JACQUELINE BETANCOURT, on behalf of RUBEN BETANCOURT, Plaintiff/Respondent v. TRINITAS REGIONAL MEDICAL CENTER. Defendant/Appellant	SUPERIOR COURT OF NEW JERSEY APPELLATE DIVISION DOCKET NO. A-003849-08T2 **CIVIL ACTION** Sat Below: Honorable John F. Malone, P.J.Ch. On Appeal From A Decision of the Honorable John F. Malone, of The Superior Court of New Jersey, Chancery Division, Union County, Entered on March 4, 2009 Docket No.: UNN C-12-09

BRIEF AND APPENDIX OF *AMICI CURIAE* NEW JERSEY HOSPITAL ASSOCIATION, CATHOLIC HEALTHCARE PARTNERSHIP OF NEW JERSEY, AND MEDICAL SOCIETY OF NEW JERSEY

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INTEREST OF THE *AMICI CURIAE*

This Brief is submitted on behalf of the New Jersey Hospital Association ("NJHA"), the Catholic HealthCare Partnership of New Jersey ("CHCPNJ"), and the Medical Society of New Jersey ("MSNJ"). As set forth in their applications to appear *amici curiae*, these are organizations with a significant interest in the issues presented by this appeal. NJHA is a not-for-profit trade organization promoting the common interests of its 105 members consisting of hospitals, hospital systems, nursing homes, rehabilitation hospitals, home health care and hospice care facilities with regard to providing quality, accessible, and affordable health care to New Jersey communities. CHCPNJ is another nonprofit trade association established to advance the healing ministry of the Catholic Church. The MSNJ was the first state society of physicians and is the primary organization of physicians in New Jersey and provided advocacy and leadership with regard to quality health care and health services for all citizens in New Jersey. These organizations have been involved in developing documents and guidance for end-of-life planning to be used in the treatment of New Jersey patients.

PRELIMINARY STATEMENT

This case poses an issue of first impression for New Jersey courts at the intersection of its end-of-life jurisprudence and its regulation of the scope of the duty of hospitals and physicians to furnish care. New Jersey has made clear (a) that a patient or his or her surrogate decision-maker can make a decision for cessation of life-sustaining medical treatment, (b) the criteria on which the decision to terminate treatment must be made, and (c) the obligations of hospitals and physicians when the decision to terminate treatment is made. Equally established by common law, statute, and regulation is the obligation of hospitals to provide medically indicated treatment. However, no appellate case in New Jersey has yet addressed the issue of whether a patient or surrogate can demand the continuation of life-sustaining medical treatment in violation of professional medical standards and ethics or the right of a hospital, physician or other health care professional to implement the cessation of life-sustaining medical treatment over the objection of a patient or patient's family when such treatment is deemed to be medically, ethically, and morally inappropriate and medically futile to cure, palliate or ameliorate a patient's condition. The trial court's opinion appointing a family member as medical guardian entirely avoided the issue: it refused to address the question of whether or not further life-sustaining medical treatment was medically

justified. Instead, it enjoined the hospital from discontinuing treatment without authorization from the guardian.

This case involving the hospitalization, treatment, and ultimate death of Mr. Reuben Betancourt at Trinitas Hospital ("Trinitas") presents an opportunity to address these issues. Posed narrowly, the question presented by the trial court's decision is whether health care professionals may be compelled through court order to provide life-sustaining medical treatment indefinitely to a dying patient in a permanent vegetative state on the demand of the guardian despite the determination of the medical professionals that the treatment is not medically justified and is against the standard of care. Consistent with prior New Jersey case law and public policy decisions embedded in numerous New Jersey statutes, this case also affords the court an opportunity to set forth reasonable, responsible, and compassionate procedures to be followed by physicians and hospitals when similar situations arise in the future. For sure, similar situations will inevitably present themselves.

The importance of the issue, its likelihood of repetition, and its potential for evading judicial review should not render this appeal moot because of Mr. Betancourt's death on May 29, 2009.

