PUBLIC HEARING

before

SENATE JUDICIARY COMMITTEE

on

SENATE BILL 935
(Designated the "Death With Dignity Act")

SENATE BILL 2387
(Designated the "Right to Die Act")

SENATE BILL 875
(Designated the "Natural Death Act", permits adults to execute a directive providing that life sustaining procedures be withheld or withdrawn in the event of terminal illness)

Held:
February 4, 1985
Room 114
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Senator John A. Lynch, Chairman
Senator John F. Russo, Vice Chairman
Senator Edward T. O'Connor, Jr.
Senator Carmen A. Orechio
Senator Richard Van Wagner
Senator Raymond J. Zane
Senator Donald T. DiFrancesco

ALSO PRESENT:

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

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SENATE, No. 935

STATE OF NEW JERSEY

PRE-FILED FOR INTRODUCTION IN THE 1984 SESSION

By Senator RUSSO

AN ACT permitting certain persons to execute documents directing discontinuance of maintenance medical treatment in the event of terminal illness.

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

1. This act shall be known and may be cited as the "Death with Dignity Act".

2. The Legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition.

In order that the rights of patients may be respected even after they are no longer able to participate actively in decisions about themselves, the Legislature hereby declares that the laws of this State shall recognize the right of an adult person to make a written declaration instructing his physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition.

3. As used in this act:

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

b. "Declaration" means a witnessed document in writing, voluntarily executed by the declarant in accordance with the requirements of this act.

c. "Life-sustaining procedure" means any medical procedure or intervention which, when applied to a qualified patient, would serve

only to prolong the dying process and where, in the judgment of the attending physician, death will occur whether or not the procedures are utilized. "Life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care.

d. "Qualified patient" means a patient who has executed a declaration in accordance with this act and who has been diagnosed and certified in writing to be afflicted with a terminal condition by two physicians who have personally examined the patient, one of whom shall be the attending physician.

4. a. Any person of sound mind and 18 years of age or older may execute a declaration directing the withholding or withdrawal of life-sustaining procedures in a terminal condition. The declaration shall be signed by the declarant in the presence of two subscribing witnesses who are not (1) related to the declarant by blood or marriage, (2) entitled to any portion of the estate of the declarant under any will of declarant or codicil thereto then existing or, at the time of the declaration, by operation of law then existing, (3) a claimant against any portion of the estate of the declarant at the time of his decease at the time of the execution of the declaration, or (4) directly financially responsible for the declarant's medical care.

b. It shall be the responsibility of the declarant to provide for filing of the declaration with the agency established by section 4 of this act. The attending physician of an individual with a terminal condition for whom the decision of whether to utilize life-sustaining procedures is required to be made shall contact such agency to determine the existence and contents of a declaration.

5. a. The declaration shall be substantially in the following form: Declaration made this day of (month, year). I, ..., being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artifically prolong the dying process, I direct that the procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the per-

formance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration 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 the refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

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 .....

b. A declaration may include other specific directions. Should any of the other specific directions be held to be invalid, the invalidity shall not affect other directions of the declaration which can be given effect without the invalid direction, and to this end the directions in the declaration are severable.

6. A declaration may be revoked at any time by the declarant, without regard to his or her mental state or competency, by any of the following methods:

a. By being canceled, defaced, obliterated, or burnt, torn, or otherwise destroyed by the declarant or by some person in his or her presence and by his or her direction.

b. By a written revocation of the declarant expressing his or her intent to revoke, signed and dated by the declarant. The attending physician shall record in the patient's medical record the time and date when he or she received notification of the written revocation.

c. By a verbal expression by the declarant of his or her intent to revoke the declaration. The revocation shall become effective upon communication to the attending physician by the declarant or by a person who is reasonably believed to be acting on behalf of the declarant. The attending physician shall record in the patient's medical record the time, date and place of the revocation and the time, date and place, if different, of when he or she received notification of the revocation.

7. a. An attending physician who has been notified of the existence of a declaration executed under this act shall, without delay after the diagnosis of a terminal condition of the declarant, take the necessary steps to provide for written certification and confirmation of the declarant's terminal condition, so that declarant may be deemed to be a qualified patient.

b. An attending physician who fails to comply with this section shall be deemed to have refused to comply with the declaration and shall be liable as specified in Section 9 of this act.

8. a. The desires of a qualified patient who is competent shall at all times supersede the effect of the declaration.

b. If the qualified patient is incompetent at the time of the decision to withhold or withdraw life-sustaining procedures, a declaration executed in accordance with this act is presumed to be valid. For the purpose of this act, a physician or health care facility may presume in the absence of actual notice to the contrary that an individual who executed a declaration was of sound mind when it was executed. The fact of an individual's having executed a declaration shall not be considered as an indication of a declarant's mental incompetency.

c. In the absence of actual notice of the revocation of the declaration, none of the following, when acting in accordance with the requirements of this act, shall be subject to civil liability therefrom, unless negligent, or shall be guilty of any criminal act or of unprofessional conduct:

(1) A physician or health facility which causes the withholding or withdrawal of life-sustaining procedures from a qualified patient; or

(2) A licensed health professional, acting under the direction of a physician, who participates in the withholding or withdrawal of life-sustaining procedures.

9. a. An attending physician who refuses to comply with the declaration of a qualified patient pursuant to this act shall make the necessary arrangements to effect the transfer of the qualified patient to another physician who will effectuate the declaration of the qualified patient. An attending physician who fails to comply with the declaration of a qualified patient or to make the necessary arragements to effect the transfer shall be civilly liable.

b. Any person who willfully conceals, cancels, defaces, obliterates, or damages the declaration of another without the declarant's consent or who falsifies or forges a revocation of the declaration of another shall be civilly liable.

c. Any person who falsifies or forges the declaration of another, or willfully conceals or withholds personal knowledge of a revocation as provided in section 6 of this act, with the intent to cause a withholding or withdrawal of life-sustaining procedures contrary to the wishes of the declarant, and thereby, because of the act, directly causes life-sustaining procedures to be withheld or withdrawn and death to thereby be hastened, shall be subject to prosecution for unlawful homicide.

10. The withholding or withdrawal of life-sustaining procedures from a qualified patient in accordance with the provisions of this act shall not, for any purpose, constitute a suicide.

11. The making of a declaration pursuant to this act shall not affect in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.

12. No physician, health facility, or other health provider, and no health care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or non-profit hospital plan, shall require any person to execute a declaration as a condition for being insured for, or receiving, health care services.

13. Nothing in this act shall impair or supersede any 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 this respect the provisions of this act are cumulative.

14. This act shall create no presumption concerning the intention of an individual who has not executed a declaration to consent to the use or withholding of life-sustaining procedures in the event of a terminal condition.

15. This act shall take effect immediately.

STATEMENT

Death with dignity is to be a personal decision if humanly possible. This bill permits a person of sound mind, 18 years of age or older, to legally direct that in the event of a terminal illness no maintenance medical treatment is to be used to prolong his or her life.

SENATE, No. 2387

STATE OF NEW JERSEY

INTRODUCED NOVEMBER 19, 1984

By Senators FELDMAN and DUMONT

Referred to Committee on Judiciary

AN ACT concerning the withholding or withdrawal of life-sustaining medical procedures from a person diagnosed and certified as suffering from a terminal condition.

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

1. This act shall be known and may be cited as the "Right to Die Act."

2. The rights of a person include the right to a peaceful and natural death. Artificial prolongation of life for a person with a terminal condition may cause loss of individual dignity and unnecessary pain and suffering. The Legislature finds that a person has the fundamental right to control decisions relating to the rendering of medical care, including the decision to have life-sustaining procedures withheld or withdrawn if a terminal condition exists.

The dignity, privacy, and sanctity of a person with a terminal condition is to be respected even after the person is no longer able to participate actively in medical decisions. Therefore, the Legislature declares that the laws of this State shall recognize the right of a person to execute an oral or written declaration instructing an attending physician to withhold or withdraw life-sustaining procedures in the event that the person is diagnosed and certified as suffering from a terminal condition.

3. As used in this act:

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

b. "Declaration" means (1) a written document which is witnessed and voluntarily executed by the declarant in accordance with section 4 of this act, or (2) an oral document which is witnessed and voluntarily made by the declarant in accordance with section 4 of this act.

c. "Life-sustaining procedure" means a medical procedure, treatment, or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a spontaneous vital function or which affords a patent no reasonable expectation of recovery from a terminal condition, and, if applied, serves only to prolong the dying process. The term shall not include the administration of medication or the performance of a medical procedure deemed necessary to provide comfort, care, or the alleviation of pain.

d. "Person" means an individual 18 years of age or older.

e. "Physician" means a physician or surgeon licensed by the New Jersey State Board of Medical Examiners.

f. "Qualified patient" means a patient diagnosed and certified in writing to be suffering from a terminal condition by the attending physician and by another physician chosen by the patient, his immediate family, or the attending physician.

g. "Terminal condition" means an incurable condition caused by injury, disease, or illness which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death and the application of life-sustaining procedures serve only to postpone the moment of death for the patient.

4. a. A person may execute at any time a written declaration directing the withholding or withdrawal of life-sustaining procedures if the person is diagnosed and certified as suffering from a terminal condition. The written declaration made under this section shall be (1) dated; (2) signed by the declarant or by another person in the presence and at the direction of the declarant; and (3) signed in the presence of two or more witnesses. The witnesses shall not be related to the declarant by blood or marriage, shall not be entitled to any portion of the estate of the declarant under a will or codicil to the best of knowledge of the witnesses, shall not be a claimant against any portion of the estate of the declarant, and shall not be directly responsible for the cost of the medical care provided to the declarant.

b. An oral declaration may be made by a person at any time subsequent to the diagnosis of a terminal condition in the presence of a physician and two witnesses. No more than one of the wit-

nesses may be related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant by will or codicil, a claimant against any portion of the estate of the declarant, or directly responsible for the cost of the medical care provided to the declarant.

c. If the declarant is a resident of a sanitorium, rest home, nursing home, or related institution at the time he wishes to execute a declaration, one of the witnesses to the execution of that declaration shall be a representative from the Division on Aging in the Department of Community Affairs. The representative shall ascertain that the declarant is making a voluntary declaration and is aware of the consequences of the declaration.

d. The declarant shall notify the attending physician of the existence of a declaration. If the declarant is comatose, incompetent or otherwise mentally or physically incapable of notifying the attending physician, any other person may notify the physician of the existence of a declaration. An attending physician who is notified of a written declaration shall promptly make a copy of the declaration a part of the medical record of the declarant. If the declaration is oral, the physician shall promptly make a notation of the existence of the oral declaration a part of the medical record of the patient.

e. Unless revoked, a declaration is effective and binding from the date of execution. If the declarant has executed more than one oral or written declaration, the last declaration to be executed shall control.

f. If the declarant is diagnosed as pregnant and that diagnosis is known to the attending physician, the declaration shall have no effect during the course of the pregnancy.

5. A written declaration shall be in the following form, but may include other specific directions. If a specific direction is held invalid, the invalidity shall not affect the remainder of the declaration.

This declaration is made the ..... day of .....
..... (month, year). I, ...,
being of sound mind, willfully and voluntarily do declare:

If at any time I am diagnosed and certified as suffering from an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the two physicians have determined that my death will occur whether or not life-sustaining procedures are used and the use of these procedures would serve only to extend the dying process, I direct that life-sustaining pro-

cedures shall be withheld or withdrawn. I direct that I am permitted to die naturally with only the administration of medication or the performance of medical procedures deemed necessary to provide me with comfort, care and the alleviation of my pain.

If I am unable to give directions regarding the use of the life-sustaining procedures, this declaration shall be honored by my family and my attending physician as the final expression of my legal right to refuse life-sustaining medical or surgical treatment. I shall accept the consequences of my refusal.

If I have been diagnosed as pregnant and that diagnosis is known to my attending physician, this directive shall have no effect during the course of my pregnancy.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

....
Date Declarant

.....
City, County, State of Residence

The declarant is personally known to me and I believe the declarant to be of sound mind.

....
Date Witness

....
Address

....
Date Witness

....
Address

6. A declaration may be revoked at any time by the declarant without regard to his mental state or competence. A declaration may be revoked by:

a. Being canceled, defaced, obliterated, burnt, torn or otherwise destroyed by the declarant or by another person in the presence of and at the direction of the declarant;

b. A written statement dated and signed by the declarant expressing his intent to revoke the declaration; or

c. A verbal or other physical expression of the declarant expressing his intent to revoke the declaration.

The revocation shall become effective upon communication to the attending physician by the declarant or by a person who is reasonably believed to be acting on behalf of the declarant. Civil or criminal liability shall not be imposed against a person for a failure to act on a revocation unless the person had actual knowledge of the revocation.

7. An attending physician who has been notified of the existence of a declaration executed under this act shall, without delay after the diagnosis of a terminal condition of the declarant, take the necessary steps to provide for confirmation and written certification of the terminal condition so that the declarant may be certified to be a qualified patient. An attending physician who fails to comply with this section shall be held liable in accordance with section 10 of this act.

8. A declaration executed in accordance with section 4 of this act is presumed to be valid even if the declarant is incompetent at the time the decision is made to withhold or withdraw life-sustaining procedures subsequent to the certification of the terminal condition. A physician shall presume in the absence of actual notice to the contrary that a person who executed a declaration was of sound mind at the time the declaration was executed. The fact that a person executes a declaration shall not be considered an indication of mental incompetency.

9. a. In the absence of actual notice of the revocation of a declaration, civil and criminal liability shall not be imposed against: (1) a physician or health care facility which withholds or withdraws life-sustaining procedures from a qualified patient who had executed a declaration; or (2) a licensed health care professional, acting under the direction of a physician, who participates in the withholding or withdrawal of life-sustaining procedures from a qualified patient who had executed a declaration.

b. The provisions of this section shall apply unless it is shown by a preponderance of the evidence that the person authorizing or effectuating the withholding or withdrawal of life-sustaining procedures was negligent or did not in good faith comply with the provisions of this act.

10. An attending physician may refuse to comply with the declaration of a qualified patient only if the physician makes the necessary arrangements to transfer the qualified patient to another physician who will comply with the declaration. An attending physician who fails to comply with the declaration of a qualified patient or to make the necessary arrangements to transfer the patient is liable in a civil action.

11. a. A person who knowingly conceals, cancels, defaces, obliterates, or damages the declaration of another person without the consent of the declarant, or a person who falsifies or forges a revocation of the declaration of another person, is guilty of a crime of the fourth degree.

b. A person who falsifies or forges a declaration for another, or

a person who knowingly conceals or withholds knowledge of a revocation of a declaration with the intent to cause the withholding or withdrawal of life-sustaining procedures contrary to the wishes of the declarant, and, thereby, directly causes life-sustaining procedures to be withheld or withdrawn, is guilty of criminal homicide.

