual hospitals wish to provide copies of the Guidelines and Directive to the public is a decision which will have to be made by each facility. While there is no statutory requirement that physicians or hospitals provide such copies, many will undoubtedly do so as a public service. If your facility does decide to provide copies to the public, CHA strongly recommends that the enclosed Guidelines to Signers and Summary and Guidelines to Physicians be distributed with the Directive to insure a

legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such cases, the physician must continue to take into account the diverse factors which guided such determinations previously, in addition to good medical practice. If it is known that the patient has revoked a previously executed directive, there is a clear expression of the patient's wishes, which physicians would and should respect.

To eliminate any uncertainty as to the validity of directives executed prior to the January 1, 1977 effective date of the Act, Assemblyman Keene has already introduced legislation (AB 14) establishing the validity of such directives. Additional legislation will be introduced to resolve other ambiguities in the present Act.

# # #

If you have further questions, please contact Gordon Simonds at CHA.

CFF:GS:jks

Enclosures

Mr. Chairman and Honorable Members of this Committee: My name is Frank Niemeyer, I am Chairman of the Middlesex County Right to Life. I am here to testify on the two bills S992 and S1039 which seek to put into law a "brain death" standard for determining when a person has died.

As an employee of one of the worlds largest pharmaceutical companies, I have access to just about every medical publication produced in the United States, Canada and England. Throughout my testimony I will refer to articles from these publications. The articles to which I refer are reproduced in their entirety and are attached to my written testimony.

In considering these bills you are infact, dealing with matters pertaining to homicide, burial, family relations, inheritance and indeed all the legal and moral rights possessed by and the duties owed to a living human being. As a person who could definitely be affected by this legislation I welcome the opportunity and thank this committee for allowing me to testify.

As a point of clarification, and hopefully to be considered by this Committee, is the news release that was issued announcing the hearing on these bills. It is titled "Hearing on Issues Related to the Case of Karen Ann Quinlan." Gentlemen I quote from the article titled "Brain Death -a Useful but not Infallible Standard" Modern Medicine 9/15/76, p. 70.

"Both the medical and legal authorities agreed at that time she (Karen Ann Quinlan) did not fulfill any of the presently

stances that should be taken into account. In the diagnosis of brain death the doctors' loyalties must be undivided and conspicuously so". The Lancet, 11/13/76, p. 1066.

Dying is a continuing affair, death is not. It is an event that takes place at a precise time. Death is the concluding event of life and dying. A living body turns into a corpse by biological reasons - not by laws, declarations or the signing of certificates.

The bills before you (S992 and S1039) if passed will put into law "brain death" as a standard for determining when a person has died. What is Brain Death? Both bills state "Vital Brain Functions" meaning discernible central nervous system activity. How does one measure "Vital Brain Functions?" Some states have legislated that the Electroencephalograph (EEG) can measure "Vital Brain Functions" and thus a flat EEG means Brain Death has occurred. In the article I previously referred to "Brain Death a Useful but not Infallible Standard" stated:

"It was discovered that survival of a patient was possible even though the EEG was flat for up to 12 hours. These observations have been confirmed by extensive clinical experience and the Northwestern (University Medical School) also established that a flat EEG is not diagnostic of death in children, particularly the younger child". op. cit. pp. 68, 69.

The Royal Colleges of medicine, fully aware of the limitation of the EEG as a diagnostic tool in the determination of Brain Death developed criteria for Brain Death which excluded the use of an EEG. Their



respiratory functions are aided and assisted by broncho dilating medication and whose circulatory functions are aided and assisted by a "pacemaker". This type of patient is not rare to the medical community.

The first portion of bill S1039 states:

"A person shall be considered dead if in the announced opinion of a physician, based on ordinary standards of medical practice, he has undergone an irreversible cessation of spontaneous respiratory and circulatory functions..."

Members of this Committee, the hypothetical patient, I described above could be considered dead under the first part of this law. Infact, for insurance and other reasons the patient may sue to be declared dead. Similar circumstances could be applied to S992.

You may say this is absurd, no doctor would pronounce such a patient dead. Gentlemen absurdity has become legal in more instances than you or I could ever relate, and each absurdity was upheld in some court by its' interpretation of the law.

We do not need a law defining death, in particular Brain Death. I quote "Yet, is it wise to redefine the present statutes to include brain death when the definition of brain death is still evolving?... Moreover, the American College of Legal Medicine and the American Medical Association have not officially accepted the concept of brain death." Brain Death- Useful but not Infallible Standard, op. cit. p. 70.

Members of the Committee, ask yourselves in what way these two bills benefit the person to be declared dead. The enactment of these bills does not provide more protection, it in fact, decreases it.

## 'Brain death'— a useful but not infallible standard

HAROLD L. HIRSH, MD, JD

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The flat EEG "merely heralds death; it does not represent it," writes this physician-lawyer, who cautions doctors to use the EEG only as an aid, not as the final diagnostic indicator

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■ "Brain death"—evidenced by an isoelectric reading on continued electroencephalographic monitoring—has become a widely accepted medical and legal standard. Certainly it seems to be more precise than the traditional signs—an absence of heartbeat, pulse beat, and respiratory function. Yet studies leading up to this newer definition of death showed that comatose patients with persistent respiratory and circulatory activity could still have an isoelectric, or "flat," electroencephalogram (EEG).