Mr. Betancourt was an elderly, incapacitated man being treated as an in-patient in Trinitas, an acute care hospital. He

was in an irreversible permanent vegetative state and most accurately described as an elderly moribund patient who was actively and palpably dying even with the provision of the artificial life-sustaining treatment. Trinitas, in accordance with medical, ethical and moral standards of care, including national guidelines for the cessation of dialysis for patients with end-stage renal disease ("ESRD"), sought to discontinue dialysis treatment for Mr. Betancourt's ESRD, and to place a Do Not Resuscitate ("DNR") Order in Mr. Betancourt's medical records over the objection of the patient's family. *Amici* NJHA, CHCPNJ, and MSNJ firmly believe that under these circumstances, Trinitas should have been permitted to do so.

PROCEDURAL HISTORY

This matter was commenced by Verified Complaint seeking an Order that Trinitas Hospital be required to continue all available treatment and/or care necessary for the patient Ruben Betancourt. The Verified Complaint was filed by the patient's daughter. [Da-1 to 3][1]

The Verified Complaint was supported by a certification from Carl S. Goldstein, M.D., a physician who was not involved in the

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[1] The following legend will be used in referring to the record in this matter:

Db	-	Brief of Defendant Trinitas Hospital
Da	-	Appendix to Defendant's Brief
Aa	-	Appendix to this Brief

patient's care and who had examined Mr. Betancourt on one occasion after being engaged by counsel for plaintiff. [Da-7 to 8] An Order to Show Cause was signed by the Honorable John F. Malone, J.S.C. on January 23, 2009 scheduling an initial hearing on January 30, 2009. [Da-9 to 10]

Responding certifications from various physicians who had treated or evaluated Mr. Betancourt were filed by Trinitas Hospital. The court issued a further Order on February 10, 2009 restraining Trinitas Hospital from discontinuing treatment, compelling the resumption of dialysis, feeding tubes, and ventilation. [Da-42 to 43]

After an initial hearing on January 22, 2009, the court heard testimony on February 17 and 23, 2009.[2] It rendered a written decision dated March 4, 2009 [Da-44] and a final Order dated March 20, 2009 requiring Trinitas to maintain the treatment regime in place. [Da-53]

In its written decision, the court wrote:

> The decision to continue or terminate life support systems is not left to the courts. The position of the hospital argues that the court take the role of surrogate decision maker. The hospital seeks to have the court exercise its judgment in determining the proper course of treatment

[2] The transcripts in the trial court are identified as follows:

1T	-	January 22, 2009
2T	-	February 17, 2009
3T	-	February 23, 2009

for Mr. Betancourt, a task which the Court in Jobes ruled is outside the role of the court.

> This court concludes that Mr. Betancourt is in a persistent vegetative state and unable to communicate his wishes with respect to the continuation of life supporting treatment. Accordingly, the appointment of a guardian is required. The court grants the application of the plaintiff Jacqueline Betancourt to be the guardian of her father. … As guardian for Mr. Betancourt, Ms. Betancourt is his surrogate decision maker. The plaintiff's application to restrain the defendant from discontinuing or suspending treatment of Mr. Betancourt is granted. The guardian is authorized to make decisions respecting medical treatment of Mr. Betancourt. [Da-51 to 52]

This appeal followed. On May 29, 2009, Ruben Betancourt died. By Orders dated July 15 and 20, 2009, this court granted the applications of NJHA, CHCPNJ, and MSNJ to appear as *amici curiae*.

STATEMENT OF FACTS

Mr. Betancourt was admitted to Trinitas on July 3, 2008, and was not moved or transferred from that date through the hearing and his eventual death on May 29, 2009. (2T 16:24 to 17:1; Decision 1-2).

Trinitas is a full-service health care facility serving those who live and work in Eastern and Central Union County. (Trinitas Website,http://www.trinitashospital.org/about_us.htm).

The patient Ruben Betancourt was 73 years old. (2T 10:21, 3T 5:17-19). He had previously been a patient at Trinitas for surgery to remove a large tumor in his thymus glad. In connection with his surgery, he was intubated and placed on a ventilator after surgery to remove the tumor. (2T 10:24; 3T 10:22 to 11:2).

However, Mr. Betancourt self-extubated while in the ICU, resulting in lack of oxygen to his brain and severe brain damage. (2T 10:22 to 11:3). As a result, Mr. Betancourt was in a non-cognitive state, with no higher mental function. (2T 12:2-3). The only functioning part of Mr. Betancourt's brain was the brain stem. (2T 12:4-5). Mr. Betancourt was unable to communicate. (3T 15:2).