12. This act shall not be deemed to create the presumption that a person wants extraordinary life-sustaining measures to be taken if the person has not made a declaration.

13. The withholding or withdrawal of life-sustaining procedures from a qualified patient in accordance with the provisions of this act shall not, for any purpose, constitute suicide.

14. The making of a declaration directing the withdrawal or withholding of life-sustaining procedures under section 4 of P. L. , c. (C.) (now pending before the Legislature as Senate Bill No. 2387 of 1984) shall not restrict, inhibit, or impair the sale, procurement, or issuance of any policy of life insurance nor shall it be deemed to modify the terms of an existing life insurance policy. A policy of life insurance shall not be legally impaired or invalidated by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.

15. A physician shall not require a person to execute a declaration as a condition to receiving health care services.

16. A health facility or other health care provider shall not require a person to execute a declaration under P. L. , c. (C.) (now pending before the Legislature as Senate Bill No. 2387 of 1984) as a condition to receiving health care services.

17. A health care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan or nonprofit hospital plan shall not require a person to execute a declaration under P. L. , c. (C.) (now pending before the Legislature as Senate Bill No. 2387 of 1984) as a condition to being insured for, or receiving, health care services.

18. a. Subject to the requirements of subsection b. of this section, life-sustaining procedures may be withheld or withdrawn from a qualified patient who (1) is comatose, incompetent, or otherwise physically or mentally incapable of communicating, and (2) has not made a declaration in accordance with this act, provided there is confirmation of the condition of the patient by a committee of at least three physicians, not including the attending physician, appointed by the medical staff of the health care facility.

b. If the requirements of subsection a. of this section are met,

life-sustaining procedures may be withheld or withdrawn upon the direction and supervision of the attending physician at the request of any of the following persons in the following order of priority:

(1) The judicially appointed guardian of the qualified patient if one has been appointed, except that this section shall not be construed to require an appointment so that a withholding or withdrawal decision can be made;

(2) The spouse of the qualified patient, if the spouse is 18 years of age or older;

(3) An adult child of the patient or, if the patient has more than one adult child, by a majority of the children who are reasonably available for consultation;

(4) The parents of the patient; or

(5) The nearest living adult relative of the patient.

If the decision is made by a person specified in paragraphs 2, 3, 4, or 5 of this subsection, two witnesses shall be present at the time that the decision is made.

19. a. If a minor has been certified under this act as a qualified patient, the following persons in order of priority may execute a declaration on behalf of the minor:

(1) The spouse, if the spouse is 18 years of age or older; or

(2) The parent or guardian of the minor.

b. A person named in subsection a. of this section shall not execute a declaration if:

(1) The person has actual notice that the minor opposes a declaration; or

(2) A parent or guardian has actual knowledge of opposition to a declaration from either another parent or the spouse of the minor regardless of the age of the spouse.

c. A minor may revoke this declaration in the manner provided under section 6 of this act.

20. This act shall not be construed to condone, authorize, or approve of mercy killing nor to permit any deliberate act or omission to end a life other than to permit the natural process of dying.

21. This act shall take effect immediately.

STATEMENT

The purpose of this bill is to establish a procedure whereby a person 18 years of age or older could execute an oral or written declaration providing that life-sustaining procedures should be withheld or withdrawn if that person is diagnosed and certified as

suffering from a terminal illness and the procedures would serve only to prolong the dying process.

This bill relieves physicians, licensed health professionals acting under the direction of a physician, and health facilities from civil or criminal liability if life-sustaining medical procedures are withheld or withdrawn.

The bill provides that a withholding or withdrawal of life-sustaining procedures shall not constitute a suicide or impair or invalidate life insurance policies, and the bill specifies that the making of an oral or written declaration shall not restrict, inhibit, or impair the sale, procurement, or issuance of life insurance policies or modify existing life insurance policies. The bill provides that health insurance carriers could not require the execution of a directive as a condition to being insured for, or receiving, health care services.

SENATE, No. 875

STATE OF NEW JERSEY

PRE-FILED FOR INTRODUCTION IN THE 1984 SESSION

By Senator HURLEY

AN ACT allowing an adult to execute a directive providing that life-sustaining procedures be withheld or withdrawn in the event of terminal illness, prescribing the form of the directive and providing for the means of revocation thereof.

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

1. This act shall be known and may be cited as the "Natural Death Act."

2. As used in this act:

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

b. "Directive" means a written document voluntarily executed by the declarant in accordance with the requirements of section 3. The directive, or a copy of the directive, shall be made part of the patient's medical records.

c. "Life-sustaining procedure" means any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician, death is imminent whether or not the procedures are utilized. "Life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain.

d. "Physician" means an individual licensed to practice medi-

cine and surgery by the State Board of Medical Examiners.

e. "Qualified patient" means a patient diagnosed and certified in writing to be afflicted with a terminal condition by two physicians, one of whom shall be the attending physician, who have personally examined the patient.

f. "Terminal condition" means an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serve only to postpone the moment of death of the patient.

3. Any adult person may execute a directive directing the withholding or withdrawal of life-sustaining procedures in the event of a terminal condition. The directive shall be executed with the same formalities as a will under chapter 3 of Title 3B of the New Jersey Statutes. In addition to the formalities required under chapter 3 of Title 3B of the New Jersey Statutes the directive shall be signed by the declarant in the presence of two witnesses not related to the declarant by blood or marriage and who would not be entitled to any portion of the estate of the declarant upon his decease under any will of the declarant or codicil thereto then existing or, at the time of the directive, by operation of law then existing. In addition, a witness to a directive shall not be the attending physician, an employee of the attending physician or a health facility in which the declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his decease at the time of the execution of the directive. The directive shall be in the following form:

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, and do hereby declare:

1. If at any time I should have an incurable condition caused by 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 attending physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that the 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 physicians as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from the refusual.

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.

7. I understand that I may revoke this directive at any time.

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. I am not related to the declarant by blood or marriage, nor would I be entitled to any portion of the declarant's estate on his decease, nor am I the attending physician of declarant or an employee of the attending physician or a health facility in which declarant is a patient, or a patient in the health care facility in which the declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his decease.

Witness .....

Witness .....

STATE OF NEW JERSEY

COUNTY OF .....

Before me, the undersigned authority, on this day personally appeared ....., ..., and ....., known to me to be the declarant and witnesses whose names are subscribed to the foregoing instrument in their respective capacities, and, all of these persons being by me duly sworn, the declarant, ..., declared to me and to the witnesses in my presence that the instrument is his Directive to Physicians, and that he had willingly and voluntarily made and executed it as his free act and deed for the purposes therein expressed.

Declarant .....

Witness .....

Witness .....

Subscribed and acknowledged before me by the Declarant, ...
, and by the witnesses, ..., and ..... , on this ... day of ..... , 19 .

Notary Public in and for

..... County, New Jersey

4. a. A directive may be revoked at any time by the declarant, without regard to his mental state or competency, by any of the following methods:

(1) By being canceled, defaced, obliterated, burnt, torn, or otherwise destroyed by the declarant or by some person in his presence and by his direction;

(2) By a written revocation of the declarant expressing his intent to revoke, signed and dated by the declarant. The revocation shall become effective only on communication to an attending physician by the declarant or by a person acting on behalf of the declarant or by mailing the revocation to an attending physician. An attending physician or his designee shall record in the patient's medical record the time and date when he received notification of the written revocation and shall enter the word "VOID" on each page of the copy of the directive in the patient's medical records; or

(3) By a verbal expression by the declarant of his intent to revoke the directive. The revocation shall become effective only on communication to an attending physician by the declarant or by a person acting on behalf of the declarant. An attending physician or his designee shall record in the patient's medical record the time, date, and place of the revocation and the time, date, and place, if different, of when he received notification of the revocation and shall enter the word "VOID" on each page of the copy of the directive in the patient's medical records.

b. Except as otherwise provided in this act, there shall be no criminal or civil liability on the part of any person for failure to act on a revocation made pursuant to this section unless that person has actual knowledge of the revocation.

5. A directive shall be effective for five years from the date of its execution unless sooner revoked in a manner prescribed in section 4 of this act. Nothing in this act shall be construed to prevent a declarant from reexecuting a directive at any time in accordance with the formalities of section 3 of this act, including reexecution subsequent to a diagnosis of a terminal condition. If

the declarant has executed more than one directive, the five years shall be determined from the date of execution of the last directive known to the attending physician. If the declarant 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 declarant's condition renders him or her able to communicate with the attending physician, but in any event shall terminate at the end of five years from the date of execution.

6. No physician or health facility, which, acting in accordance with the requirements of this act, causes the withholding or withdrawal of life-sustaining procedures from a qualified patient, shall be subject to civil liability therefrom unless negligent. No licensed health professional, acting under the direction of a physician, who participates in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this act shall be subject to any civil liability unless negligent. No physician, or licensed health professional acting under the direction of a physician, who participates in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this act shall be guilty of any criminal act or of unprofessional conduct unless negligent. No physician, health care facility, or health care professional shall be liable either civilly or criminally for failure to act pursuant to the declarant's directive where such physician, health care facility, or health care professional had no knowledge of the directive.

7. a. Prior to effecting a withholding or withdrawal of life-sustaining procedures from a qualified patient pursuant to the directive, the attending physician shall determine that the directive complies with the form of the directive set out in section 3 of this act, and, if the patient is mentally competent, that the directive and all steps proposed by the attending physician to be undertaken are in accord with the existing desires of the qualified patient and are communicated to the patient.

b. If the declarant was a qualified patient at least 14 days prior to executing or reexecuting the directive, the directive shall be conclusively presumed, unless revoked, to be the directions of the patient regarding the withholding or withdrawal of life-sustaining procedures. No physician, and no health professional acting under the direction of a physician, shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subsection. A failure by a physician to effectuate the directive of a qualified patient pursuant to this subsection may con-

stitute unprofessional conduct if the physician refuses to make the necessary arrangements or fails to take the necessary steps to effect the transfer of the qualified patient to another physician who will effectuate the directive of the qualified patient.

c. If the declarant becomes a qualified patient subsequent to executing the directive, and has not subsequently reexecuted the directive, the attending physician may give weight to the directive as evidence of the patient's directions regarding the withholding or withdrawal of life-sustaining procedures and may consider other factors, such as information from the patient's family or the nature of the patient's illness, injury, or disease, in determining whether the totality of circumstances known to the attending physician justified effectuating the directive. No physician, and no health professional acting under the direction of a physician, shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subsection.

8. a. The withholding or withdrawal of life-sustaining procedures from a qualified patient in accordance with the provisions of this act shall not, for any purpose, constitute a suicide.

b. The making of a directive pursuant to section 3 of this act shall not restrict, inhibit, or impair in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from an insured qualified patient, notwithstanding any term of the policy to the contrary.

c. No physician, health facility, or other health provider, and no health care service plan, or insurer issuing insurance, may require any person to execute a directive as a condition for being insured for, or receiving, health care services nor may the execution or failure to execute a directive be considered in any way in establishing the premiums for insurance.

9. A person who purposely conceals, cancels, defaces, obliterates, or damages the directive of another without the declarant's consent is guilty of a crime of the fourth degree. A person who falsifies or forges the directive of another, or purposely conceals or withholds personal knowledge of a revocation as provided in section 4 of this act, with the intent to cause a withholding or withdrawal of life-sustaining procedures contrary to the wishes of the declarant, and thereby, because of any act, directly causes life-sustaining procedures to be withheld or withdrawn and death to thereby be hastened, shall be subject to prosecution for homicide as provided under Title 2C of the New Jersey Statutes.

10. Nothing in this act shall be construed to condone, authorize, or approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying as provided in this act.

11. Nothing in this act shall impair or supersede any 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 this respect the provisions of this act are cumulative.

12. This act shall take effect immediately.

STATEMENT

This bill allows an adult to execute a directive providing that life-sustaining procedures should be withheld or withdrawn if that person becomes terminally ill and the procedures would serve only to prolong the moment of death. The directive would generally be effective for five years from the date of execution unless sooner revoked. This act 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 act.

The bill would provide that a withholding or withdrawal of life-sustaining procedures shall not constitute a suicide or impair or invalidate life insurance, and the act would specify that the making of a directive shall not restrict, inhibit, or impair the sale, procurement, or issuance of life insurance or modify existing life insurance. The act would provide that health insurance carriers 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 crime to purposely 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 purposely 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 criminal homicide.

SENATOR JOHN A. LYNCH (Chairman): Good morning. As far as the order today is concerned, we have three bills on the agenda dealing with the Death With Dignity Act, the Right to Die Act, or the Natural Death Act, depending on which one you are referring to. We will start off the hearing with opening statements by Senator Russo, who has S-935; Senator Feldman will follow with S-2387; and, Senator Hurley on S-875.

Senator Feldman has indicated that he has to go to an Education Committee meeting. Senator Russo, would you like to say something first?

SENATOR RUSSO: I wouldn't dare not afford the courtesy to Senator Feldman. I would pay a high price for it if I didn't, Mr. Chairman. Because of that, I will have to defer.

SENATOR LYNCH: Good morning, Senator Feldman.

SENATOR MATTHEW FELDMAN: Good morning. Thank you, Mr. Chairman, and thank you, Senator Russo, for your kindness.

At the outset, Mr. Chairman, I wish to compliment the aide to the Senate Judiciary Committee, John J. Tumulty, and his staff, for what I know to be a very worthy comparison of the three bills before us. It is something that those in the audience -- witnesses to come -- should read and digest. So, Mr. Tumulty, you have done a favorable job, even though the report somehow tilts toward my bill. It is honest; it is direct; and, it is forthright.

The right to die with dignity is now law in 22 states of our nation. We have the Conroy decision by our own Supreme Court. Of course, these bills were in prior to the Supreme Court decision. My colleagues and I believe in the same principle -- death with dignity -- but, the bills are slightly different on how to accomplish it.

The purpose of my bill, S-2387, is to establish a procedure whereby a person 18 years of age or older could execute an oral or written declaration providing that life-sustaining procedures should be withheld or withdrawn if that person is diagnosed and certified as suffering from a terminal illness, and the procedures would serve only to prolong the dying process.

This bill would relieve physicians, licensed health professionals acting under the direction of a physician, and health facilities from civil or criminal liability if life-sustaining medical procedures were withheld or withdrawn. The bill provides that a withholding or a withdrawal of life-sustaining procedures shall not constitute a suicide or impair or invalidate life insurance policies, and the bill specifies that the making of an oral or written declaration shall not restrict, inhibit, or impair the sale, procurement, or issuance of life insurance policies, nor modify existing life insurance policies.