Therefore, I propose that a flat EEG may not be diagnostic of total or actual death under certain circumstances. First, the EEG merely depicts electric energy produced during the functioning of the cerebral cortex and not of the brain stem where the nuclei or brain centers controlling respiration and circulation are located. A flat EEG, therefore, measures only "cerebral death" and not "brain" or total death. Recently "brain waves" have appeared on EEG recordings with electrodes inserted in gelatin and jiggled by the movement of persons walking about, by the running of a nearby

*Dr Hirsh is a professorial lecturer in law at George Washington, American, and Catholic universities and clinical assistant professor of medicine at Howard University College of Medicine.*

intravenous drip, or by vibrations from a respirator. This usefulness of the EEG as a diagnostic tool in brain death has thus been further demeaned.

### Challenging the concept

Two groups of investigators—one in France, the other in the United States—recently challenged the concept of brain death when they reported that a flat EEG alone may not be a reliable standard in cases where hypothermia or overdoses of sedatives, tranquilizers, or narcotics cause coma and a flat EEG.

Among such patients who died, the French group observed an increase in certain enzymes—type 5 lactate dehydrogenase transaminase and alkaline phosphatase—in the spinal fluid. Although there are significant technical and interpretative problems in performing these chemical tests, the imminence of death could be predicted accurately on the basis of a combination of the two.

The inadequacy of the single EEG test is suggested by a two-year "cerebral death" study at Northwestern University Medical School. It was discovered that survival of the patient was possible even though the EEG had been flat for up to 12 hours. These observations have been confirmed by extensive clinical experience, and the Northwestern study also established that a flat EEG is not

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Today, the physician is best advised not to rely exclusively on the flat EEG in determining if death has occurred

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ant and for what is he liable? Also, what are the potential legal liabilities of surgeons who actually do the transplantation?

Another problem involves the physician's duty to treat and the right of the next of kin to refuse treatment so that the victim may "die in dignity." This arises in a situation where the patient is hopelessly ill and has a flat EEG. There are conflicting opinions as to what physicians should or should not do under these circumstances. In practice, it appears that most doctors institute and maintain supportive measures until circulatory and respiratory functions cease. May treatment be withheld when life-supportive measures will sustain vital functions for only a short period of time? It is conceivable that if the physician fails to take life-supportive measures he may incur criminal liability for homicide or civil liability for negligence or both in the absence of the acceptance of brain death.

#### Getting the consent

Whatever course the physician takes, there should be "informed consent" by the next of kin. If treatment is refused, the physician is best advised to retire from the case if it violates his professional ethics or personal moral code. Not all such decisions are reached with unanimity. As a

result, court contests have developed regarding the right to refuse treatment. Depending on such factors as age and socioeconomic conditions, some courts have sustained the right to refuse, while others have ruled that treatment must be given.

The recent Quinlan case decision did not help to resolve the issue of brain death. Both the medical and legal authorities agreed at that time that she did not fulfill any of the presently accepted criteria for brain death.

There are other significant objections to withholding treatment. As I have indicated, there is no absolute certainty that revival is impossible in brain death situations. Physicians agonize that a miraculous scientific breakthrough will be forthcoming to revive some patients. The possibility of setting a precedent for using the brain death standard where less certainty of death exists or as a pretext in other situations is awesome.

Yet there is significant support for the "pulling-the-plug" philosophy. Some argue that hospital beds are in short supply and patients who might be helped medically may be denied admission because of a brain death patient. Skilled hospital personnel also are in short supply. Their time and energy are diverted from other patients when they have to care for a lingering patient until the vital signs cease. The cost of medical care during this period is not insignificant. All these problems might be avoided by withholding treatment after the diagnosis of brain death.

Most important, of course, are decisions as to when organs may be removed for transplantation. Clinical experience indicates that transplantations are most successful when the donated organs are "fresh." This means that little time should elapse before their removal after the diagnosis of brain death. Does this pressure

lead to less consideration for treating the donor?

It also becomes important to resolve these issues from another legal viewpoint. The time of death may be critical in the settlement of insurance claims and in probate matters where inheritance may have to be determined. Yet is it wise to redefine the present statutes to include brain death when the definition of brain death is still evolving?

#### The concluding event

Although dying may be a continuing affair, death is not. It is an event that takes place at a precise time. Death is the concluding event of life and dying. The flat EEG—and the concept of brain death that it represents—is only graphic evidence of dying. It merely heralds death; it does not represent it. It may appear viable even after the brain substance has deteriorated beyond recovery.

It is obvious that the ensuing problems are more than mere philosophic discussions. Since the concept of brain death as evidenced by the flat EEG has been shown to be fallible and sometimes inaccurate or unreliable, the diagnosis of death on this basis carries a risk of legal consequences. As of now, the physician is best advised not to rely exclusively on the flat EEG. Signs of cessation of circulatory and respiratory function, although not completely problem-free, still remain the accepted methods of ascertaining death. Even the eight states that recognize the concept of brain death do not require the flat EEG to establish it. Moreover, the American Medical Association and the American College of Legal Medicine have not officially accepted the concept of brain death. Meanwhile, medicine and the law must seek to resolve this dilemma so that physicians and lawyers will know the proper course of action under the law. ■

stop beating within a few days. This biological artefact, achieved by technological progress, is the state of brain death. If this state can be recognised with confidence, the arguments for stopping ventilation are strong. The criteria for the diagnosis of brain death set out on p. 1069 bear the authority of all the medical Royal Colleges and their Faculties in the United Kingdom. We have expressed doubt<sup>1</sup> about the possibility of reaching wide agreement on so delicate an issue; and the Colleges' document does not in fact propose anything new. But, in a careful examination of today's practice by experts in many disciplines, the Colleges have given a view which can help those seeking support in a difficult situation, particularly when the question of organ donation arises. The criteria emphasise the importance of the opinion of the doctor in charge of the patient, with his knowledge of all the circumstances. But doubts will still be raised about the wisdom of nominating as the deputy for an absent consultant a doctor who may have been registered for no more than five years, even with the proviso that he shall have had "adequate experience" in the care of such patients.