The uncontradicted testimony of the physicians at the hearing established that Mr. Betancourt had permanently lost all cognizant brain function due to this anoxic episode. (2T 10:10-12). While family members provided testimony regarding observations of Mr. Betancourt, which they interpreted as showing some awareness, there was no medical support for any neurological capacity or recovery.

As a general proposition, the likelihood of return from a persistent vegetative state is lower for an older patient such as Mr. Betancourt. (2T 10:17-19). Mr. Betancourt had been in a persistent vegetative state for more than one year. (2T 64:13; 2T 81:7-10; Decision 8). A patient in a persistent vegetative state for more than a year is said to be in a permanent vegetative state. (2T 81:10-12). There had been no change in Mr. Betancourt's neurological status from July of 2008 until the time of the trial. (2T 104: 19-23). There was no treatment that would improve Mr. Betancourt's condition and he would not regain consciousness. (2T 13:19-22; 2T 25:4-6; 2T 64:21 to 65:2; 2T 116:22-23). The family

contended that they observed Mr. Betancourt react to stimuli in a manner suggesting that he was not in a persistent vegetative state. (3T 19:2 to 20:6; 3T 77:8 to 78:14; 3T 86:11 to 87:15). However, they have offered no medical testimony to support the contention that he was not in a permanent vegetative state, and the family did not dispute the testimony of Dr. Schanzer, Mr. Betancourt's neurologist, who testified that these symptoms were simply reflexive, consistent with a persistent vegetative state. (2T 87:22 to 88:4). Observation of such things as eye movements in PVS patients are a source of confusion for family members.

The overwhelming undisputed evidence showed that Mr. Betancourt was dying. (2T 11:6). He suffered from multiple decubitus ulcers, two of which were stage 4, the worst classification. (2T 14:3; 2T 17:3-18:23; 2T 116:25 to 117:1). These Stage 4 ulcers went through the entire skin and into the subcutaneous tissue. (2T 19:1-2). As a result, Mr. Betancourt had developed osteomyelitis, or an infection of the bone. (2T 14:5-6). His skin had the consistency of parchment and fell apart at the slightest touch. (2T 14:24-25). Mr. Betancourt lost the ability to heal from these wounds due to an inability to digest food properly, proteins in particular. (2T 14:7-9; 2T 118:21 to 119:16). Although the Trinitas staff was doing a very good job of ensuring that these wounds would not get worse, the decubitus ulcers would not get better. (2T 19:7 to 20:1). Despite these

efforts, Mr. Betancourt's condition continued to deteriorate and the medical professionals were helpless to stop the deterioration. Mr. Betancourt was a diabetic with chronic obstructive pulmonary disease, renal failure, and hypertensive cardiovascular disease with past congestive heart failure. (2T 64:13-17; 3T 6:13). Mr. Betancourt also suffered from end-stage renal disease, requiring dialysis three times a week. (3T 66:13-15). The condition of end-stage renal disease would not improve. (3T 66:21 to 67:5).

The effect of discontinuing dialysis would be that Mr. Betancourt's end-stage renal disease would be allowed to run its course. His potassium level would increase. He would develop multi-organ system failure. Ultimately he would experience death. (1T 5:11-14). Because of the PVS neurological status, Mr. Betancourt would not experience pain.

If Mr. Betancourt were given a DNR Order, the result would be that if his heart stopped, if he had a problem with blood pressure, or if his breathing became worse than it already was, nothing active would be done to ameliorate this condition. (2T 24:19-22). Cardiopulmonary resuscitation - CPR - would not be administered. CPR can be a brutalizing process resulting in broken ribs and without restarting the heart.

LEGAL ARGUMENT

POINT I

NEW JERSEY LAW AND PUBLIC POLICY SUPPORT THE PROPOSITION THAT A PATIENT'S RIGHT WITH RESPECT TO END-OF-LIFE HEALTH CARE DECISIONS IS NOT ABSOLUTE. THE LOWER COURT ERRED IN REQUIRING THE CONTINUATION OF LIFE-SUSTAINING MEDICAL TREATMENT IN THE CIRCUMSTANCES OF THIS ELDERLY, INCAPACITATED, AND MORIBUND PATIENT AT AN ACUTE CARE HOSPITAL WHO WAS ACTIVELY DYING.