The bill also says that any declaration made by a woman will not be valid if she is pregnant at the time she becomes terminally ill. My colleagues, this act shall not be construed to condone, authorize, or approve mercy killings, nor to permit any deliberate act or omission to end a life, other than to permit the natural process of dying.

Something has come to my attention through a former nurse by the name of Janet Kelly of Westwood. She went to Rutgers Law School, after graduating from nursing, and was very concerned about her experiences as a nurse, where patient after patient, afflicted with a terminal disease, would say, "Why are you keeping me alive? Why are you feeding me? I can't be cured." Ms. Kelly listened to these lamentations, to the pleadings of the families, and yes, to spiritual advisers. Ms. Kelly's last act at law school was to get together with a number of Rutgers Law School seniors. This bill is the fruition of their labors.

There should be justice for the dying. I received a call, Mr. Chairman -- that I would like to bring to your attention -- from Dr. Luka of the Board of Medical Examiners of New Jersey. Dr. Luka advised me that the Board of Medical Examiners has not taken a vote as yet. The vote will be taken next week. However, he told me that I could relay to the Judiciary Committee, and to its Chairman, Senator Lynch, that the Board of Medical Examiners look with favor upon S-2387. They feel the bill is comprehensive and takes in many of the problems that the Medical Society would have with a bill such as this.

I know you expect to have a long day today--

SENATOR LYNCH: (interrupting) Senator Feldman, since I'm sure we are not going to complete this hearing today, we will await the report from the Board of Medical Examiners.

SENATOR FELDMAN: Fine, that will be forthcoming. I know this is going to be a decision by this Committee that will make history in New Jersey, supplementing the Supreme Court decision. I know you are going to view it with a great deal of sensitivity.

For the record, I am a religious person. I believe very firmly in the Creator of mankind: I believe very firmly and strongly in God. I do not attempt to play God, but I feel there are people who-- Why should we prolong the lives of persons when their brains are no longer functioning, and only by some mechanical processes are we keeping them alive. Death is natural. It is the finality of life. Those whom we can cure, yes, by all means cure them with medication. But, let's not prolong life where people will only vegetate and become a source of great sorrow to their families, as well as to those who are serving them in the medical fraternities.

Thank you very much for listening, and for your courtesy. If you need me to answer any questions, you may summon me from the Education Committee meeting where we have some heavy bills today. Thank you.

SENATOR LYNCH: Senator DiFrancesco has a long list of questions he would like to ask you later. Are there any questions from the other members of the Committee?

SENATOR RUSSO: I will defer my questions perhaps to a later hearing.

SENATOR LYNCH: Senator Feldman, Senator Russo may wish to recall you at a later date.

SENATOR FELDMAN: Fine. Thank you.

SENATOR LYNCH: Senator Russo?

SENATOR RUSSO: Thank you, Mr. Chairman. I will be brief because I think that Senator Feldman states the issue well. I think probably there is very little disagreement between his position and mine, if I understood him correctly.

First of all, let me make it clear regarding Senate Bill 935, sponsored by myself, that it is my intention to amend that bill, unless I hear any reasons why it shouldn't be done, because the bill is just a starting point. Frankly, I think the bill goes too far. I also feel that the Supreme Court decision in the Conroy case goes too far. I would propose that the bill be amended so that it applies only when -- in my words -- there is irreversible brain damage, and, as Senator Feldman just indicated, in his words, "when the brain is no longer functioning." In that regard we disagree. But, it should be made clear that none of the bills before us at the present moment read that way. The bill, as originally drafted by me at its starting point, and I think Senator Feldman's bill, as well as the Conroy decision, in my judgment, actually border on euthanasia. Each of these bills, as originally drafted, talks about the determination of life support facilities, but without the requirement of irreversible brain damage.

There is a very strong humane argument that can be made for keeping the bills the way they are. Imagine, if you will, a person with an illness which everyone medically agrees is terminal. The patient is not brain dead, but is being kept alive by life support systems including, as I understand it, intervenous feedings, and things of that sort. The bills, as originally drafted, and the Conroy decision, would allow determination of those life support systems upon certification that the illness is terminal and that there is no hope of recovery.

I can imagine, for example, being in that situation myself -- God forbid -- and certainly I can tell you now that if I had the choice, I would not want to be kept alive. I can probably imagine a similar situation where I would not want members of my family kept alive. However, I am just not sure that I ought to have that power, or that anyone else ought to have that power where, in fact, a person is still alive, but the illness is hopeless and terminal. I don't want to get involved with esoteric things such as miracles -- medical, religious, or otherwise. I don't think we can discuss legislation on that basis, but I just don't know if legislatively we ought to be able to say that there is no hope of recovery, the illness is terminal, and

we should terminate life support systems so as not to drag it on and cause tremendous emotional and financial burdens. I recognize those emotional and financial burdens. It is difficult. I think most people, if they were asked if they wanted to be kept alive under those circumstances, would say "no." I recognize that. I am not talking about doing something that a patient wouldn't want done. I am assuming that the patient would want it done. I just think it gets too close to a dangerous precedent, where without irreversible brain damage, or whatever, we in government have the right to say on behalf of someone else, or even on behalf of ourselves, that we want to terminate life. Then, I think, we would be treading in dangerous waters, because the next argument will be, what happens, for example, when someone is born hopelessly afflicted with, say, a mental illness, or what have you? It is a short step to go that step further.

So, I think we need a bill in order to establish a law. I think legislatively this has to be responded to. I think, though, as Senator Feldman said, when the brain is no longer functioning or, in my case, where there is irreversible brain damage -- as I would suggest my bill read -- that we could at least take a step so that the hospitals and doctors will know what the procedure is and that legally they may terminate keeping a person artificially alive, even though he is dead. That I can accept. I have difficulty, though, with the Conroy decision and the bills as originally drafted which basically, in each case, do not provide that provision. I suspect most people would favor the bills as originally drafted if they were to apply to their own case or their own families. I acknowledge that, but I just don't feel that legislatively we can go to that extent, or go that far, because if it isn't euthanasia, I think we are coming very close to it.

Perhaps to set the initial tone of the discussion, Mr. Chairman, I think we all agree we need a death with dignity law in this State. I see no quarrel with that. We need something. I think the question, though, is, do we go too far when we terminate life support facilities when the person's brain is still functioning and still alive, even though terminal? It is a tough, tough decision. I am not comfortable when answering this in the affirmative. I prefer to answer

it in the negative and only apply this bill where there has been irreversible brain damage. Perhaps an argument could be made for irreversible circulatory damage where the person could never function with it. I would not want to terminate ordinary life support procedures just because a person had a terminal illness, or at least had what the medical profession said at the time was a terminal illness, with no hope of recovery.

Thank you, Mr. Chairman.

SENATOR LYNCH: Thank you, Senator Russo. Our next speaker will be Senator James Hurley, sponsor of S-875, which has been rereferenced to this Committee through the exercise of sound discretion by our Senate President. We wish he would use that same discretion in rereferencing some of the other bills which are pending before this Committee. Senator Hurley?

SENATOR JAMES R. HURLEY: Senator Lynch and members of the Senate Judiciary Committee: I want to thank you for allowing me to appear here. I particularly want to thank the Senate President for moving my bill from where it was to where it is.

My interest in this subject goes back eight or nine years to the Karen Ann Quinlan case. This bill, as a matter of fact in its exact form, has been before the Legislature for all those years. During those intervening years, there has been very little interest in having this bill heard. I requested it over and over again and, as you know, it is only because of the interest that has been peaked by the Supreme Court decision, and I think by the changes in medical science, and the discussion that has been obvious in the press, that we have arrived at this hearing. I commend this Committee for coming to grips with this issue.

When the Karen Ann Quinlan matter was before the court eight or nine years ago, Legislative Services took ideas from several states in the nation which then had right-to-die or natural-death acts, or whatever you want to term them. We took what we thought at the time was the best of those bills, or the best from those bills. I want to tell you too that it is fascinating to observe legislation as it lives through these various years, as courts speak to issues, and as other states address issues.

At the time I put this bill in, the attention this legislation received was not popular at all. As a matter of fact, to the contrary, it was controversial legislation and was not about to be heard by members of this Committee or any other committee. I am not going to take a lot of time describing my bill. It calls for a written directive that is witnessed by two people when it is executed. It requires two physicians, one of whom may be the attending physician to the patient. It is valid for a five-year period, and it can be renewed. The directive imposes a 14-day waiting period after certification of terminal illness before it can be executed. It can be revoked by being physically destroyed or by a written or verbal statement. It differs from the other two bills before you because, as in four other states, it requires physicians to determine the validity of the declaration. The other two bills do not require a physician to do that. I happen to think that is an important point. It provides for an exemption from liability, as the other bills do. It provides for criminal penalties up to the fourth degree, penalties up to 18 months and/or a $1,500 fine for destroying or forging the document. It is not valid if the declarant is pregnant. On the advice of learned legal counsel, it satisfies or responds to all of the tests of the Conroy case of the Supreme Court, but I hasten to say that I agree wholeheartedly with the comments of Senator Russo. I think we ought to move in the direction he led us in his testimony.

Very frankly, we are long past the time in New Jersey -- particularly because of the activity of the Supreme Court -- when we ought to speak to this issue legislatively. I commend you for your willingness to tackle this, and I certainly believe it ought to be a bipartisan bill that addresses it. I am going to leave the disposition of this matter to this Committee. I am neither an attorney nor a physician; however, I do have a long and active interest in it. I wanted very much to come here today to give you my thoughts on why I sponsored this bill so many years ago.

Thank you, Mr. Chairman.

SENATOR LYNCH: Are there any questions from the members of the Committee? Senator Russo?

SENATOR RUSSO: Jim, I think I am clear on this issue, but I just want to make sure how you feel. I gather from your statement that you agree with the comment I made that it should only apply where, in fact, the person is brain dead.

SENATOR HURLEY: That's right, yes.

SENATOR RUSSO: Because you see, all of our bills, as drafted by Legislative Services, went further than that. They actually went as far as the Conroy decision, and I gather from your comments that you and I agree that goes a little too far.

SENATOR HURLEY: That is the reason I wanted to make that clear here. Even though it has been examined against the Conroy case, it satisfies all of those tasks. But, I want to go on record as stating that I agree with your comments that our legislation goes beyond the brain dead category, and that final legislation ought to address what you spoke to.

SENATOR RUSSO: Fine. Thank you, Jim.

SENATOR LYNCH: Thank you. Jim, are you and Senator Russo going to collaborate on preparing an amended version of your two bills for submission to this Committee before we complete our hearings?

SENATOR HURLEY: Mr. Chairman, I would be happy to collaborate with Senator Russo at any time. As I stated earlier, I would like to see this as a bipartisan measure which comes out of this Committee. I am certainly disposed to leave whatever happens to the bill in the hands of this Committee. I commend you for bringing it to the public's attention by having these hearings. I have no pride of authorship in the final product of this Committee; I simply want to have my feelings and thoughts known on this subject. For that I thank you.

SENATOR RUSSO: The problem with that is, there are now two bills pending which we are here to discuss today. There are many people here who have analyzed these two bills and are prepared to testify as to the substance of the bills contained in the legislation before us. However, since it is such a topical subject, I'm sure most of the speakers are going to talk about it generally, as well as give a specific analysis. The issue is certainly not moot.

SENATOR LYNCH: Thank you very much, Senator Hurley.

SENATOR HURLEY: Thank you.

SENATOR RUSSO: Mr. Chairman, I think that probably applies to all three bills, as indicated by Senator Feldman's comment, "once the brain is no longer functioning." I suspect we three are all in agreement on that particular "amendment" -- we'll call it -- at least at this point. I think Senator Feldman would probably agree.

SENATOR LYNCH: The next speaker today will be Commissioner Joseph Rodriguez, from the Department of the Public Advocate. Good morning, Commissioner. Thank you for waiting: I apologize for the delay. You know all of the members of the Committee who are here. Some of them have stepped out to other meetings, etc., so why don't you go ahead with your testimony.

COMMISSIONER JOSEPH H. RODRIGUEZ: Good morning, Senators. I would like to thank Senator Lynch and the rest of the members of the Senate Judiciary Committee for allowing me to address you today on the subject of living will legislation and the broader aspects of death and dying raised by the Supreme Court's recent decision in the case of Claire Conroy.

My Department -- the Department of the Public Advocate -- was a party in that case, having intervened several days after the trial court decision was announced. I personally argued the case before both the Appellate Division and the Supreme Court. I believe that the Conroy ruling is not only an important decision of national significance, but also, if understood, a compassionate one that will help patients and their families better come to terms with the agony of death and dying.

Let me note that the Department of the Public Advocate favors living will legislation, and that we have testified several times in the past before the Legislature in support of this concept. Senators Feldman, Dumont, Hurley, and Russo are to be commended for their efforts. For reasons that I will go into in a minute, I think that whatever legislation is eventually passed on the subject should be as comprehensive as possible and the best features of these bills and others should be incorporated into a composite bill.

I also believe, again for reasons I will explain, that Conroy lays the foundation for broad legislation that deals not only with the subject of living wills, but also surrogate decision-making on behalf of incompetent patients and a host of related topics, including various procedures that should apply in hospitals, nursing homes, hospices, and State institutions for the handicapped. I think these issues should be considered together by a joint Legislative Branch/Executive Branch commission, and a unified legislative package developed. I believe a piecemeal approach should be avoided.

I am troubled that the public might misconstrue the Conroy case. It is inaccurate to categorize it as a right-to-die decision. What the court held was that, as a general rule, patients have a right to determine the course of their treatment, and in so doing, can refuse or discontinue treatment. Conversely, patients are free to continue treatment if they wish. More properly, Conroy involves the right of patients to make treatment decisions and control what will be done to their bodies, stating, "even if that decision appears to be against the values of the medical profession."

Perhaps the most significant aspect of Conroy is the rejection of such treatment labels as "ordinary" versus "extraordinary," "artificial" versus "natural," or "passive" versus "active." The court noted that such terms confuse the issue and stand in the way of clear analysis. Instead, the court ruled that the patient's right of self-determination extends to any form of care or treatment, including feeding. The key element in decision-making is the opinion of the patient and not the nature of the treatment itself.

The Supreme Court in Conroy extended this right of self-determination in a carefully limited way to incompetent patients. Surrogate decision-makers may refuse treatment when the wishes of the patient are known, life expectancy is short, and appropriate procedures have been followed. Where the wishes are not known with precision, several rigorous tests must be met which involve the patient's medical condition. Repeatedly, the court emphasized that where the evidence is equivocal, it is best to err in favor of preserving life.