The Colleges maintain that in most situations brain death can be readily and reliably recognised on clinical criteria alone by doctors in intensive-care units, without the need to ask neurologists or neurosurgeons. It declares also that an electroencephalogram is not necessary, as indeed was pointed out by BEECHER<sup>2</sup> in 1969 and by others since.<sup>3-5</sup> Not all hospitals where such patients may lie have an E.E.G. machine, let alone the technical skill to establish beyond doubt the fact of electrocerebral silence. Other proposed laboratory investigations are even less widely available—such as cerebral angiography and measures of cerebral circulation and metabolism. Few doctors appreciate the technical limitations of these methods (including E.E.G.). Those unfamiliar with these techniques sometimes insist on the inclusion of such tests, in the belief that they would provide added protection for the patient who is wrongly suspected of being brain dead. When it is alleged that brain death has been mistakenly diagnosed, the explanation is usually obvious.<sup>6</sup> In some discussions there seems to have been confusion between brain death and other forms of irreversible brain damage, particularly the vegetative state.<sup>7</sup> Such patients are not dependent on the ventilator and, although the cerebral cortex is permanently out of action and the patient may be thought no longer to function as a human being,<sup>8</sup> bodily life can continue for months

or even years. How long life support should be provided for such survivors of brain damage is a harrowing question; but vegetative patients are not brain dead and the questions of ethics and of the use of resources are different. Occasionally, failure to realise that spinal reflexes can persist after brain death leads to an unjustified accusation that brain death has been anticipated. But most patients reported to have survived after they were suspected of being brain dead were in fact suffering from the effects of depressant drugs or hypothermia, which all codes of practice insist must be excluded. It is usually when someone is found unconscious and no history is available that these possibilities arise, and it is then that specialist opinions and laboratory investigations can be vital—not in order to declare brain death but to diagnose the cause. Often the matter is obvious, because the patient has a head injury or some other intracranial catastrophe, or he has endured a long spell of cardiorespiratory arrest. Measures of resuscitation are now so readily to hand in hospital that it is becoming common practice to specify that certain patients, with known incurable conditions, should not be vigorously resuscitated if they collapse. But collapse may be entirely unexpected in patients in whom it could not be foreseen; and it may be that only the combination of the recent brain damage and the impact of the primary disease makes it obvious (sometimes within half an hour or so) that the situation is irretrievable. Unless there are clear criteria for withdrawing support in such circumstances, doctors may be reluctant to embark on resuscitation, because of the difficulty they may foresee in stopping it.

The Colleges' document makes no reference to organ transplantation; and the omission emphasises that brain death is common and that the issues of organ donation arise only rarely, though they are paramount. Nevertheless, the public understandably associate brain death with organ donation, and they are not fully confident about the accuracy of the diagnosis of brain death. A survey of public attitudes to renal transplantation showed that over 80% of those questioned had no objection to it; but many stated that one reason why they themselves did not carry a kidney-donor card was fear that organs might be taken before they were really dead.<sup>9</sup> Uncertainty in the minds of doctors about brain death was one reason for their reluctance to make organs available from their own dying patients.<sup>10</sup> They may have been reluctant to stop the ventilator or to contemplate organ donation because they feared criticism from their colleagues or even legal censure. As the law of Britain stands, a person is dead when a doctor states that he is dead: there is no indication of how a doctor

1. See *Lancet*, 1974, i, 341.

2. Beecher, H. K. *New Engl. J. Med.* 1969, 281, 1070.

3. Mohandas, A., Chou, S. N. *J. Neurosurg.* 1971, 35, 211.

4. See *Br. med. J.* 1975, i, 356.

5. Walker, A. E. *J. Neurosurg.* 1976, 44, 1.

6. Jennett, B. *J. med. Ethics*, 1975, 1, 63.

7. Jennett, B., Plum, F. *Lancet*, 1972, i, 734.

8. See *ibid.* 1971, ii, 590.

9. Moores, B., Clarke, G., Lewis, B. R., Mallick, N. P. *Br. med. J.* 1976, i, 629.

10. British Transplantation Society. *ibid.* 1975, i, 251.

## Diagnosis of Brain Death

*In 1974 the Chief Medical Officer of the Department of Health and Social Security asked the Royal Colleges to consider the definition of brain death and its diagnosis. The matter had arisen in the context of establishing death of possible organ donors but was clearly of much wider interest, particularly to all clinicians caring for those whose vital functions are preserved solely by mechanical means. In response to the invitation a paper was written which has now been endorsed unanimously by the Conference of Royal Colleges and Faculties of the United Kingdom. This document, which follows, describes in general terms the diagnosis of death and sets out detailed diagnostic criteria for establishing when death has occurred in cases where vital functions are being maintained mechanically.*

WITH the development of intensive-care techniques and their wide availability in the United Kingdom it has become commonplace for hospitals to have deeply comatose and unresponsive patients with severe brain damage who are maintained on artificial respiration by means of mechanical ventilators. This state has been recognised for many years and it has been the concern of the medical profession to establish diagnostic criteria of such rigour that on their fulfilment the mechanical ventilator can be switched off, in the secure knowledge that there is no possible chance of recovery.