Responsible judicial dialogue concerning end-of-life decision-making has its genesis in New Jersey. In re Quinlan, 70 N.J. 10 (1976), cert. denied sub nom., Garger v. New Jersey, 429 U.S. 922 (1976), is the seminal decision in this area of the law. The current appeal presents an opportunity for the court to advance the conversation in a significant - and urgently needed - way but not necessarily conclude and certainly not abandon it. The issues presented in this matter, while of compelling importance, do not provide the necessary context to address fully the remaining profound permutations of the decision to withdraw life-sustaining medical treatment. It is not necessary, for example, to resolve the conflicts about the value of life, especially profoundly diminished life, or what quality of life justifies the administration or foregoing of life-sustaining medical treatment. Nevertheless, certain questions must be answered on this appeal.

With Quinlan the Court recognized that responsible medical practitioners "distinguish between curing the ill and comforting

and easing the dying; that they refuse to treat the curable as if they were dying or ought to die, and that they have sometimes refused to treat the hopeless and dying as if they were curable." 70 N.J. at 47. Eleven years later the Court eloquently declared in the opening paragraph of In re Farrell, 108 N.J. 335 (1987) that:

> Death comes to everyone. However, in our society, due to great advances in medical knowledge and technology over the last few decades, death does not come suddenly or completely unexpectedly to most people. ... Instead, most people who die are under the treatment of health care professionals who are able to continue physical existence for human beings "even when most of our physical and mental capacities have been irrevocably lost." ... While medical advances have made it possible to forestall and cure certain illnesses previously considered fatal, they also have prolonged the slow deterioration and death of some patients. [Id. at 340 (citations omitted).]

In Quinlan and Farrell together with the related cases of Matter of Conroy, 98 N.J. 321 (1985), Matter of Jobes, 108 N.J. 394 (1987) and Matter of Peter by Johanning, 108 N.J. 365 (1987), the Court articulated principles of patient autonomy that would enable a competent patient or the family or surrogate of an incapacitated patient to make a choice to reject the artificial prolongation of a patient's life. However, those decisions did not hold, and cannot be interpreted as supporting a concept, that patient autonomy and related privacy interests in this area are unlimited and not subject to the accommodation of other equally vital interests and concerns.

To date the relevant case law in New Jersey has revolved solely around the request of a patient or patient's surrogate to terminate life-sustaining medical treatment ("LSMT"). To be sure, these decisions, which are grounded in the concept of the patient's personal autonomy, privacy, and right of self-determination, have firmly established that where a patient or patient's surrogate wishes to **refuse** the continuation of LSMT, the patient's right to self-determination overrides virtually all other interests. It is the patient's consent - and sometimes request - that makes the termination of LSMT lawful. In essence, these cases have established the patient's right to be left alone, which, in many cases, results in imminent death. However, the issue here, on the other hand, is whether the patient or patient's surrogate has the right to demand and receive the indefinite continuation of LSMT - more specifically, to compel a health care professional to continue providing LSMT even when the continued treatment is or has become contrary to accepted health care professional standards, morals and ethics.

While recognizing that Mr. Betancourt was a PVS patient and not one who was brain-dead, the issue and role of the court is more clearly seen by considering the setting of a brain-dead patient. By statute found at N.J.S.A. 26:6A-1 et seq. and related regulations of the State Board of Medical Examiners, New Jersey adopted alternative criteria for declaring a person dead. It

maintained the traditional cardio-respiratory criteria of irreversible cessation of all circulatory and respiratory functions. N.J.S.A. 26:6A-2. But it also adopted "neurological criteria" for an individual whose circulatory and respiratory functions can be maintained solely by artificial means and who has sustained irreversible cessation of all functions of the entire brain, including the brain stem. N.J.S.A. 26:6A-3. A person meeting the neurological criteria can be declared dead even though the lungs and heart continue to function by virtue of the mechanical life support systems.