The court encouraged the use of written directives prepared by patients while competent, and expressly invited the Legislature to adopt living will or other suitable legislation that would help patients record their views on the subject. I would like to point out that if a person believes, for religious or ethical reasons, that treatment should never be discontinued as long as a glimmer of life remains, a written directive coupled with his right of self-determination would normally guarantee continued treatment.

The Conroy court also established a procedure for surrogate decision-making on behalf of elderly nursing home residents that involves family, health care providers, the courts, and, importantly, the Ombudsman for the Institutionalized Elderly. But because the Ombudsman's jurisdiction is restricted to nursing home residents age 60 or older, the Conroy court, by necessity, limited this procedure to that population. Again, the court explicitly invited the Legislature to develop procedures governing other situations such as those involving younger nursing home residents, patients in hospices, institutions for the developmentally disabled, and hospitals that lack ethics committees. As I read Conroy, the Legislature is even free to modify the procedure regarding elderly nursing home residents, provided their safety is assured.

One aspect of Conroy must be mentioned. I am comforted that the court embraced the Public Advocate's request to clearly distinguish severely handicapped persons from the dying. The court expressly declined to authorize decision-making based on assessments of quality of life or social utility. To do so would, according to the court, "create an intolerable risk for socially isolated and defenseless people suffering from physical or mental handicaps."

The court noted the unique difficulties posed by the innumerable variations on Conroy which they did not address, like the case of a severely impaired newborn, a mentally alert quadriplegic who has given up on life, or an adult suffering from a painful and debilitating illness. But the court declined to rule on such cases, again pointing out that the Legislature is better equipped to frame a comprehensive plan to resolve these difficulties.

Where are we in the aftermath of Conroy? The hardest question posed by the death and dying debate has been answered -- all forms of care and treatment can be refused under appropriate circumstances. We now have a workable framework in which to analyze treatment decisions, and a rudimentary procedure to permit decision-making on behalf of elderly incompetent persons has been established. What we need now is comprehensive legislation that brings all of these pieces together and sets forth the procedures necessary to implement them. Beyond this, I personally think we must begin to help people with terminal illnesses spend their final days at home, in a hospice, or in another comforting place, instead of in the sterile and laboratory-like world of a hospital.

Notwithstanding my reservations about a piecemeal legislative approach, I would like to give several examples of the issues this Committee should examine if it proceeds with living will legislation:

All three bills bar relatives and other persons who stand to inherit property from the patient from being witnesses. This prohibition should be extended to include persons financially responsible for the patient's care, nursing home staff, and other facility operators. Senate Bill 2387 requires that in nursing home settings, one witness should be the Division on Aging. In keeping with the Conroy opinion, we believe it would be more appropriate for the Ombudsman to be given the authority in that case, but that concept is an excellent idea.

All three permit the verbal revocation of living wills without regard to the patient's mental state. I am afraid this might be unworkable in practice. How is a doctor to regard the declaration of a semiconscious patient to "help me" or "save me"?

None of the bills require medical certification that the person is incompetent before the living will can be activated. This is necessary and further safeguards might be in order for nursing home patients and residents of State-operated institutions.

All three qualify or limit what treatment can be withdrawn by using terminology that has not been made legally obsolete by Conroy.

None of the bills give mature minors or their parents a say in how they will be treated.

I could go on, but I think these examples illustrate the point that living will legislation involves a host of complex issues which must be studied carefully. There are close to 10 different bills before various committees of the Legislature, and each has its own set of pluses and minuses. At the very least they should be examined together and a composite bill developed.

One final note: The Supreme Court in Conroy observed that the death and dying issue involves an interplay of many disciplines and that "no one person or profession has all of the answers." It is necessary to collect data from a variety of fields and synthesize it into comprehensive legislation which reflects the social values at stake in ways applicable to a variety of cases.

I am hopeful that we in New Jersey can build upon the Conroy decision to show the rest of the nation how to realistically, and yet compassionately, approach the consequences of aging and rapidly developing medical technology. We should not rush ahead and enact legislation in a piecemeal fashion and miss the great opportunity that Conroy presents. For this reason, I believe a Commission on Death and Dying comprised of some of New Jersey's most knowledgeable citizens, directed to examine the broad implications of Conroy and to recommend a complete legislative package, will best serve the needs of our State.

I think in that way we can give real meaning to what we mean by way of the policy of the State to the dignity of life and what that dignity and that life deserve at the moment of death.

Thank you for your attention. I will be happy to answer any questions you may have.

SENATOR LYNCH: Commissioner, I'm sorry. You referred to Senator Dumont's bill and, unfortunately, we do not have that before us. However, your report does not do an analysis of each specific bill. Do you have the number of Senator Dumont's bill by chance?

COMMISSIONER RODRIGUEZ: Yes. Senator Dumont -- as I read the proposed bill -- is the cosponsor with Senator Feldman.

SENATOR LYNCH: Oh, right; I'm sorry. I thought you had him as a prime sponsor of one of the bills. Do I take it, Commissioner, since you start out with the premise that Conroy is not a right-to-die

decision, and that the basic ruling is that patients have a right to determine the course of their treatment-- I take it that you would disagree with the attempts here to limit the scope of this bill to those situations dealing with the brain dead only.

COMMISSIONER RODRIGUEZ: I am slightly confused, Senator, with the words we use stating that there should be a unified framework of reference. If we look at the Quinlan case -- and we have been living with that case now for some seven or eight years -- brain function is divided into, let's say, three separate categories. The main category is the intellectual component. When you remove the intellectual component, you are left with brain stem function. Karen Quinlan is functioning with brain stem function. Let's say that any time you delve into another discipline's words, you have trouble. I am aware of that as you delve into medical profession terminology. But let's say for the purpose of understanding that the intellectual component is missing in Karen Quinlan, and what survives is the brain stem. The brain stem gives rise to the involuntary action. Quinlan, at that level, said that certain decisions could be made with respect to removing treatment -- a respirator. They did not address feeding. So, treatment decisions were made in Quinlan with brain stem function.

The other category is brain death. Now, once the brain stem does not function either, you have brain death, which we know today. It is from that patient that the transplants are taking place, because there is brain death, there is no brain stem, and there is no intellectual component. I would assume when we refer to brain death here that we are saying what the patient has is brain stem activity, in that there is a possibility of living without a respirator, but no intellectual component.

The area where we have to be very careful is where there is brain stem activity. Rigorous guidelines should be set as a matter of policy to determine when those decisions can be made on that patient. If there is the intellectual component, that patient today has the right to make treatment choices. We know that under the concepts of informed consent. So, we have to determine the level of brain activity at which we say the threshold has been passed, which will then dictate when surrogates can make decisions for the patient.

Conroy tells us that the individual has the right to dictate the course of treatment, but not the right to die, because he is not dying. Conroy says you can surrender to a disease. It does not say you can take your life. Now, if we understand that, we know that we are talking about the right to make decisions that are treatment decisions, and not the right to life and death decisions.

That is why I think it will take a comprehensive analysis of the levels we are discussing so the Legislature, as a matter of policy, can say what this dignity of life means at the moment of death, and where the definitions are for the thresholds.

SENATOR LYNCH: Senator Russo?

SENATOR RUSSO: Thank you, Mr. Chairman. Commissioner, do you agree with the concept that we should allow people to surrender to a disease by choice?

COMMISSIONER RODRIGUEZ: Yes, because that has been the rule of New Jersey since we adopted informed consent. A competent person can surrender to a disease. Today in New Jersey, if a person has gangrene of the foot and has informed consent, the doctor can say, "Without an amputation of that foot, you are going to die," and the patient has a right to say, "Well, let me die," as long as he has informed consent. So, that right has been with us now for quite some time.

SENATOR RUSSO: I gather he would have the same right to refuse penicillin in the case of an infection.

COMMISSIONER RODRIGUEZ: Yes. A competent person with informed consent would have that right.

SENATOR RUSSO: Okay. Assume for the moment -- and I am not quarreling at all with that -- that a person has the right to, in effect, say, "I want to die, and the quickest way to do it is to catch pneumonia and not let them give me penicillin or whatever cures pneumonia." Would you then extend that concept to a person who is not able to make that decision for himself, providing a relative or guardian is willing to make the decision for him?

COMMISSIONER RODRIGUEZ: No. See, I want to be very careful about the surrogate decision-making. The Conroy opinion says that the

individual has that right today with informed consent. They specifically say it is not a right-to-die case. A prisoner in New Jersey cannot starve to death. A person who is carrying a child cannot refuse a transfusion if that transfusion will terminate the life of that child.

You can make decisions, but you cannot, even with your informed consent, offend the medical profession, in the sense that you can't go into a hospital and say, "I don't want the transfusion." You have the right to say that, but you don't have the right to say that if you say, "I want surgery, but I don't want a transfusion." You can't handcuff the medical profession to just go halfway.

Conroy says, "If you know the person's intention, his individual intention, and he is close to the moment of death, let that intention rule." The problem is that when you have a surrogate decision-maker, the surrogate decision-maker has to look back to see if he can find out what this person would have wanted, and the degrees of proof are laid out in the opinion. Barring that, the court says, "If equivocal, you suffer on the side of life. You continue life." So, where the court is asking for legislative oversight, it is not really saying that that surrogate can terminate life, because it took from that package the terribly deformed newborn. It took from that package the quadriplegic who wants to give up on life. See, he is not dying. He can't say, "Give me the lethal injection." He can't say to a third party, "Stop feeding me," because he has not reached the threshold of dying, so he doesn't have the right to die. That is why I say it is not a right-to-die opinion.

I think we have to carefully set the guidelines for when we determine a person is competent or incompetent for this decision. Some of these bills allow the revocation orally, but there is missing that step of being very careful to determine the competency level of the patient, because Conroy's opinion says that even though a guardian has been appointed for the purpose of managing affairs, that is not to say-- We still have to look to see if this patient is sufficiently competent to make his own judgment. So, they keep drawing attention to the individual right, leaving open that one category for decision-makers where it becomes so burdensome.

Where can it be burdensome? What do we do with the child who goes into the hospital and says to the parent, or the doctor: "Mommy, I'm afraid to die," and says no more? Under Conroy, a strict reading, all must be done to preserve that life no matter what means or methods, because if you can take that to be the knowledgeable will of the patient, you can't terminate life. So, it depends on how you read it. But, it touches on so many sensitive and emotional areas that it calls for a deep analysis, because it is not just a will making. This is a good first step, and we are for it if properly composed. But there is so much more in that opinion that has to be addressed, and should be addressed by a compassionate society. That is basically what we are saying. The issues are not simply about will making; they are death and dying issues.

SENATOR RUSSO: Well, you know, one of the difficulties-- For example, you said -- and I gather that you accept the Conroy decision and rationale -- where the patient has reached the threshold of dying, as you put it. I think, though, that clearly we are going to agree, without any question, that you do not cross some point where a green light goes up instead of a red one saying we have now reached that threshold. That threshold is probably going to be one of the most debated and difficult things to determine that one can imagine, isn't it?

COMMISSIONER RODRIGUEZ: Well, I think once you introduce the definition of terminal-- See, terminal is used in this opinion. Let's take for instance a very young person who suffers horrible injuries in an accident. He is otherwise healthy. When he goes into the hospital, all must be done to preserve that life, no matter how painful the administration of medication. When you say "terminal," something new has occurred. What has occurred is a dying process, not a variety of illnesses that you say eventually he will die from, but he is dying. Now, if he is dying, we then have to understand what is occurring to the body. Is it possible -- and this is one of the issues which was raised in the Conroy argument -- to stop feeding a patient who is dying? We argued the distinction between basic care and treatment. A compassionate society can never stop loving a person and must give him

the basic care that he deserves. What is feeding? Is it treatment, or is it basic care? The court has indicated it is part of treatment in the category that they obliterated. If a person is dying and his kidneys are shutting down, if you continue to try to hydrate that body, you will drown it. That feeding becomes a burdensome intervention, and it should never be called for simply to be humane.

So, what we ask is -- and several bills refer to feeding -- what is occurring to the body? What treatment is indicated? What is the will of the patient? Yes, it may be difficult, but I think if we are going to address it-- See, it is addressed now in the opinion and people will be working within the four corners of the Conroy opinion. If it needs polish to demonstrate the policy judgment of this Legislature and this State, I think a commission should look at the full picture as we perhaps address living will legislation. Perhaps we should polish durable power legislation. More importantly, we should be sure that we put protective guidelines into place for people we do not want to put on a slippery slope. The court did say in Conroy that handicapped persons, no matter how serious their disability, are not dying, and you cannot touch them under this opinion if you try. The issue is, close to the moment of death. Incidentally, Senator, in that opinion, they indicated that regarding treatment conditions in nursing homes, the time frame in which death would occur should be projected to within one year. Now, that may be difficult to determine, but they want to make sure that these are dying decisions that are being made.

SENATOR RUSSO: Well, you know, the interesting problem, and one that I have a great deal of difficulty with, is the analogy to your arguments on the capital punishment bill. I find myself now in a reversal of roles with you. You argued at that time -- as I recall -- that one of the dangers of capital punishment was the possibility that we might execute someone who was not really guilty. So, we tried to meet that by making the bill so strong that it would not be likely to happen. We are in the same situation now. I think you will agree with me that there have been instances where a person who came within the definition of Conroy as being hopelessly terminally ill, who could never recover, did, in fact, recover. How, why, we don't know. The

religious say these are miracles; medical science says there is an explanation. But, it has happened.

I find myself now with the same concern you had on another issue. Might we not be terminating the life of someone who might otherwise not have died, even though this would be extreme, unless, of course, we have irreversible brain damage? Now, with that, I will not accept the argument that anyone has ever recovered. At least I have never even seen an allocation made that anyone with irreversible brain damage -- anyone brain dead -- ever recovered from it. That is why I can be comfortable with having a death with dignity law when you have brain death. But, short of that, under the situations in Conroy, I am awfully concerned that we might be taking a step that our society has never taken. The surrender to a disease argument has got me terribly perplexed because what do you do in a situation where a competent person says, "I don't want penicillin for my pneumonia." Then he says to his guardians, or whomever, or anyone else who will listen, "Look, if I lose consciousness, I don't want penicillin for this." We know what his wishes are, and he now becomes terminally ill with pneumonia. Aren't we in a situation then, under those circumstances, under the legislation we are talking about, or Conroy, where we can hold back penicillin from him, because he has made his intentions clear? Or, am I missing something? That may well be.

COMMISSIONER RODRIGUEZ: Senator, what we then have to determine-- See, let's understand that under informed consent, the patient has that right today. Will you take away that right because he becomes unconscious, if he clearly tells you that he still wants that right after he is unconscious?