There has been much philosophical argument about the diagnosis of death which has throughout recorded history been accepted as having occurred when the vital functions of respiration and circulation have ceased. However, with the technical ability to maintain these functions artificially the dilemma of when to switch off the ventilator has been the subject of much public interest. It is agreed that permanent functional death of the brainstem constitutes brain death and that once this has occurred further artificial support is fruitless and should be withdrawn. It is good medical practice to recognise when brain death has occurred and to act accordingly, sparing relatives from the further emotional trauma of sterile hope.

Codes of practice, such as the Harvard criteria (1968),<sup>1</sup> have been devised to guide medical practitioners in the diagnosis of brain death. These have provided considerable help with the problem and they have been refined as the knowledge gained from experience has been collated.

More recently Forrester<sup>2</sup> has written on established practice in Scotland and Jennett<sup>3</sup> has made useful observations.

The diagnostic criteria presented for brain death here have been written with the advice of the subcommittee of the Transplant Advisory Panel, the working-party of the Royal College of Physicians, the working-party of the Faculty of Anaesthetists, and the Royal College of Surgeons and have been approved by the Conference of Medical Royal Colleges and their Faculties in the United Kingdom. They are accepted as being sufficient to distinguish between those patients who retain the functional capacity to have a chance of even partial recovery and those where no such possibility exists.

## Conditions under Which the Diagnosis of Brain Death Should be Considered

1. *The patient is deeply comatose.*
  - (a) There should be no suspicion that this state is due to depressant drugs. *Note 1*
  - (b) Primary hypothermia as a cause of coma should have been excluded.
  - (c) Metabolic and endocrine disturbances which can be responsible for or can contribute to coma should have been excluded. *Note 2*
2. *The patient is being maintained on a ventilator because spontaneous respiration had previously become inadequate or had ceased altogether.*
  - (a) Relaxants (neuromuscular blocking agents) and other drugs should have been excluded as a cause of respiratory inadequacy or failure. *Note 3*
3. *There should be no doubt that the patient's condition is due to irremediable structural brain damage. The diagnosis of a disorder which can lead to brain death should have been fully established.* *Note 4*

### NOTES

#### Note 1

Narcotics, hypnotics, and tranquillisers may have prolonged duration of action particularly when some hypothermia exists. The benzodiazepines are markedly cumulative and persistent in their actions and are commonly used as anticonvulsants or to assist synchronisation with mechanical ventilators. It is therefore recommended that the drug history should be carefully reviewed and adequate intervals allowed for the persistence of drug effects to be excluded. This is of particular importance in patients where the primary cause of coma lies in the toxic effects of drugs followed by anoxic cerebral damage.

#### Note 2

Metabolic and endocrine factors contributing to the persistence of coma must be subject to careful assessment. There should be no profound abnormality of the serum-electrolytes, acid-base balance, or blood-glucose.

#### Note 3

Immobility, unresponsiveness, and lack of spontaneous respiration may be due to the use of neuromuscular blocking drugs and the persistence of their effects should be excluded by elicitation of spinal reflexes (flexion or stretch) or by the demonstration of adequate neuromuscular conduction with a conventional nerve stimulator. Equally, persistent effects of hypnotics and narcotics should be excluded as the cause of respiratory failure.

#### Note 4

It may be obvious within hours of a primary intra-cranial event such as severe head injury, spontaneous intra-cranial haemorrhage or following neurosurgery that the condition is irremediable. However, when a patient has suffered primarily from cardiac arrest, hypoxia or severe circulatory insufficiency with an indefinite period of cerebral anoxia, or is suspected of having cerebral air or fat embolism then it may take much longer to establish the diagnosis and to be confident of the prog-

has just been the guest in Moscow of the very doctors whose record is so shameful and has been reported as offering no criticism of his hosts and only fulsome praise.<sup>8</sup> If the World Psychiatric Association is to continue to exist it should condemn Soviet practices. The Royal College of Psychiatrists, which has taken a stand against Soviet abuses, should put its condemnation on the agenda of the W.P.A. world congress in Hawaii in 1977.

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### E.E.G. AND "BRAIN LIFE"

SIR,—Your editorial (July 12, p. 63) effectively points out diagnosis of brain death has come under review,<sup>9</sup> and it has been suggested that in some cases clinical criteria alone may be sufficient.<sup>10</sup> We describe here, a patient who showed clinical signs suggesting brain death 12 h after acute cerebral anoxia but recovered completely during the next 10 days. E.E.G. recordings suggested a better prognosis than clinical signs had indicated.