Consider the following: can a family member insist that the ventilator that had been providing life-sustaining treatment be continued with a patient who has become brain-dead? There is no New Jersey case that has dealt with this situation. But it has been addressed in several decisions from other jurisdictions. The answer uniformly has been that the continuation of this treatment cannot be compelled.

The matter of In re Haymer, 450 N.E.2d 940 (Ill. App. 1983), was commenced by the hospital which sought declaratory judgment that a seven-month old child was dead, thereby permitting the hospital to remove the mechanical ventilation system. The parents opposed the removal as did a court-appointed guardian ad litem. The trial court entered an order identifying the date when

irreversible cessation of brain function had occurred as the date of death and authorized the discontinuation of the mechanical ventilation. The trial court stayed the order to allow an appeal and the child's heart stopped while the appeal was pending. The court did not have a legislative enactment that included "brain death" within the definition of death. After reviewing legislative acceptance of the "brain death" criteria elsewhere around the country, the court judicially adopted the criteria in addition to the traditional definition of death with the stopping of the heart. It affirmed the order authorizing the discontinuation of the life-support equipment.

To similar effect is In re Bowman, 617 P.2d 731 (Wash. 1980). The guardian ad litem appealed the decision that because of irreversible loss of brain activity a 5 year old boy was dead and the hospital could remove the ventilator that had been supporting his breathing and heart. The guardian ad litem had requested the court to enjoin the withdrawal of life support. On appeal, the Washington Supreme Court affirmed the action of the trial court.

The same conclusion was reached in Dorrity v. Superior Court, 193 Cal.Rptr. 288 (Cal. Ct. App. 1983) where the parents of a 19-day old infant was admitted to the hospital, deteriorated, and was determined to be brain dead. The parents withheld consent to the withdrawal of the life support equipment. The hospital petitioned

the court for appointment of a guardian with instructions to authorize the discontinuation of the life support device. After finding that the determination of brain death was in accord with accepted medical standards, the trial court appointed a guardian and directed that the temporary guardian give consent to the withdrawal of the life support system being used to maintain the infant. The parents and the attorney for the minor child sought a writ of prohibition against the discontinuation. Referring to the Quinlan line of cases involving patients in a persistent vegetative state, the California Court of Appeals stated:

> If removal of life-support devices can be proper as to persons who are still in some sense alive, then a fortiori appropriate procedures may be devised for removal of such devices from persons who are brain dead. [Id. at 291.]

The court concluded that based on the unrefuted medical evidence as to the status of the infant, the trial court's order was proper and appropriate. It recognized a role for the court in being available to address a contention that the diagnosis of brain death had been mistakenly made or where the diagnosis was not made in accordance with accepted medical standards. Id. at 292.

See also In re Long Island Jewish Medical Center, 641 N.Y.S.2d 989 (N.Y. Sup. Ct. 1996)(trial court decision authorizing

withdrawal of artificial respiratory support from 5-month old baby who was brain dead).[3]

As developed in the record below, the Renal Physicians Association and the American Society of Nephrology have issued a clinical practice guideline that advises nephrologists on when it is appropriate to withhold or discontinue dialysis. Clinical Practice Guideline on Shared Decision-Making in the Appropriate Initiation of and Withdrawal from Dialysis (2000). [Da-33] The guideline states that it is "appropriate to withhold or withdraw dialysis for patients with either A[cute Renal Failure] or E[nd Stage Renal Disease] in the following situations: . . . Patients

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[3] This New York decision involved consideration of a provision in New York law requiring reasonable accommodation of religious or moral objection to the determination of brain death. The New Jersey statute provides that the neurological criteria is not to be the basis for a declaration of death when the licensed physician has reason to believe, on the basis of information in the individual's available medical records or information provided by a family member or other person knowledgeable about the individual's personal religious beliefs that such declaration would violate the personal religious beliefs of the individual. In that circumstance, death is to be declared solely on the basis of cardio-respiratory criteria. N.J.S.A. 26:6A-5. There is no case law interpreting this provision. To the extent that it implies that ventilatory support must be continued when there is reason to believe that a declaration of brain death would "violate the personal religious beliefs of the individual," it is germane to note here that according to the medical records Mr. Betancourt was a Roman Catholic. The use of brain death criteria to determine death does not violate the teaching of the Catholic Church. See Paul A. Byrne et al., Brain Death - An Opposing Viewpoint, 242 JAMA 1985, 1989 (1979); Pontifical Academy of Sciences, Why the Concept of Brain Death is Valid as a Definition of Death (2008).