That is a very different issue. I don't think that right will be taken away from him in either Conroy or Quinlan, because he is exercising the treatment decision. When I say surrendering to a disease, I say that almost as a word of art for this reason: If you accept that I talk about surrendering to a disease, you have immunized my clients. My clients are the mentally retarded in institutions. They are not dying. The severely handicapped in Totowa are not dying. They have serious disabilities which are going to accompany them to the

grave. They do not yet have the medical judgment that we should have before we use the word "terminal" as a diagnosis.

Now, terminal is a specific body function, or body inability, that is leading them to the grave. Therefore, all of the handicapped and mentally retarded are preserved. The elderly in nursing homes are preserved, unless someone says they are dying. Now, I want to know what that dying means. If treatment decisions are made for the dying, a competent has a right to say, "I don't want," or "I want." If he now becomes incompetent-- If he had the right while competent and could clearly demonstrate that that was what he meant, almost with the same informed consent in the process of dying, then it should be honored. You don't want to take someone's life who doesn't want to die. I always say, "We shouldn't take anyone's life who doesn't want to die." That is consistent with our argument on capital punishment, because society is taking it, and it is a healthy person. So, it is not part of this.

Now you are looking at that dying person. He can make treatment decisions because he has that right. He is not incompetent; he is unconscious. You can make judgments if he doesn't want treatment, yielding to the disease. As the kidneys shut down, you give no further water. He no longer needs whatever medication because the body is rejecting it. The body is almost telling you, in an unstated way, that it doesn't need the treatment. These are things that happen to terminal patients. Yet, we are using these as laymen and lawyers. Probably if there are any doctors in the crowd, the hair on the back of their heads is standing up as we play with these concepts. But they are important, because each concept crosses a threshold.

SENATOR RUSSO: Well, you know, you keep talking about the informed patient, the conscious patient. Forget that for the moment. I do not dispute with you on that. Let's assume that for six months a patient insists he will not take penicillin. I use that as an example. He says, "I will not take it; I will not take it; I will not take it." He has that right, as you said. Now, he lapses into unconsciousness. I gather what you are saying is-- And, he also drew his will and it said, "I don't want penicillin," or whatever you want

to say. Then society should not inject him with penicillin after he lapses into unconsciousness because he has made it clear that he didn't want it. Do I correctly understand your view?

COMMISSIONER RODRIGUEZ: Because that is the state of the law today, yes.

SENATOR RUSSO: Even after he is unconscious that is the state of the law today?

COMMISSIONER RODRIGUEZ: That is the state of the law as a result of the--

SENATOR RUSSO: (interrupting) Stay there for just a minute because I may have just learned something I didn't know. I do that every day. If that is so, why do we have the Conroy or any other decision? All we need is the patient, unless you mean that is the state of the law under Conroy--

COMMISSIONER RODRIGUEZ: (interrupting) Yes, it is the state of the law today.

SENATOR RUSSO: Okay, all right, because of the Conroy decision. Our concern here is whether that should be the law. It is your position that under the hypothesis I just gave you, our legislation should be so drafted that we will not give that person the penicillin.

COMMISSIONER RODRIGUEZ: I think the legislation you have drafted gives the patient the right to make that judgment on penicillin now, even under your legislation.

SENATOR RUSSO: Bear in mind that my legislation, as drafted, will not be the legislation that I will present to this Committee for a vote. I stated in the beginning, as basically all three Senators did, that the legislation will only apply where there is irreversible brain damage, or brain death. Okay? So, it is kind of unfair, because you came here expecting to address yourself to one thing, and we sort of changed the rules of the game on you real quick. With that consideration in mind, and the rules now being changed, I am proposing to this Committee that the right-to-die legislation only apply where, in fact, there is irreversible brain damage, or brain death.

Would you agree with that approach, or do you think it should apply to something beyond that?

COMMISSIONER RODRIGUEZ: Let's take this person you are talking about with the penicillin. He is competent and alive; he has the right to make the judgment; and, he doesn't get the penicillin. He now lapses into unconsciousness and has a diagnosis made of irreversible intellectual brain death, which is the Quinlan level. He has made that judgment before.

SENATOR RUSSO: Well, he doesn't have to have made that judgment before.

COMMISSIONER RODRIGUEZ: Well, let's assume he did.

SENATOR RUSSO: Okay.

COMMISSIONER RODRIGUEZ: That is the brain death I think you are referring to. You would honor his wish about the penicillin in the three pieces of legislation which are before us now.

SENATOR RUSSO: Correct.

COMMISSIONER RODRIGUEZ: And, I agree with that. See, the brain death that we do not want to confuse is when even the brain stem has terminated, because that is where we do work with transplants. We maintain that person on a respirator just to continue to oxygenate the organ before we remove it. That is brain death. Brain death plus one is brain stem. That is what I think we are talking about. Permanent unconsciousness, no intellectual component, brain stem activity -- here is the judgment making we are talking about. We are taking organs today without any concern because there is no possibility of anything. The serious problem is-- Incidentally, in the Conroy case the court ruled that Claire Conroy, if alive, would not have met the test to have her life terminated and would have to meet the proofs. Even though they reversed the Appellate Division, they agreed with some of our concerns that the record below was loose with respect to the neurological findings of Claire Conroy. The court agreed. Why? Because you can't guess whether the brain stem is mimicking the intellectual component; you need very clear neurological testing. The bills provide for the diagnosis. Once they drop into that brain stem, they are never going to have the intellectual component. This is where the decision-making takes place. You will permit it under the three bills, so I have no problem with that.

SENATOR LYNCH: Commissioner, let me interrupt for a second because I don't know how long we can debate this issue. It seems to me there needs to be some clarification on the answer to Senator Russo's question, if you can address the question itself. Maybe this doesn't have any practical effect on the medical realities, but when Senator Russo spoke about a patient who had pneumonia, who made a declaration or whatever it is that he didn't want to be treated with penicillin, and he lapsed into unconsciousness, he is not brain dead; he is not at that level or at that point where it is irreversible in any fashion. I think the question was, in the first instance, can that person have made that decision, and do the hospital, the doctors, and the technicians have to honor that decision knowing that they are not dealing with a brain dead, irreversible brain damaged patient? It may ultimately lead to that, but I'm talking about a patient who is headed downhill quickly if he or she is not treated with penicillin.

COMMISSIONER RODRIGUEZ: You would honor that wish. The confusion--

SENATOR LYNCH: (interrupting) You would honor the wish by not treating him?

COMMISSIONER RODRIGUEZ: By not treating him.

SENATOR LYNCH: And that is what you say the existing law is as a result of Quinlan and Conroy?

COMMISSIONER RODRIGUEZ: And what the three bills envision.

SENATOR LYNCH: Is this the practice that is going on in hospitals with the medical profession today?

COMMISSIONER RODRIGUEZ: Well, no. See, in the medical profession there is confusion. That is the very reason why it has to be addressed. Senator, not to leave that point, but I will comment this way. If you say unconsciousness but not irreversible unconsciousness, you have to be very careful with that label.

SENATOR LYNCH: I'm assuming that it is not irreversible. That is the question.

COMMISSIONER RODRIGUEZ: Well, no, there you would want to be careful because if he has the ability to regain consciousness, you want to be sure you are dealing with the last competent wish. That is why

you need that neurological evaluation. If there is a chance to be bouncing back and forth, you do not really trigger what you are doing in these bills. You trigger it only when it becomes irreversible. At that point then, the living will moves in. That is why--

SENATOR LYNCH: (interrupting) The question that was raised by Senator Russo is really not dealt with in the context of this bill. It is something that is a matter of practice, but yet on the other hand, you indicate that we need to answer those questions.

COMMISSIONER RODRIGUEZ: No, it is dealt with in the bill.

SENATOR LYNCH: How is it dealt with?

COMMISSIONER RODRIGUEZ: If he leaves it as his last direction with respect to treatment and then lapses into unconsciousness that is irreversible--

SENATOR LYNCH: (interrupting) If it is not irreversible?

COMMISSIONER RODRIGUEZ: Then he is still not at the category that you are asking him to be--

SENATOR LYNCH: (interrupting) Then, it is not covered in the bill. And, you say it is not covered in medical practice. So, where is it?

COMMISSIONER RODRIGUEZ: Well, in medical practice today what they would probably do would be to continue to give the penicillin.

SENATOR LYNCH: Not continue; you mean start to give the penicillin.

COMMISSIONER RODRIGUEZ: Probably some would start, but they would do it in a great sense of confusion, because see, the--

SENATOR LYNCH: (interrupting) So, there is a problem, and this bill doesn't address it because we are not dealing with irreversible brain damage. So it is purely self-determination, and that depends on whether the medical profession in that area or that hospital decides to handle it one way or the other.

COMMISSIONER RODRIGUEZ: If it understands what it is that is being done. It is not handled in a uniform way. I think we have to give them some uniformity.

SENATOR LYNCH: Then, we have a problem. Is that what you're saying?

COMMISSIONER RODRIGUEZ: That is why what I am trying to do here today is indicate the variety of problems and why there should be a commission to study it in a comprehensive manner.

SENATOR LYNCH: We heard that. Senator Zane, do you have a question?

SENATOR ZANE: Yes, I have a couple of things which concern me. Number one, I am a bit surprised, and I am not so sure I agree with the decision of the sponsor to limit it only to situations where there is brain damage. At the same time, I am also concerned with what the Commissioner said, which I also understand to be the state of the law, that someone can refuse penicillin. It strikes me that somehow there should be some safeguards when there is something that is-- I think the mortality rate for pneumonia, as the example given, without treatment is somewhere in the neighborhood of 50%. I think with penicillin, if there are no other complications in a reasonably healthy person, recovery is almost assured. Somehow there should be some provision that where medical science is at such a level that recovery would certainly be anticipated, that that right should not be given to anyone. That is the thought I have on that.

Commissioner, a question I have is -- and this may go beyond what you are addressing -- you mentioned the mature, competent minor and his parents. What do they do? Something that concerns me -- not knowing exactly in what form this bill will come out, because I guess with brain death, as Senator Russo mentioned, it might not even apply -- is the parents, and possibly this mature adult minor, who have religious problems with any form of medical treatment. I believe there are such religions. I think we are all familiar with cases where parents have been brought into court because of not wishing a child to have a transfusion or, I guess, not wishing a child to have certain medication. It strikes me that somewhere along that line, again not knowing if the bill is going to come out in the form that Senator Russo suggested, there should be some sort of a safeguard. What was your thinking when you were talking in terms of the minor -- the competent minor, as you said -- and the rights of his parents? How would you separate that out? Do you have any suggestions for instances where

there might be one of those religions involved which does not accept medical science?

COMMISSIONER RODRIGUEZ: Senator, the state of the law today is-- When I talk about informed consent and the fact that the person can make his own treatment decisions, a person because of religious beliefs can refuse to have a blood transfusion. But if parents bring their child to the hospital, they cannot impose that refusal on the child. The hospital will treat the child. It will take the child away from the custody of the parents and give him or her the transfusion.

So, that part of it today is pretty clear. As a matter of fact, if a woman is expecting and can, by Caesarean section, deliver a healthy child, and she refuses the surgery, some courts have enforced the surgery because the child is the innocent victim. Where do we then have a concern? The concern comes when we now take that infant who has the right to wait until he becomes an adult to make his own judgment, and cross a threshold with it. That threshold you are now crossing is a place where that child is now dying -- not handicapped, dying. The terminal process is taking place. The parent has a right to tell the doctor that he has a right. One thing the doctors do not have in their bags of cures is the white flag of surrender. There are times when the treatment becomes more oppressive than letting the child alone.

At that threshold, the parent has a right to measure the burden of dying -- not handicap, not serious illness, dying; at that point, in a moment of compassion, a right to make treatment decisions for that child because death is overcoming the child.

Another situation is where that child can be saved by whatever means. That child does not get put into the decision-making category in either Quinlan or Conroy. That is why I'm saying that as we talk about these terms and these areas, these areas have to be very carefully carved out so that as a matter of policy we only put that infant past the threshold that the Legislature dictates for decision-making. But, we cannot say, "Always do everything," because if that infant's kidneys shut down, to continue hydration is torturing the child into drowning. That is a medical statement, but that means we cannot impose legislation that will create inhumane conditions.

Therefore, it very clearly calls for a combination of legal, medical, legislative, societal, and health care providers to more clearly define these thresholds on what it is we are getting into, before we use words like terminal, dying, treatment, and withholding.

That is basically what I am trying to say, Senator. I am not trying to give you all of the answers. I know where the law is today, and I want to reflect, because we are the lawyers in the case, that we need a careful study as a result of Conroy.

SENATOR LYNCH: Are there any other questions? Senator O'Connor?

SENATOR O'CONNOR: I do not have a question, Mr. Chairman, but an observation. I think that the example that Senator Russo posits about the person refusing penicillin and suffering from pneumonia would still be covered by all of the bills, or at least by S-2387 and S-875, because of their definition of terminal condition, that being an incurable condition. In that situation, all you have to do is start giving the person the penicillin and the situation can be reversed. I think the way a terminal condition is defined, we still do deal with it under your bills.

SENATOR LYNCH: Do you think the bills would change something that is out there now where a doctor would be able to inject penicillin once a person lapses into a coma, if he had refused treatment before? What does he do then?

SENATOR O'CONNOR: I don't know.

SENATOR LYNCH: Is he going to hit the patient with chemotherapy when he refused chemotherapy before without the bill?

SENATOR RUSSO: That is where the bill doesn't cover it. I don't think it does. I don't think the Commissioner says that it does with those issues.

SENATOR VAN WAGNER: Would you please clarify the point that was made, because I am not quite sure I understand what the distinction was in the example given by Senator O'Connor as opposed to the--

SENATOR LYNCH: One is reversible. In one situation, there is a condition where death is inevitable and the situation is not reversible. In the other situation, by the giving of medication, it would be reversible.

SENATOR VAN WAGNER: I thought you were addressing the fact that if the patient had indicated a wish not to have that medication administered and then lapsed into unconsciousness, later, under medical advice, the medication could, in fact, be administered.

SENATOR LYNCH: I think we're saying that that isn't covered by these bills at the present time because, as Senator O'Connor indicated, by definition, these bills are only dealing with a situation that is irreversible, regardless of whether or not they are amended to conform to Senator Russo's wishes.

SENATOR ZANE: Senator Lynch?

SENATOR LYNCH: Senator Zane.

SENATOR ZANE: I think Senator O'Connor is indicating -- if I understood him reading from the comments -- just the opposite. He is talking in terms of where, by definition, the illness would have to be incurable, and it is pretty clearly recognized -- which is what I was alluding to before -- that someone with pneumonia is very, very likely to be cured with penicillin; therefore, not covered by this; therefore, contrary to what is existing law, that being the right of the individual to refuse that treatment. So, I think he is pointing out and resolving a concern I had. I think the bill is giving greater safeguards in that area so the bill ends up in that final form, but it is apparently also changing what is present law, which I happen to think is a step in the right direction. I think the present law allowing someone to refuse penicillin, if their only problem is pneumonia--

SENATOR LYNCH: (interrupting) Do you think that is wrong?