A 60-year-old man had been on digoxin, dexamethasone, diazepam, frusemide, and a theophylline-ephedrine-phenobarbitone combination for chronic asthma. In an attempt to relieve an attack of asthma, he took six puffs on an aerosol device containing salbutamol and then smoked a cigarette. There was no immediate effect, but 6 min later he fell unconscious and quickly became unresponsive. His daughter promptly called an ambulance. The driver found the patient deeply cyanotic and unresponsive, with a pulse of 120/min and shallow respirations. An oropharyngeal airway was inserted during transportation to hospital. 1 h later, he was still deeply cyanosed and unresponsive to stimuli; his heart-rate was 90/min and systolic blood-pressure was 60 mm Hg. After endotracheal intubation and placement on a respira-

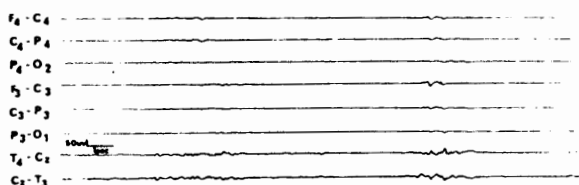


Fig. 1—First E.E.G. 12 h after onset of cerebral anoxia when patient showed clinical signs of brain death.

tor, the cyanosis subsided.  $PO_2$  was 72,  $PCO_2$  75 mm Hg, bicarbonate 24 meq/l, pH 7.22. 1 h later blood-pressure had risen to 130 mm Hg and pulse had fallen to 80/min, but spontaneous respirations had ceased. The  $PO_2$  was then 78 mm Hg and the  $PCO_2$  40 mm Hg. An electrocardiogram showed non-specific ST changes. Haemoglobin, blood-urea-nitrogen, blood-glucose, and electrolytes were all normal. The serum-barbiturate was 2.63 mg/dl.

Supportive care was continued, but 12 h after the onset he was still unresponsive to voice and painful stimuli. There were no spontaneous respirations after stopping the respirator for 1 min. The pupils were semi-dilated and fixed. The eyes were in the mid-position and unresponsive to the doll's head manoeuvre and vestibular stimulation using 200 ml ice water in each ear. All other brain-stem reflexes, including corneal and gag reflexes, were absent. The limbs were flaccid and unresponsive to painful stimuli. The deep tendon reflexes were minimally present but abdominal, cremasteric, and Babinski reflexes were absent. The E.E.G., made on a Beckman portable machine using techniques recommended by Prior,<sup>11</sup> showed low voltage or isoelectric activity interrupted every 10 s by 3 s bursts of generalised higher-voltage activity (fig. 1); these bursts were unaffected by touch or sound stimuli.

An E.E.G. 24 h after the first was greatly improved (fig. 2). The patient was still totally unresponsive to painful stimuli but showed normally reactive pupils and weakly responsive corneal reflexes. A third E.E.G. recorded 72 h after admission was almost normal (fig. 3). The patient had now completely recovered, except for mild mental confusion which disappeared within a week.

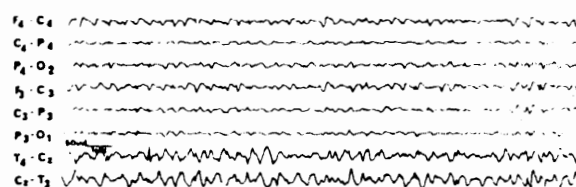


Fig. 2—E.E.G. 24 h after the first when cranial-nerve reflexes were starting to return.

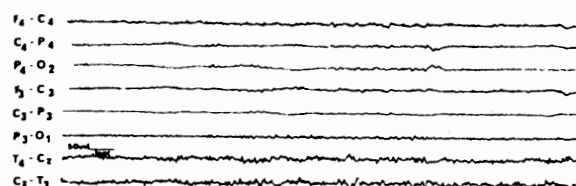


Fig. 3—E.E.G. 4 days after onset when almost full clinical recovery had occurred.

Our patient had severe cerebral anoxia as a result of bronchospasm, was resuscitated, but worsened 12 h later, possibly because of brain oedema. At that time, clinical signs suggesting brain death were present.<sup>12</sup> Spontaneous respirations were not shown to be absent for a period of 3 min; this procedure was considered too risky, even with oxygen insufflation, since the E.E.G. still showed cerebral electrical activity.

In Prior's series,<sup>11</sup> only three of thirty-seven patients with a first E.E.G. similar to ours recovered completely; two had barbiturate overdosage and the third had cerebral anoxia. In Jorgenson's patients,<sup>13</sup> if cranial-nerve reflexes were not regained after resuscitation from cerebral anoxia, the prognosis was invariably poor.<sup>13</sup> Thus, besides having demonstrated the value of E.E.G. in these situations, our patient recovered to a degree not expected on previously held criteria.

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### HYDATIDIFORM MOLE: TWO ENTITIES

SIR,—Dr Vassilakos and Dr Kajii (Jan. 31, p. 259) suggest that "... complete moles constitute a high-risk group for malignant trophoblastic neoplasia." Patients who have had hydatidiform moles in the U.K. are followed up under a scheme established by the Royal College of Obstetricians and Gynaecologists and the Department of Health and Social Security, with regular radioimmunoassay measurements of human chorionic gonadotrophin (h.c.g.). Evidence from this follow-up scheme is consistent with the view that classic or complete moles carry a higher risk than partial moles but it does not allow the inference that the risk following partial or transitional moles is negligible.

During a 2½-year period, 611 patients were registered with this laboratory within 2 months of mole evacuation. Of these, 61 patients ultimately underwent chemotherapy because of invasive mole or choriocarcinoma. The classifications made by the referring gynaecologist and pathologist on the moles are shown in the accompanying table with similar data for a random selection of 292 of the remaining 550 patients who did not require treatment. Non-classical moles constituted approximately one-third of cases followed up and one-sixth of those requiring treatment. The 5 Patients treated after transitional or partial mole had daily h.c.g. excretion rates of 2800–48 000 I.U. when admitted for treatment between 5 and 60 weeks after initial uterine evacuation. Two of them had pulmonary metastases.