with irreversible, profound neurological impairment such that they lack signs of thought sensation, purposeful behavior, and awareness of self and environment." Id., Recommendation No. 6. Using this guideline, it would be appropriate, as consistent with accepted practice, to withdraw dialysis from a patient who suffers from severe neurological impairment such as the permanent vegetative state that Mr. Betancourt was in.

The medical witness for the Betancourt family, Dr. Goldstein, acknowledged that withdrawal of dialysis from a patient in such a state "may be appropriate" under accepted standards of care but was of the view that physicians were in the service of patients and their family and that even where he felt that "dialysis was futile" he would respect the family's request to continue the dialysis. [3T 51:22-25; 56:21-24; 58:22 to 59:1]

The testimony from the physicians testifying on behalf of Trinitas set forth the position that the continued treatment was contrary to medical standards and ethical principles because it would not aid the patient in recovering and would simply prolong the dying process and the unpleasant deterioration of Mr. Betancourt's body. Trinitas' Medical Director Dr. William J. McHugh stated:

> This could go on for quite a while. I think he will continue to deteriorate, continue to break down, he will not wake up. He will not become conscious. He'll basically get no better and likely slowly get worse. … The skin will break down

further. You have to realize that the only organ that's functioning really is his heart. Everything else is mechanically supported at this time. His brain is irreparably damaged. His kidneys don't work. His lungs don't work. His skin is broken down. I guess his liver is working, but everything else is irreparably damaged. [2T 66:12-25]

When challenged on cross-examination, he further testified:

Q Doctor, in your opinion, is any of the treatment that's currently being administered to this patient doing him harm?

A Only in the sense that we're continuing to treat a hopeless situation.

Q Other than your opinion on that score, there's nothing about the treatment that's ineffective or doing harm.

A It all seems to be ineffective because it's not getting us anywhere.

Q Is any of the treatment doing him harm?

A Yes. I think we're doing damage here.

Q What damage is - what treatment is doing this damage?

A We're allowing the man to lay in bed and really deteriorate -

Q That's not treatment, is it?

A - virtually right under our eyes.

Q That's not treatment, is it, Doctor?

A That's <u>because</u> of the treatment. [2T 67:10 to 68:4 (emphasis added).]

Mr. Betancourt's attending physician Dr. Millman testified:

Well the skin is breaking down, and there are multiple huge ulcers that the wound service at the hospital has been treating aggressively, but despite that, he's developed infection into the bone, that's called osteomyelitis which is very pernicious thing, and with poor serum proteins and with his general debilitated state, he just doesn't heal, which makes it very difficult.

When someone is at - always in bed, which of course, he has to be, since he couldn't possibly stand, since he doesn't

function, you get a catabolic state, that is, things start to break down, particularly proteins.

Even when you nourish the patient with food, you still generally have a negative nitrogen balance so that the patient still doesn't feel as well as someone who could move above, can get out of bed, can be ambulated, and this become all the worse if you're on dialysis or if you're on a ventilator, or both, and it's compounded by generalized episodes of sepsis and pneumonia, urinary tract infections, all of which he's had.

The skin becomes virtually parchment like and falls apart at the slightest touch. [2T 14:2-25]

Four of the physicians from Trinitas explicitly testified that the continued treatment of Mr. Betancourt with dialysis and the use of the ventilator would be contrary to accepted standards of medical care and medical ethics. (2T 23:13-17; 2T 65:12-25; 2T 119:22 to 120:3; 3T 68:1-4). One doctor described Mr. Betancourt's treatment as "desecrating [his] body". (2T 118:8-9). The American Medical Association provides in its Opinion E-2.035, issued pursuant to its Code of Medical Ethics, that "Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients. Patients should not be given treatments simply because they demand them." Available at http://www.ama-assn.org/ad-com/polfind/Hlth-Ethics.pdf.