SENATOR ZANE: Yes.

SENATOR LYNCH: I don't see how this bill would change that anyhow because it doesn't speak to it. So, specifically, since it doesn't speak to it, it is not going to change the current law. Secondly, I don't know how you can go that far into not letting a person have self-determination. Are you going to tell him he has to take chemotherapy if he does not want it, if he lapses into a coma? Would it be the same with any kind of treatment a person didn't want?

SENATOR ZANE: If the state of the art of chemotherapy was to the level that someone taking the chemotherapy had a great assurance that he was going to be cured, yes, I think he should have to. I hate to get into chemotherapy because that is so far off. With penicillin, it is such a simple thing that is easily administered, and it does, in fact, cure pneumonia. And the bill, by definition, as I understand it, unless the comments are incorrect, says that for this to apply, the disease, illness, or injury must be incurable.

SENATOR LYNCH: Exactly, so it doesn't cover the other situation.

SENATOR ZANE: To the contrary, pneumonia with penicillin is curable.

SENATOR DiFRANCESCO: The definition speaks to incurable, even if you do something to prolong it.

SENATOR LYNCH: These bills cover beyond the scope of what they seek to address, but by inference they do not clarify the problem of existing law that the Commissioner referred to.

COMMISSIONER RODRIGUEZ: If I may, Senator, not to interrupt-- Again, only for clarification, what might be the concern there? The patient says, "If I reach a certain level of irreversible brain damage." Now, you are going to give him penicillin, which he chooses not to have, because you say you are going to cure the pneumonia. You have cured the pneumonia, but he is still irrevocably brain damaged. You have not cured what it is that has made him brain damaged. So, you are maintaining him at a level where he is telling you he does not want to be maintained, even if it means refusing the penicillin. You have not cured him. Have I made the distinction? You see, you are putting him back into his level of permanent unconsciousness for a more permanent period, having violated his wish not to have the penicillin, not that the penicillin was going to be a cure.

SENATOR LYNCH: Are there any other questions? (negative response) Thank you very much, Commissioner.

COMMISSIONER RODRIGUEZ: Thank you very much.

SENATOR LYNCH: Our next speaker will be Jack D'Ambrosio, Ombudsman for the Institutionalized Elderly.

JACK. R. D'AMBROSIO, JR.: Thank you, Mr. Chairman and members of the Committee. I will be brief because I know there are a lot of people who are here to speak today.

I would like to begin by commending the Committee for holding today's hearing on this most controversial and important issue. It is an issue that deserves careful study and analysis, and giving the public an opportunity to be heard is essential in understanding the many sides of this issue.

I would also like to take this opportunity to applaud the New Jersey Supreme Court for its recent decision in the matter of Claire Conroy. This decision addresses a most difficult and serious dilemma by outlining guidelines for deciding whether to continue life-sustaining treatment for the terminally ill. Great effort was taken to point out that these guidelines address only the situation and the particular facts before the Court. It is clearly stated, however, that there are many other situations with different circumstances that should be addressed and for which procedures should be established. The Court suggested that the Legislature is best equipped for many reasons to study and review these other situations, and then to act in doing what is necessary to resolve the problems presented to them. I wholeheartedly agree with this recommendation, and I congratulate those legislators who attempted these resolutions even before the challenge was given.

The Court warns that the Legislature should move slowly and gain experience in this highly sensitive area. While I agree with this warning, I would also point out that the Legislature should not move too slowly, because I believe that there are many who would admit that everyday, and possibly at this very moment, all across this nation, there are "Do Not Resuscitate" orders being given. There are requests for over-medication from sympathetic families, and there are physicians and medical personnel faced with dilemmas that no one should have to face alone; that is, the dilemma of the patient asking to die, and the physician trapped between what the law requires and what the patient wants. We must realistically deal with the situation because it will not go away. Procedures must be established that will create checks

and balances for all of the interested parties who will participate in making a decision for someone who is not able to make that decision for himself or herself.

As a beginning, I would urge the Legislature to be consistent with the Common Law in recognizing the legal right of self-determination. In New Jersey, we must create a procedure that enables a patient to effectively assert his right to refuse treatment. After a lifetime of deciding how to live, one should be able to decide how to die. I believe that the right of a competent adult to write a living will, or some similar legal document that will have the same effect, is absolutely essential. Such written documents will serve to make the jobs of physicians, hospitals, and other health-care facilities less difficult when addressing the decision of whether or not to use life-prolonging equipment. They will facilitate the fulfillment of the declarant's wishes. In fact, shouldn't those wishes be the most important consideration in arriving at an ultimate decision?

There are no easy answers to the many questions that will be raised here today, and there are no easy answers for the many families facing the subject of this Senate Judiciary Committee hearing. I hope that the comments made here today by representatives for all sides of the issue of the right to refuse treatment will, in some way, give added strength to the Legislature, so that this most serious dilemma can be dealt with.

Thank you for your time.

SENATOR LYNCH: Are there any questions from any members of the Committee? (negative response) Thank you very much.

MR. D'AMBROSIO: Thank you.

SENATOR LYNCH: Our next speaker on the list is Elmer Matthews representing the New Jersey Catholic Conference.

Good morning, sir.

ELMER MATTHEWS: Good morning, Senator. Mr. Chairman and members of the Senate Judiciary Committee, I appreciate the opportunity to appear before you this morning. I realize your list of speakers is long, so I will not abuse a privilege I trust.

I get a little feeling of deja vu sitting here before you because I can remember, only three years ago, discussing this very subject before the Senate Judiciary Committee with regard to Senator Russo's bill, and also before the Assembly Judiciary Committee to discuss living will legislation. The result of those hearings was, at that time, that these Committees didn't feel that living will legislation was necessary.

Since that time, the President's Committee on Biomedical Research and Ethics conducted extensive studies and arrived at no real conclusion in the area of living will legislation, although they were stronger in the area of the de-power of attorney.

Interestingly enough, with all of this studying, New Jersey has been the focus State in America on these issues. It is probably more attributable to our New Jersey Supreme Court decision in the Quinlan case more than anything else. You will recall that after the Quinlan case, a state of bills were introduced in the Legislature to try, again, to confront the problem. This Legislature, in its wisdom, chose not to legislate, but to follow the tests and the leads as laid down by our Supreme Court in the Quinlan case. Those tests, leads, and procedures have served us well over the years.

The Conroy case came on the scene about 18 months ago, and, of course, it was considered by the Supreme Court. Now we have a new set of rules and guidelines -- a new set of theories, if you will -- about this whole problem of death and dying. I just wonder how we got there. Why are we where we are today?

Interestingly enough, with the progress in medical science, it has become more and more evident that maintenance therapy seems to have caught up with and passed the curative ability of the medical profession.

Over the years, all of these decisions have been made in hospitals and even nursing home situations with the doctors and the patients participating in these decisions. In those areas where the patient is comatose, many times the decisions are made by the family, the treating physician, and the consulting physician. It only appeared that in those cases where disagreement existed between the family, the

patient, and the medical physician that these cases found their way into our courts.

But, we must never lose sight of the fact that the basic decision in all of these matters, no matter what is legislated and no matter what the courts decide, has to be made by the medical profession in order to create the scene under which these decisions are going to be made.

The previous witnesses testified about the treatment that can be administered in specific situations. I don't think we can lose sight of the fact that what we are talking about here is treatment in the face of imminent death. Quinlan and Conroy were both placed in that frame of reference.

What we should approach here is a situation where death is imminent, not a situation where the patient feels that the comforts of life no longer exist and he would like to surrender them.

We must be very, very careful in our zeal to face the problem that faces us today, and that we do not do harm where we intend to do good. The bills before the Committee this morning are all well-intentioned bills. I don't say that in a condescending manner, because they really are well-intentioned. They attempt to face a problem, but interestingly enough, they all have a genesis in other jurisdictions, and in some cases, in other motivations.

I think Senator Russo's bill, which we discussed before this Committee about three years ago, first appeared in New Jersey in an appendix or an article in The Seton Hall Law Journal. That legislation originally came from an organization in New York that drafted it under the name of "Concern for Dying." Their former title was The Youth and Aging Society. The Russo bill also appears in the appendix of the President's Commission on Biomedical Research.

The bill that is sponsored by Senator Feldman and Senator Dumont appears, to a great extent, again, in the appendix of the President's Commission on Biomedical Research, and seems to attract most accurately legislation that is now extant in the State of Washington.

These are all products of other jurisdictions. Perhaps it is time though for New Jersey to approach the problem in its own jurisdiction, and to not only look at Senator Russo's bill, Senator Feldman's bill, Senator Hurley's bill, and Assemblyman Wiedel's bill, but to look at it from the standpoint of, "What do these bills mean to the people of New Jersey?" In looking at these bills, there are certain things that we must concern ourselves with. First of all, we must respect the dignity of a person's life, but I hasten to add, if we cannot in our zeal prolong life, we must not degrade it in a misguided attempt to defeat that. We have to realize that death will come, and sickness that creates the imminence of death is the situation under which we should be acting in this legislation.

Some of the questions that were posed to the Public Advocate raised some of these issues. For example, what is a terminal illness? Hardly pneumonia. But, is myasthenia gravis or muscular dystrophy considered a terminal illness? By medical definition, the answer is yes, but not in the thoughts of this Legislature, I hope, in framing bills of this kind.

What are life-sustaining procedures? This question was the subject of discussion in the Conroy case. Is dialysis a life-sustaining procedure? Is nutrition? Is oxygen?

All of these things must be dealt with. How does this Legislature hope to treat the idea of familial relationships to the patient? I have difficulty carving out of the decision-making process the spouses and the children -- all of the relatives of a patient -- under perhaps the misguided idea that anyone who is related to the patient has the idea in the back of his mind that he might be the recipient of a bequest or a devise. I think that with the concern that we, as a jurisdiction, have for family life and for the dignity of people, it would behoove us not to be too ready to carve those people out of consideration in legislation of this type.

We also have to look at--

SENATOR RUSSO: (interrupting) May I interrupt you for a moment?

MR. MATTHEWS: Sure.

SENATOR RUSSO: How would the amendment I proposed-- How would you feel if the bill were amended to read "only irreversible brain damage?"

MR. MATTHEWS: To be very candid with you, Senator, I would have some problems with that.

SENATOR RUSSO: You would?

MR. MATTHEWS: I bring you back to the consideration of your bill that this Committee had on the definition of death, a bill which was conditionally vetoed by the Governor and never did become law because the Legislature never acted on it.

We define death -- I say "we," and I am using it arbitrarily as you did and the President's Commission did -- as the cessation of all brain activity, including the brain stem. Now, when that happens, a person is dead. Forty jurisdictions, I think, now have laws on their books to that effect, so I don't think it enters into this type of situation. Where you have brain stem death, you don't need legislation of this type. What you are talking about is the mechanics of taking a cadaver off of a respirator.

If you want to redefine brain death -- to go back through the levels as Joe Rodriguez attempted to do, to go back through the levels of the brain, to the second level and to the first level, and to go back into a simple unconsciousness -- I think you will have real problems. I think you have the problem in a nursing home because you have to use sophisticated equipment in order to define whether or not a person is brain dead.

Brain death was discussed in the Quinlan case. They used the Harvard encephalogram test where there was a flat brain wave over a certain amount of hours; I think it was 24 or 36 hours. That was a determination of brain death which incorporated the death of the brain stem. I know it is improper for a witness to ask a question of the presiding officer of a committee, but when you define brain death, are you defining the same kind of brain death you are talking about in the bill you sponsored two years ago?

SENATOR RUSSO: Well, I suspect so, yes, subject to further discussion with the Committee and hearing other witnesses. What I am

really trying to get at is a bottom line. I thought -- at least I was certain in my own mind, but I was wrong -- that at least those you represented would agree that if this bill were amended to provide that when brain death had occurred, then the life support systems could be terminated.

MR. MATTHEWS: We did endorse your determination of that bill, if you will recall. I testified in favor of it in this very room.

SENATOR RUSSO: Right, but that is not law, so we don't have a determination of death definition. I question you: If we amend these bills so that they only apply where there is brain death -- when a person is brain dead -- would you then still object to them?

MR. MATTHEWS: I don't think anyone could object to that bill because, as I said, you are just removing apparatus -- a ventilator -- from a cadaver.

SENATOR RUSSO: Okay. You know, some people would agree with that, and some wouldn't. Since we don't have a definition of death law in New Jersey, we can't assume anything. So, you have no difficulty with that?

MR. MATTHEWS: No, but what I am saying is, you are solving a different problem with that bill.

SENATOR RUSSO: Whatever we are solving, you don't object to it?

MR. MATTHEWS: I don't object to your determination of death definition, no.

SENATOR RUSSO: Okay. Now, the next question is: Do you clearly oppose the bills as they exist without amendment?

MR. MATTHEWS: There is no question about it.

SENATOR RUSSO: Am I correct that you oppose those bills on the basis that there is life and anything that terminates life-support systems to allow death to occur--

MR. MATTHEWS: (interrupting) Rather than fence on this whole thing, basically what my position would be is this: We are now faced with a situation where perhaps this Legislature ought to explore living will legislation. I think in light of the Conroy case, enough

is out there for grabs to make it time for the Legislature to exercise its function and to make a determination.

SENATOR RUSSO: You don't agree with the Conroy case, do you?

MR. MATTHEWS: That is a difficult answer to give you because there are some sections of the Conroy case that I agree with, and there are some sections I don't agree with. I am concerned about the one-year provision.

SENATOR RUSSO: Mr. Matthews, as far as the Conroy case is concerned, would you want the law to remain as is?

MR. MATTHEWS: No, I think the Legislature should act.

SENATOR RUSSO: You would not want these bills to be passed in their present form without amendment?

MR. MATTHEWS: Absolutely not.

SENATOR RUSSO: You have no problem if they are amended to include irreversible brain damage, regardless of which problem it solves. Is that correct?

MR. MATTHEWS: No, that is not right.

SENATOR RUSSO: That is not right?

MR. MATTHEWS: It is because I don't think--

SENATOR RUSSO: (interrupting) The next time I get the correct favorable answer from you on a question, I'll stop right there, and I won't ask it again.

Now, let me go through that once more. If these bills were amended so that they would only take effect when there was brain death, and only then would we terminate life-support systems, do you or do you not oppose those kinds of bills?

MR. MATTHEWS: I would probably oppose them because they would be meaningless. I would endorse a definition-of-death bill, but not a living will bill. John, we are talking about different things. We are talking about apples and oranges, as I said on the Assembly floor last week.