8. *Soviet News*, Jan. 13, 1976.

9. *Lancet*, 1974, i, 341.

10. Mohandas, A., Chon, S. N. *J. Neurosurg.* 1971, 35, 271.

11. Prior, P. F. *The E.E.G. in Acute Cerebral Anoxia*. Amsterdam, 1973.

12. Plum, F., Posner, J. *Diagnosis of Stupor and Coma*. Philadelphia, 1972.

13. Jorgenson, E. O. *Electroenceph. clin. Neurophysiol.* 1974, 36, 65.

prolongation of the dying process. In the single calendar year of 1976 death with dignity bills were considered in sixteen other states. In 1977, eleven such bills are already under consideration.

(A Legislative Manual, published by the Society for the Right to Die, an exhibit to this statement, sets forth Death with Dignity bills introduced in 1975 and 1976 with analyses.)

Why has there been so much interest in the subject of Death with Dignity in recent years? Why do so many people wish to execute Living Wills? (Two million have been distributed throughout the country. They have been requested by more than 5,000 New Jersey residents.)

One reason is a very real fear of becoming inanimately maintained objects as a result of advanced medical technology. As a concomitant of extending the period of living, we also find that zealous application of medical technology frequently lengthens the dying process without benefitting the patient. In fact, a competent physician can now keep a patient dying for quite an extended period of time.

Physicians and hospitals have been slow to face up to this problem. When two major hospitals, both teaching



Even if he has signed a Living Will, it is only advisory. Consider the letter written from a distinguished hospital in Texas to an individual who had mailed the hospital his "Living Will" with the request that the hospital keep it in an accessible place in-the-event that it was necessary to use it. The hospital stated in a letter, "After consultation with our legal counsel, it is necessary that I advise you that (we) will not be able to honor such a will. In view of pending litigation and recent court decisions, it is the opinion of our counsel that such a document does not constitute a valid commitment on the part of the hospital. Therefore, in the event you are hospitalized as a patient here, every measure will be taken to see that your life is sustained to the best ability of our staff. Every effort will be taken to restore your health to an acceptable level. I felt it was necessary to advise you of this decision in order that you would not be under the misconception that the 'Living Will' would be honored in the event you were hospitalized."

Studies indicate that as many as four physicians out of ten say they will not follow such instructions if they are presented in writing, according to Dr. Robert Veatch of



Dr. Taussig is a member of our Board of Directors. More importantly she is Professor Emeritus of Pediatrics of the Johns Hopkins School of Medicine. Probably best known to you as co-developer with the late Dr. Alfred Blalock of the "blue baby" operation, she is also known to most of you as the doctor who alerted the country to the dangers of thalidomide. Dr. Taussig said:

"I firmly believe in the patient's right to die with dignity. Many of us do not fear death, we fear being kept alive when life has lost all significance and society will not allow us to die. Modern medicine has advanced to the point that it is possible to keep a person "alive" for weeks and months on a respirator, with a pacemaker, and dialysis, and intravenous feeding, to the tune of \$500.00 or more per day. Many people dread this possibility.

It seems to me morally wrong to increase the agony of the family and relatives and to use up their financial reserve and thereafter use public funds to pay the balance of the medical bill when all that is accomplished is to postpone the inevitable. Nevertheless, this is done a thousand times in every state of the Union.

EXHIBITS

TO STATEMENT OF

SIDNEY D. ROSOFF

PRESIDENT-

SOCIETY FOR THE RIGHT TO DIE

- (1) 1976 Death with Dignity Legislative Manual.
- (2) "The Prolongation of Life", An Address of Pope Pius XII to an International Congress of Anesthesiologists, 1958.
- (3) "Patient's Bill of Rights" adopted by The American Hospital Association.
- (4) Letter from The Methodist Hospital, Houston, Texas, dated May 12, 1976, advising individual that Living Will will not be honored.
- (5) "Dying in a System of 'Good Care': Case Report and Analysis" by Martin G. Netsky, M. D., April 1976.
- (6) "Statement on Measures Employed to Prolong Life in Terminal Illnesses" adopted by The New York Academy of Medicine, December 1972.

**TO MY FAMILY, MY PHYSICIAN, MY LAWYER, MY CLERGYMAN  
TO ANY MEDICAL FACILITY IN WHOSE CARE I HAPPEN TO BE  
TO ANY INDIVIDUAL WHO MAY BECOME RESPONSIBLE FOR MY HEALTH, WELFARE OR  
AFFAIRS**

Death is as much a reality as birth, growth, maturity and old age—it is the one certainty of life. If the time comes when I, \_\_\_\_\_ can no longer take part in decisions for my own future, let this statement stand as an expression of my wishes, while I am still of sound mind.

If the situation should arise in which there is no reasonable expectation of my recovery from physical or mental disability, I request that I be allowed to die and not be kept alive by artificial means or "heroic measures". I do not fear death itself as much as the indignities of deterioration, dependence and hopeless pain. I, therefore, ask that medication be mercifully administered to me to alleviate suffering even though this may hasten the moment of death.

This request is made after careful consideration. I hope you who care for me will feel morally bound to follow its mandate. I recognize that this appears to place a heavy responsibility upon you, but it is with the intention of relieving you of such responsibility and of placing it upon myself in accordance with my strong convictions, that this statement is made.

Signed \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

Witness \_\_\_\_\_

Copies of this request have been given to \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I am Dr. Joseph Warganz, Professor of Philosophy at the County College of Morris. I am also an officer of the State Board of the New Jersey Right to Life Committee, on which I have served for 4½ years. I testify today as a representative of that organization and in my professional capacity as a professor of natural philosophy and of ethics.

I would like to preface my remarks by recalling a traditional understanding of law that goes back to the 13th century; namely that law is an ordinance of reason that is promulgated for the common good. Law is not, therefore, an overflowing of sentiment generously proffered for the benefit of an organized few. I suggest that much recent legislative effort has failed of its purpose because of our sliding imperceptibly from the former definition of law to the latter.

There are three distinct things to be considered in reference to the subject of this hearing: 1) the definition of death; 2) the drawing up of criteria by which an individual is to be judged dead according to law; and 3) the application of these criteria to Jones, for example, so as to make the determination that Jones is, in fact, dead. This third has been, and must always remain, the work of the attending physician. In the past, moreover, the first of these was not a matter of debate among the general public and, in practice, the second was left to the medical profession. In these days of tug-of-war and pressure-group politics, however, the public is no longer willing to leave these first two areas to the medical profession or to the individual physician.

is the well-being of the organism itself. Thus digestion, circulation, vision, respiration are all immanent activities, and signs of life, but they are not life. Since life is the power of immanent activity rather than the activity itself, Jones is alive as long as he still has the power to generate immanent activity. (This is the reason why the discussion of proposed changes in the traditional criteria for determining death speak of the "irreversible" cessation of spontaneous life processes. Such cessation can only be "irreversible" if a radical power is lost.)

A power is not the same as the exercise of that power; and although an activity can be observed, a power can not. Thus it is of paramount importance not to confuse the cessation of an activity with the loss of the power to exercise that activity, which loss alone is death. (In this connection we might recall that an electro-cardiogram can record only a brain's activity, not its potential for such activity.)

Since activity is the only sign we have of the existence of a power, it might seem safe to assume the absence of life (the power) in the absence of the activity. This is safe procedure in regard to processes like respiration and circulation, for these are usually immediately observable to the unaided senses. Furthermore, experience confirms that soon after the cessation of these signs of life, the corpse undergoes changes, like rigor mortis and putrefaction, that make it obvious the loss is irreversible. When dealing with brain waves that unaided sense cannot observe, however, rather complex machinery is needed; and while we can see what the machine records, we cannot know what it fails to record. Hence more evidence is needed before equating the vital processes with the power of life itself. With this preliminary caveat that we must not lightly identify life and the signs of life, we turn now to the conclusions of the Task Force on

the apparatus and let him die? The question of determination of death is entirely distinct from the question of terminating treatment, and this committee has done well to consider definition bills and living-will bills in separate sessions.

In an effort to provide guidelines for the treatment of comatose patients, a team of physicians at the Harvard Medical School proposed in 1968 the oft-quoted and oft-misunderstood Harvard Criteria for determining death in these few cases. I will summarize and paraphrase them.<sup>3</sup>

It is of the utmost importance to note that the so-called "brain-death" bills do not suggest substituting all four of the Harvard Criteria for the traditional criteria. Rather they choose only the last of the criteria, which the Harvard researchers termed merely "confirmatory". Furthermore, they never intended these criteria to serve generally in the determination of death, but, as the Task Force report says,

The new criteria are meant to be necessary for only that small percentage of cases where there is irreversible coma with permanent brain damage, and where the traditional signs of death are obscured because of the intervention of resuscitation machinery.<sup>4</sup>

Thus it would be unusual law-making to take what was intended as a guide in only a tiny fraction of cases and make it the rule for all cases, and it would be even more rash to make the most uncertain part of that guide the rule for all determinations of death. Yet this is exactly what those who rely solely on "brain death" ask you to do.

\* \* \* \* \*

4. The use of "brain-death" as a determinant - and even more so, as the sole criterion - of death is dangerous and can easily lead to euthanasia, both passive and active. The Task Force states: "Recent proposals to place

In other words, when the neo-cortex of test rabbits was removed, other parts of the brain took over functions that had been thought to be the exclusive property of the neo-cortex!

In respect to the last assumption that the flat EEG marks the end of human life, Dr. Ryan cites instances from her emergency room experience. "I couldn't count the number of young drug addicts who arrived at the Emergency Room completely cyanotic with no apparent signs of life and a flat EEG. After an intravenous antidote, moments later that seemingly dead body is violently cursing and abusing the house staff."<sup>8</sup>

She also cites two programs: one from France and the other from Northwestern University, which "challenge the concept of brain death." In a two year study Northwestern "found that the EEG could be flat for up to 12 hours with complete recovery of the patient." Also in children, especially younger ones, a flat EEG "is not diagnostic of death."<sup>9</sup>

The Task Force from the Hastings Institute is even more emphatic. Citing an article from the British medical journal, Lancet (on neo-cortical death), they state: "The overall conclusion that an isoelectric EEG signifies the end of human life must be questioned in the light of a recent article reporting that patients with isoelectric EEG's (and subsequently verified anatomic death of their neo-cortices) continued to breathe spontaneously for up to six months."<sup>10</sup>

Relying on an article in the 1969 issue of Eletroenceph. Clinical Neurophysiology, the Report adds: "a majority of neurologists have rejected the proposition that EEG determinations are sufficient as the sole basis for a determination of death."<sup>11</sup>

\* \* \* \* \*

5. Let us turn now to the bills under consideration in the light of what

tory functions and brain functions before certifying death. This is certainly an improvement in intent, but it does not go far enough. If we wish to prevent arbitrary acts by physicians through stricter formulations of law, why not include all the Harvard Criteria?