SENATOR RUSSO: You would oppose it because it is nothing more than chicken soup. It does no harm nor any good. Is that right?

MR. MATTHEWS: Right.

SENATOR RUSSO: Okay, that is clear. Have you put together any suggestions for us, since you agree that we should meet this issue?

MR. MATTHEWS: I was prepared this morning to critique every one of the bills that have been introduced, but I think in the interest of time and in the interest of another recommendation I am going to make, that to critique them is not the answer.

I was going through some of the problems I saw in the bill when you interrupted me and asked me a question.

In the final analysis, what I would like to see is -- given the tremendous indecision that exists even here this morning about what should be the content of this legislation -- this Legislature, or the Administration and the Legislature jointly, set up some sort of a blue-ribbon commission along the lines of what Mr. Rodriguez indicated, and to report back within a certain period of time. This blue-ribbon commission should not just be made up of legislators, although I have respect for the legislative staff. I think we should add the medical profession to it -- possibly administrators, theologians, attorneys, doctors, and other interested parties -- so that we can come up with some sort of a recommendation that this Legislature could endorse.

SENATOR RUSSO: Okay. Mr. Matthews, your first suggestion is this commission. Since we won't complete this hearing today, in addition to that, if you would like to present your thoughts as to what the legislation should say, we would be happy to receive them.

MR. MATTHEWS: I would be very happy to critique every individual bill if you like.

SENATOR RUSSO: No, I didn't ask you that. I asked you if you would like to tell us what you think the bill should say. That is all.

MR. MATTHEWS: I would be glad to do that too.

SENATOR RUSSO: That is more positive than telling us what we did wrong. Okay?

MR. MATTHEWS: Okay.

SENATOR RUSSO: Thanks, Elmer.

MR. MATTHEWS: Thanks, John.

SENATOR RUSSO: We will be having another-- I'm sorry, are there any other questions from any member of the Committee? (no response) We will be having another hearing, so there will be time for that.

Are there any other questions? Senator DiFrancesco?

SENATOR DiFRANCESCO: No, not of Elmer.

SENATOR RUSSO: Okay, thanks, Elmer. Senator DiFrancesco?

SENATOR DiFRANCESCO: I would like to ask you a question in-between witnesses. You are going to address the concept of the written declaration in your bill no matter what, aren't you?

SENATOR RUSSO: I would assume so.

SENATOR DiFRANCESCO: This is a written declaration. This can be made even before anyone becomes ill. Is that correct?

SENATOR RUSSO: That is correct.

SENATOR DiFRANCESCO: All right.

SENATOR RUSSO: Joseph Henry, New Jersey Hospital Association? If you have a written statement, we would like to ask you to present it and then summarize. Obviously, there are many, many witnesses, and we are not going to be able to even make a dent in them today. There is no sense in reading a five-, six-, or seven-page statement; we can read it just as easily ourselves.

SENATOR DiFRANCESCO: By the way, will you have Elmer put something in writing?

SENATOR RUSSO: I suggested to him-- Did he leave? Oh, he left. Senator DiFrancesco suggests that he put something in writing to us as to what he thinks the bill should contain.

Mr. Henry?

JOSEPH HENRY: Thank you, sir. The membership and the agencies of the New Jersey Hospital Association are currently studying and analyzing, to the best of their ability, with all the help they can get across the State, all of the issues that are involved in these very, very sensitive items of legislation. Our studies have produced some concerns up to date, and many of them have been expressed here already this morning.

We would be much obliged if we could have the opportunity to present our findings, recommendations, and suggestions at a later date for the Committee's consideration. In the meantime, I would like to introduce Mrs. Betty Sanderson of the Monmouth Medical Center in Long Branch, who has had much experience and exposure to the issues we are talking about in these proposed items of legislation. If you please?

BETTY SANDERSON: Thank you. The remarks I am going to make today were prepared in conjunction with Dr. Kern, who is chairman of our Prognosis Committee and Director of the Department of Medicine at the hospital.

SENATOR RUSSO: Is that J. Kern?

MRS. SANDERSON: Yes, J. Kern. We, at Monmouth Medical Center, have been attempting to develop guidelines for the care of our hopelessly ill patients for the past two years, and our tasks have been made particularly difficult because there isn't any appropriate legislation, as you are all well aware.

The recent Conroy decision is helpful to us, and if it could be extended to include hospitals, that would probably meet most of our present needs. However, if you proceed with legislation, we would like to support the efforts, at least in the bills I have in front of me of Senators Russo, Feldman, Dumont, and Hurley.

I am not prepared to support, however, the bill as you have indicated you would change it. I certainly would like to see that before I would go on record as supporting it.

We would like to make a few suggestions, which in review of the bills, and in light of the day-to-day application and dilemmas we meet, we hope you will consider in the final bill or package of bills. Hopefully, you will do this expeditiously.

Your bill, Senator Russo, is fine as far as it goes. It does not, however, provide for the incompetent patient who did not make a declaration as to discontinuance of medical treatment when he was competent. Care of the incompetent, comatose, terminally-ill patient for whom there is no possible hope for return to a cognitive state, presents the greatest dilemma for all of us -- the families, the physicians, and the health care providers.

SENATOR DiFRANCESCO: Do you mean incompetent because of the comatose situation?

MRS. SANDERSON: Absolutely. We would like to have you add under the word "medication" on Page 2, the words "pain relieving." We feel this should be added, because otherwise, you face the problems of a terminally-ill patient being required to be given chemotherapeutic

agents, a patient with pneumonia and some other terminal illness being required to be given antibiotics, or a patient with a terminal heart problem for whom there is no hope of recovery being given anti-arrythmic drugs. As I am sure that there are physicians in the group who could attest better than I, many of these drugs have side effects that may make the patient pretty miserable and uncomfortable.

Senator, I am interested in your proposition of forming an agency, which would determine the existence and contents of the declaration. This could be a very helpful resource to those of us in the hospitals; however, in some fashion, it would have to be available 24 hours a day, seven days a week, so that when the patient came into the emergency room, we would be able to contact the agency.

We are also concerned that the bills not make the requirements so complex that a patient would require a lawyer, along with his fees, to make a living will.

There are some items I will skip over, but there is one I would like to mention. The physicians would like to know what the words "without delay" mean. Is this 24 hours, 48 hours, or could it mean as soon as possible? Our physicians are concerned about being held civilly liable if they are unable to make the necessary arrangements to effect a transfer to another physician. If they do not wish to follow the living will, and they are unable to find another physician to accept the patient, they would like the bill to read "make an attempt" to find another physician.

Senator Dumont's and Senator Feldman's bill, in general, is very helpful to those of us in the hospitals. It gives clear standards for withholding or withdrawing the life-sustaining medical procedures. I'm not sure, Senator Russo, which portions of this bill Senator Feldman would want to remain, since he left before your discussion.

We are a little concerned about the procedure of death, as some people have pointed out. We are concerned about the time frame. Multiple sclerosis is an incurable disease, and death is expected within five years. We certainly wouldn't consider that in the same frame as a patient with a terminal illness who is expected to die momentarily.

We particularly like the priority list on Page 7, which gives us a list of all the people who can help us in determining who could sign for the patient.

The current Conroy case helps us by saying that there should be no distinction between withholding or withdrawing life-sustaining treatment. We have great difficulty distinguishing between extraordinary and ordinary treatment. Is artificial breathing equivalent to or different than artificial feeding?

We also want a patient's family to know that when they come into the emergency room, they cannot expect an immediate response to a living will. Time is required for evaluation, assessment, and consideration before an action can be made. If families come into the emergency room with a living will in hand, we will have to institute treatment while we are evaluating whether, indeed, this is a terminal illness, and whether the living will is a valid one.

I have one final point. The Conroy decision draws a lengthy distinction between hospitals and nursing homes, leading one to believe that problems are more prevalent in nursing homes. I contend that they are as common, if not more so, in hospitals. Patients are not on respirators in nursing homes, seldom do they receive IVs, and pacemakers are not inserted.

Thank you.

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

MR. HENRY: We would appreciate the opportunity of presenting the findings of an analysis from the Association's standpoint.

SENATOR LYNCH: Absolutely.

MR. HENRY: Thank you, sir.

SENATOR LYNCH: You are very welcome. There are other Committees meeting this afternoon, so we will not be able to continue this hearing at the present time. We will continue it sometime in the future, and that date will be announced almost immediately. We will have our last group of speakers right now; they are from Summit and represent the Steering Committee of the Citizens Committee on Biomedical Ethics. We have Mary Strong, who is the Chairman; Paul

Armstrong, who is the attorney; and William Strasser. I understand you want to speak jointly.

PAUL ARMSTRONG, ESQ.: We would like to do that, Senator, if it is convenient for you.

SENATOR LYNCH: That is fine. We will continue with the rest of the speakers at our next session. In other words, some witnesses who wanted to be here today, but couldn't because of other reasons, will be notified that we will be continuing this hearing. We will probably have to have at least three hearings.

MR. ARMSTRONG: Good afternoon, Senator. In preface, let me echo the sentiments of those who have preceded us here today, and express our gratitude to you for the privilege and opportunity to share in the important labors of the Committee's profound deliberations.

In order to put the members of this Committee at ease, as a veteran of several appearances before you and the Assembly on these issues, I will not proffer an in-depth analysis of the pros and cons of each bill, although I, along with Mr. Strasser, would be happy to submit such a review in writing, should the members feel it would be of value.

SENATOR LYNCH: That would be fine.

MR. ARMSTRONG: In addition, I want to publicly express, as well, my admiration for the scholarship and draftsmanship of the bills introduced by Senators Russo, Hurley, Feldman, and Dumont. Each, after their own fashion, squarely addresses the special procedures implicit in the right of individuals to make fundamental treatment decisions while they are dying.

I would like you to know that I have eschewed the so-called right to die of the important Quinlan and Conroy decisions, as well as any law within the United States. They do not recognize so broad a prerogative. What the decisions do is, they allow for individuals, while they are dying, to make fundamental treatment decisions.

What have emerged from the public and private travail of Quinlan and Conroy are predicative procedures that are premised on the constitutional right of privacy. They spring from a central concept that the individual may, in certain circumstances, refuse medical

treatment even if death is a likely result, and that certain individuals may, in the best interest of incompetent persons, refuse treatment on their behalf. These principles, as Quinlan and Conroy underscore, have evolved from young and old alike, and thus have broad application to the terminally ill of all ages.

Senate Bills 875, 935, and 2387 recognize and honor these principles, which we, with much pride here in New Jersey, know have been recognized and vindicated by our own New Jersey Supreme Court.

What I would like to achieve by my presence here today is to point out what you, above all, already know. That is, the New Jersey Supreme Court has affirmed the ad hoc nature of its own deliberations and, at the same time, has requested that the Legislature take a long, deliberate view of the important interrelationship of the various branches of government, and the special relationship of patient, family, physician, and society. The Judiciary, Executive, and Legislative Branches, in light of the great wonders of medicine and science, must now be responsive to the pleas for individual autonomy and integrity, and at the same time, protect the innocent and weak from the abuse of arbitrary decisions.

From the perspective of nearly a decade of labor in our courts and Legislature, I join in the urging of the formation of a commission, much in the manner of the recent President's Commission and that of our sister State of New York, to address the important responsibilities delimited for the Legislative, Executive, and Judiciary Branches by the New Jersey Supreme Court in its Quinlan and decisions.

Here in New Jersey, we are rich in the genius of experience and wisdom borne of wrestling with these issues longer than any others worldwide. In addition, the hand of history has placed a special national and international responsibility on what we do here in our State. In light of this, I ask your advice, counsel, and support for such a commission, which we feel will best serve to meet this historical challenge.

Thank you, Senator. If there are any questions--

If I could step out of my prepared segment and try to address whether or not it may be appropriate to specifically limit the exercise of a constitutional right to the clinical circumstance only of brain damage-- Clearly, I would argue against that. As we are all aware, there are a number of maladies that can bring us into the terminal circumstance. First of all, none of these bills would do that, as was suggested. Clearly, if that is the interpretation, I would argue that they are indeed an impermissible, unconstitutional fettering of the exercise of that constitutional right.

SENATOR LYNCH: Thank you. Are there any questions? (no response) Mr. Strasser?

WILLIAM STRASSER, ESQ.: Senator, I would like to echo Mr. Armstrong's gratitude and my own gratitude for permitting us to appear before this Committee.

It has been almost two years to the day since Judge Stanton rendered his trial court decision in the Conroy case. On that date, I, as the attorney for Mr. Whitmore, was fully satisfied that, in fact, Judge Stanton had recognized that one does have a right to terminate medical treatment under certain circumstances, including termination of a nasogastric tube feeding.

After hearing the testimony this morning, and hearing the questions coming from the Senators on the Committee, I feel it would be most helpful to give some factual background very briefly as to how the Conroy case came about. I know Senator Russo has proposed an amendment to his bill, which would, in effect, limit it to a permanent brain damaged status. If I may go back to the Conroy facts, the Conroy case was brought on two precepts: One was that nasogastric tube feeding could be terminated, and that it did constitute medical treatment which one could terminate; and two, that, in effect, the individual, who was not brain dead, comatose, or in a persistent vegetative state, had the same rights to terminate medical treatment as those who were clinically described as being in that state.

The trial court, as you all know, agreed with this premise. The Appellate Court disagreed, and just recently, the New Jersey Supreme Court stated that, in fact, nasogastric tube feeding was medical treatment which could be terminated.

Most importantly, the Court clarified the issue -- that is, the rights of one who is terminally ill are equal to the rights of those who are brain dead, comatose, or in a persistent vegetative state.

I see the Committee hovering on the problem area of limiting the rights of those who are suffering from permanent brain damage, as opposed to those who are terminally ill.

The Court, in its decision, dealt with elderly nursing home residents. We requested the Court to set down standards and guidelines for individuals of all ages. However, we came to realize that this is and was an impossible burdensome task for the Court. The Court has stated that the Legislature is better equipped than the New Jersey Supreme Court to develop and frame a comprehensive plan for resolving the life-and-death decision-making problems and a variety of other situations that are before the Court in this case.

I believe it is most important for the Committee to remember that we must recognize and establish that just as one has the right to be sustained under any and all circumstances, we must also recognize the right of one to self-determination to cease medical treatment under certain circumstances.

I also echo the beliefs and suggestions of my prior speakers in suggesting that a commission to resolve these vast issues be formed to analyze the case carefully so that no matter is left unresolved by the pending legislation.

Again, if there are any questions, I would be happy to answer them.

SENATOR LYNCH: Thank you very much, Mr. Strasser. Are there any questions? (no response) Mrs. Strong?

MARY STRONG: Thank you for allowing me to be here. I also want to thank the others; they have spoken very eloquently.