Also, the bill makes no mention of the difficulties of ascertaining spontaneity of respiration when artificial means of support are used. Strangely enough, the bill defines "artificial means of support" but does not use the expression in its substantive section. It is defined only to clarify a previous definition. Does this suggest that, as soon as an artificial aid to breathing is in use, we may assume the patient has ceased spontaneous breathing and resort to brain criteria? (The bill makes no distinction between a device that helps a patient to breathe and one that does his breathing for him.) If this is the meaning, then this bill is equally dangerous, as we can easily see by applying it to the Quinlan case.

\* \* \* \* \*

6. As I said earlier, the Russo bill may have intended to curb capricious determinations by physicians by spelling out a law where previously there was none. But this is a misconception. We rely now on the common-law, which, if occasionally less clear than a statute, is equally forceful. With or without a new statute, we will always have to rely on the "opinion" of the physician, and he is obliged to make determinations "based on ordinary standards of medical practice." Thus a new law cannot create obligation, or add force; it can at best add clarity. But the suggested statutes I have seen do not clarify anything, and a law that established "clarity" that did not in fact exist would be an exercise of raw legislative power.

No new law is needed to establish criteria for the determination of



death. The Task Force stated, as a matter of history that,

"... the law generally treats the matter as a medical question of fact to be determined according to criteria established by physicians. No statutory change in the law will be necessary once the medical profession itself adopts the new criteria - provided of course, that the public does not object."<sup>13</sup> (emphasis added)

Frequently - and often less than sincerely - the fear of malpractice suits is thrown up as a reason for codifying medical practice. No statute is needed, in the view of the Task Force, to protect physicians from possible malpractice suits. "... we do not believe that legislation is absolutely necessary in order to permit physicians to use the new criteria, once these receive the endorsement and support of the medical profession."<sup>14</sup>

Further support for this view that a law would not help to protect physicians from malpractice suits comes from the legal profession itself. Robert B. Murphy, an attorney speaking at the Fourth National Congress on Medical Ethics (April 27, 1973), has expressed the opinion that physicians would be more liable to malpractice suits if a statutory definition of death were to be made. He said:

"Some physicians are demanding a legal definition of death in precise scientific terms because they think it is needed to protect them from legal problems that may arise when they declare someone to be dead. The expected protection, however, is illusory. A definition established by law may expose them to greater risks."<sup>15</sup>

In a letter to the weekly, America, Thomas A. Horkan Jr., the Executive Director of the Florida Catholic Conference, summed up the malpractice bogey neatly:

"Almost two million people died last year, most of them from natural causes and most of them with medical attention. Every death was different. And medical treatment was dictated by medical, personal, social, perhaps financial considerations, but not by legal technicalities. Some doctors prolonged life with extraordinary means long after hope of recovery had been lost; others did not use extraordinary means; some terminated extraordinary means; some did not. None of them were sued or prosecuted for practicing medicine the way they saw fit."<sup>16</sup>

come - to enact into law in a medical area a view that is opposed by the profession as a whole.

For all of these reasons I submit that the enactment of a definition of death bill is unwise, and potentially dangerous.

#### References

1. (Editorial), Journal of the American Medical Association, 221 (July 3, 1972), p. 65, cited hereafter simply as J.A.M.A.
2. "Refinements on Criteria for the Determination of Death: An Appraisal", J.A.M.A., p. 52.
3. Ibid, p. 50.
4. Ibid , p. 50.
5. Ibid, p. 52.
6. Testimony, Nov. 9, 1976, p. 1.
7. Nature, 233 (1971), pp. 185-187, in J.A.M.A., p. 53.
8. Testimony, p. 1.
9. Ibid, pp. 1-2.
10. Lancet, Vol. 2 (1971), pp. 560-565, in J.A.M.A., p. 53.
11. "Silverman, Masland, Saunders, et al., "EEG and Cerebral Death", in Electro. Clin. Physiol., Vol. 27 (1967), p. 549, in J.A.M.A., p. 53.
12. J.A.M.A., p. 52.
13. Ibid, p. 51.
14. Ibid, p. 52.
15. Report of the Judicial Council on Death to the A.M.A. House of Delegates, December, 1973, p. 2.
16. America, October 16, 1976, p. 222.
17. Report of the Judicial Council, p. 2.
18. Letter of Bruce Nortell to Rev. William B. Smith (Copy attached).
19. Cited in Testimony of Rev. William B. Smith before the Assembly Sub-Committee on Health Care of New York, Dec. 17, 1975, p. 4.

Mr. Michael Bruinooge

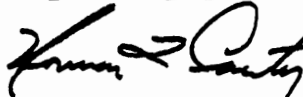
- 2 -

January 17, 1977

I cannot comment in detail about S-1751, because you did not enclose a copy in your communication to me. I would appreciate receiving such a copy, and I might then want to comment further.

Thank you for your interest.

Very truly yours,



Norman L. Cantor  
Professor of Law

NLC:sd  
Enclosure

(The article alluded to by Professor Cantor is entitled "Quinlan, Privacy, and the Handling of Incompetent Dying Patients." Too lengthy to be included here, it may be found in Vol. 30 No.2 of the Rutgers Law Review).

MAR 27 1985