Just to explain the Citizens Committee in the hopes that it can be of assistance to the Legislature and to a commission which I hope will be appointed, we were incorporated last summer. In the last year, we have had five forums with the idea of trying to glean what the public's wishes are -- what they need to know, what they want to know, and what their concerns are in this area.

We talked to about 750 people at those five forums, and it is so obvious that the public needs much more information. They are awed and anguished by the decisions they may have to make for themselves and for others.

Some of the things they want to know more about are patients' rights and to understand the principles that guard treatment decisions. They really have no idea about that. They don't know what an ethics committee is supposed to do, and many of the ethics committees are grappling with the same thing. The nature of the ethics and ethical decision-making is something they need to know more about.

It is obvious that whatever develops, it is going to be the process that will be the product of all of this. It is the process that people wish to know how to proceed with.

I would hope that in the next year, we will have many more forums and many more small gatherings of people, along with experts from all fields. We are a committee of not only citizens, but of professionals from all the medical fields -- the health care givers, the lawyers, the theologians, the chaplains, the social workers, and every other one I can think of. We have expanded it; we will be reaching more and more people. We would like to be able to get from them what I believe the Supreme Court said in the Conroy case, which was to listen to the public and see what their wishes are. I believe we can do this.

If we can be of assistance, please contact us.

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

That will conclude our hearing for today. We will be announcing a date shortly to continue with testimony. Thank you all for coming and for your attentiveness.

MR. ARMSTRONG: Thank you.

MR. STRASSER: Thank you.

MRS. STRONG: Thank you.

(HEARING CONCLUDED)

APPENDIX

VERA ROCHE
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NEW JERSEY EAGLE FORUM

LEADING THE PRO-FAMILY MOVEMENT SINCE 1972

February 4, 1985

To the members of the Judiciary Committee:

Objections of the Eagle Forum on the Right to Die decision by the New Jersey Supreme Court.

Vera Roche
N.J. State Chairman

Back in the days when the pro-abortion push first began, there were those who could see what was coming. When abortion advocates presented only the "hard cases" and demanded changes in the law, those early pro-lifers sensed the real danger in the precedent that was being set. They recognized immediately that if the basic and essential right of life could be denied to any one segment of humanity, it could also be taken away from any other group. So then it was totally obvious that if there could be "unwanted" unborn, there could also be unwanted old, unwanted sick, unwanted senile, unwanted defective and unwanted handicapped. They believed that our unalienable, right to life is indeed unalienable and that it is God-given, not state-granted.

In New Jersey, we now have another Supreme Court decision, which is an extension of the abortion decision. The Court, a monolithic and all-supreme bureaucracy, has decided that we should now have laws that threaten the second most helpless group- the aged and incurably ill. These laws are being called the Right to Die. They will soon become the Obligation to Die. Greedy relatives will force the Right to Die decision on the helpless patient, and thereby we will be killing once again for convenience and comfort. Then the right to privacy will expand these rights to embrace not just hard-core but many other undesirables that are costing the state time and money. Withholding feeding will cause death by starvation and dehydration-a terrible way to die.

This decision will also put power into the hands of those that can use it for their own benefit. If ombudsman or hospital officials are unscrupulous, many sick people could become their victims. It happened in Nazi Germany when between 200,00 and 300,000 mentally and physically handicapped people lost their lives at the hands of hospital administrators in a drive for euthanasia on sick people. This is just a terribly irresponsible and dangerous decision made by a court, that is just the next step down the slippery slope toward euthanasia.

Schiller Institute, Inc.

1010 16th Street, N.W., Room 300, Washington, D.C. 20036 (202) 955-5938

Testimony for New Jersey State Legislature
Senate Judiciary Committee hearings
February 4, 1985
Re: "Right to Die" Legislation

Submitted by:
Marianna Wertz, Vice President
Schiller Institute, Inc.
1010-16th St. N.W., Suite 300
Washington, D.C. 20036
(202-955-5938)

AMERICAN TRIBUNAL AT NUREMBERG ESTABLISHED ANTI-EUTHANASIA DOCTRINE IN 1947 EUTHANASIA IS A CAPITAL OFFENSE

These hearings are being called to draft legislation which is illegal under the codes established by the International Military Tribunal created at the close of World War II to define and deal with Nazi crimes, including euthanasia. It matters not that other states have passed similar legislation, or that this legislation is couched in humanitarian terms. It matters not that the New Jersey Supreme Court has established a precedent in the case of Claire Conroy, whose intent is to force the legislature to bend to the will of a morally corrupt judiciary. It remains a fact of natural law and of history that every one of these bills before us today is illegal, and, if enacted, would render its authors subject to prosecution under the Nuremberg Codes.

The Schiller Institute, a republican policy-making body named for the German Poet of Freedom Friedrich Schiller, has announced its determination to prevent the kind of national tragedy from occurring in America, which brought Germany to the ultimate horror of fascism a half century ago. We appeal to you today to examine in your hearts why you are drafting legislation that differs in no important way from that which Adolf Hitler was afraid to publicly announce in Nazi Germany. We urge you to have the courage to stand up to the pervasive propaganda of the death lobby, of such financial institutions as the International Monetary Fund, the World Bank and Prudential Life Insurance, whose goal in pushing such legislation is to cut costs by cutting out human beings.

And we warn you, that the people of the United States will avenge the premature death of every individual who dies as a result of the policies you are debating today, exactly as we did in 1947.

Nuremberg Tribunal Decision in 1947
United States of America v. Karl Brandt, et al.

The actions of the International Military Tribunal created at the close of World War II to define and deal with Nazi crimes yielded the precedents which cover the question before us in these hearings. The Tribunal defined war crimes, crimes against peace, and crimes against humanity as its areas of jurisdiction. In the case of the Nazi doctors--the United States of America v. Karl Brandt, et al.--the Tribunal indicted, tried, and executed individuals found guilty of

euthanasia, a crime against humanity.

U.S. Justice Robert Jackson formulated the conceptions on which the International Tribunal was based: "The real complaining party at your bar is Civilization," he told the Tribunal. The principles of natural law were to be the basis for the Tribunal's actions. Hence, actions which violated natural law were punishable, whether or not they were specifically outlawed in the laws of any individual nation.

A description of the crime for which Brandt and others were hanged in 1947, should make those among you who are still moral, shudder in recognition: "This [euthanasia] program involved the systematic and secret execution of the aged, insane, incurably ill, of deformed children, and other persons....Such persons were regarded as 'useless eaters' and a burden to the German war machine."

Brandt's final statement to the Tribunal, on July 19, 1947, differed little from the "subjective standard" established by Supreme Court Associate Justice Sidney M. Schrieber in the case of Claire Conroy. Brandt asserted "When I said 'yes' to euthanasia I did so with the deepest conviction, just as it is my conviction today, that it was right. Death can mean deliverance. Death is life--just as much as birth." Indeed, Adolf Hitler himself hid behind humanitarianism in legalizing euthanasia: "...Persons who, according to human judgment, are incurable can, upon a most careful diagnosis of their condition of sickness, be accorded a mercy death."

The Nuremberg Tribunal decision, however, was emphatic on just this point: the intent of the person committing euthanasia is not an issue. A "humanitarian" cover is just that -- a cover for crime. The Tribunal stated:

"We have no doubt that Karl Brandt--as he himself testified--is a sincere believer in the administration of euthanasia to persons hopelessly ill, whose lives are burdensome and an expense to the state or to their families. The abstract proposition of whether or not euthanasia is justified in certain cases of the class referred to is no concern of this Tribunal....The Family of Nations is not obligated to give recognition to such legislation [that is, legislation 'legalizing' euthanasia] when it manifestly gives legality to plain murder and torture of defenseless and powerless human beings."

That is, legislation that purports to "legalize" euthanasia is not in conformity with natural law, and therefore cannot be tolerated by the human community.

I bring you today telegrams from the Federal Republic of Germany, the nation that America helped rebuild after the holocaust of Hitler, from doctors, jurists and common citizens who appeal to you not to repeat Hitler's crimes. I ask you to read these with care.

International Protest

On January 15 of this year, the birthday of Martin Luther King, the Schiller Institute held a rally of 10,000 citizens from around the world in Washington, D.C. to protest the policies of the International Monetary Fund. Those policies, which are responsible for the genocide now ongoing in Africa and parts of Ibero-America, are based on the IDEA which is at the core of these bills before us today -- that there is "a life not worthy to be lived."

The Schiller Institute utterly rejects this idea. We declare ourselves prepared to draft legislation which rightly defines the limit of life as the limit of the most advanced technology of our society. TECHNOLOGY WHICH EXTENDS LIFE IS THE BEST EXPRESSION OF THE HUMAN MIND. Use of that technology is an act of human love, indeed, the most supreme act of human love.

We also declare that we will exercise every power available to us to prosecute those who commit nazi crimes. Be it the International Monetary Fund or the New Jersey Supreme Court, we will not allow the dark age of fascism to rule the world once again.

As representative of the Schiller Institute, and as a human being who has battled through ten years of cancer treatment and heart surgery, I appeal to you to make New Jersey an exception to the moral decline of our country. Let us start a new more hopeful age right here, by rejecting the dictates of the pessimists and the doom-sayers.

Let me close with a poem, written by Heinrich Heine, the great German Jew, who spent eight years on what he called his "mattress grave," incurably ill, blind, and in such pain that he often asked for death. Our modern practitioners of "mercy killing" would have killed him long before he could have written his wonderful lyric poetry. I'll let Heine tell you, in words I translated, why we must fight for life, even to the bitter end:

My day was happy, blissful was my night.
Rejoiced my people when I struck the lyre
Of poetry. My song was joy and fire;
Did many lovely glowing flames excite.

Still blooms my summer, yet the harvest bright
Have I already brought inside my bower--
And now must I give up, what made so dear
So sweet and dear the world before my sight.

The hand falls off the lyre's strings. And lying
In pieces is the glass, that I so willing
Unto my frolicsome two lips have pressed.

Oh God! how ugly bitter is our dying!
Oh God! how sweet and cosy to be dwelling
In this so cosy sweetened earthly nest.

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Text of Telegram
From the Federal Republic of Germany
Received by Schiller Institute, Inc.

To the New Jersey State Legislature Judiciary Committee
February 1, 1985

As German citizens, we strongly oppose the legalization of euthanasia, represented through the New Jersey court-decision in the case of Claire Conroy. Noone has the right to shorten the life of a human being through actve or passive measures. With small changes in ethics and law, especially the differentiation between valuable and nonvaluable life, the most brutal genocide against old, ill and handicapped people was unleashed by the Nazis in the Third Reich.

We the undersigned do not want the American population to undergo the same suffering, the Germans did during the horrors of fascism.

Therefore we call on you to listen to your allies to refuse any kind of legalization of euthanasia and to condemn the New Jersey court-decision and the "Right-to-die" bills.

Dr. Karl-Heinz Mayer, medical doctor, Dortmund
Dr. W. Hellemann, medical doctor (dentist), Bonn
Karl-Josef Hegemann, Protestant Priest, Remscheid
Dr. Maria Elisabeth Dickmann, medical doctor, Neuss
Hans Dieter Fraund, Baptist Reverend, Wuppertal
Josef Mason, Catholic priest, Euskirchen
Hans-Georg Seidel, male nurse St. Martinus Hospital, Duesseldorf

Telegram from Federal Republic of Germany
February 2, 1985

To the Judiciary Committee of the New Jersey State Legislature

The following is a statement from Mr. Ermin Briessmann, member of the Central Committee of German Catholics (Zentralkomitee der deutschen Katholiken) in the Federal Republic of Germany, and a Judge in the Bavarian State Supreme Court (Bayerischer Oberstes Landesgericht):

The right to end one's own life, has turned into a dangerous buzz-word. A majority of our population, seized with pangs of sympathy, is now demanding the admissibility of active--and hence life-shortening--euthanasia. This, however, is the sympathy of insensitive individuals who do not wish to truly take to heart the misfortune of their fellow men. Such sympathy is aimed at creating a certain distance, and consists, not in participation and living through the other's suffering, but rather is a flight into a comfortable attitude of mere acknowledgment. This kind of sympathy is not human, since it does not take in the full truth of human existence.

Whoever confronts life's reality, must recognize that human dignity becomes manifest in all forms of human existence--whether it be in times of happiness or of tragedy, in the beauty of a youthful body, or in deformation and disfigurement. In none of these phases should anyone set hand on another's life; otherwise, we would be weighing one human life against another, and we would once again arrive at the assumption that there be such a thing as a life not worth living. This would be a denial and a violation of human dignity.

Those who might desire to permit active euthanasia will have to obtain, either from the patient himself or from a doctor, a declaration favoring premature death. But who among us, is capable of completely ruling out all human error, psychological pressure, or even criminal influences?

Each encroachment on human life makes the human being into an object, and is therefore a betrayal of man's dignity.

Text of Telegram
From the Federal Republic of Germany
Received by Schiller Institute, Inc

TO THE SENATE JUDICIARY COMMITTEE
OF THE NEW JERSEY STATE LEGISLATURE
January 31, 1985

"We, the undersigned, fully condem the decision of the Supreme Court of New Jersey in the case of Claire Conroy, who was starved to death, which was declared to be legal and which can be used as a model for other similar cases. We can only emphasize, that every step to devalue human life and give up the conception that it is sacred, is very dangerous - as we in Germany had to experience during the nazi period. Therefore, we want to urge you to reject any euthanasia bills, in whichever form they are being brought forward to you!"

Sincerely yours,

Mr. Ascherl, Federal Chairman of the Catholic Workers Movement (KAB - Katholische Arbeitnehmerbewegung) and former World President, Munich, Federal Republic of Germany

Pater Guenther Firlus, member of aid society "Church in Trouble" (Kirche in Not), Munich, Federal Republic of Germany

Telegram from Hanover, Federal Republic of Germany
Received by the Schiller Institute, Inc.

We, the undersigned, are deeply dismayed at the decision of the Supreme Court of New Jersey, in which euthanasia is legalized again fifty years after Hitler.

This violation of the Inalienable Right of Life contradicts and destroys the Judeo-Christian tradition of the American Declaration of Independence, which guarantees the Right of Life in its uniqueness and inviolability.

Every culture which denies these Inalienable Rights of Life and Development condemns itself necessarily to its ruin. Therefore, we support the fight and the campaign of the Schiller Institute and the Club of Life against that inhuman decision and demand its immediate withdrawal.

We also demand the American government and the world public to condemn the scandalous statement made by Gov. Lamm (Colo.), who said that famine and starvation are God's will and therefore demanded that no food or aid be given to Africa.

Let us fight the evil idea of euthanasia and develop Africa.

Dr. Esther Volkmann, medical doctor
J. Morrisson Konneh, university student, Liberia

end of telegram