What emerges from this record is that Mr. Betancourt was an elderly, incapacitated man being treated as an in-patient in an acute care hospital. He was in an irreversible permanent

vegetative state.[4] He was a moribund patient who was actively and palpably dying. The treatments he had been receiving would not restore his cognitive capacity or prevent his continuing deterioration and the decomposition of his body. The family's request for LSMT must be seen in this matrix.

The magic of LSMT can become illusory and its implementation misplaced. In reality, in some cases no improvement in a patient's condition is possible. The patient is dying. In this setting unwarranted treatments may be ineffective or even make the patient's condition worse. While sometimes a proposed treatment can effect a change in a patient's bodily function that can be monitored (such as blood pressure, a heart beat, or the cleansing of kidneys), that same treatment may impose too great a burden on the patient to warrant its continued use. The time may arrive to withdraw unwarranted treatments and procedures and focus instead on palliative or comfort care.

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[4] There is some confusion of terminology in the trial record with the use of both terms "persistent vegetative state" and "permanent vegetative state." The phrase PVS is used to refer to both but they have different implications. The adjective "persistent" should be used to refer only to a condition of past and continuing disability with an uncertain future in contrast to "permanent" which implies irreversibility. "Persistent vegetative state is a diagnosis; permanent vegetative state is a prognosis." Multi-Society Task Force on PVS, "Medical Aspects of the Persistent Vegetative State," 330 N.E.J.M. 1499 (1994).

Recognizing that this time has arrived can be difficult and provoke resistance from family and loved ones. Patients, surrogates, and families may be reluctant to move from curative to palliative care because it can be viewed as "giving up." The circumstances that justify this shift in care gave rise to what has become known as the medical futility debate.[5]

However, there has been no agreement on how to define medical futility. See generally "The Rise and Fall of the Futility Movement," 343 N.E.J.M. 293 (2000). Some define futility in terms of whether the treatment will have a desired effect or promote the patient's goals, however minimally defined, while others define futility in terms of whether the treatment will help a patient achieve a certain objective level of functioning. There is disagreement about how high a degree of expected functioning is required before the treatment will be considered not futile. For some, treatment must afford the patient a chance of leaving the hospital, whereas others believe that a treatment is not futile as long as it may produce some benefit such as additional minutes of nonconscious life. The futility debate has been further complicated by various and varying justifications that are offered

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[5] In their analysis, *amici* NJHA, CHCPNJ, and MSNJ emphasize the clinical aspect of the "futility" question in terms of cure or improvement rather than subjective value judgments. The use of the term "medically inappropriate or futile" is used in this sense.

for the competing positions - for example, autonomy, best interests, and efficient allocation of resources.

The court need not resolve the issue of medical futility in this case. In point of fact, the issue in this case, although not yet adjudicated, has been weighed and addressed in New Jersey's end-of-life jurisprudence. New Jersey case law recognizes that a patient has no right to compel a health care professional to violate generally accepted professional standards. In Farrell, the New Jersey Supreme Court stated:

> Health care standards are not undermined by the medical authorities that support the right to self-determination that we recognize today. **Even as patients enjoy control over their medical treatment, health care professionals remain bound to act in consonance with specific ethical criteria.** We realize that these criteria may conflict with some concepts of self-determination. **In the case of such a conflict, a patient has no right to compel a health care provider to violate generally accepted professional standards**. *Cf. President's Commission Report, supra*, at 44.[6] ("A health care professional has an obligation to allow a patient to choose from among medically acceptable treatment options . . . or to reject all options. No one, however, has an obligation to provide interventions that would, in his or her judgment, be countertherapeutic.") [108 N.J. at 351-52 (emphasis added).]

In this passage the Court makes the critical distinction between the virtually unlimited scope of the patient's "negative" rights, i.e., the patient's right to refuse all treatment options,

[6] "President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forgo Life-Sustaining Treatment" (1983).

and the significantly more limited scope of the patient's "positive" rights, i.e., the patient's right to compel the provision or continuation of treatment regardless of the health care professional's view of the appropriateness of such treatment. Similarly, in Vacco v. Quill, 521 U.S. 793, 807 (1997), rejecting a claim for physician-assisted suicide the United States Supreme Court observed that a patient's right to refuse treatment was not grounded in "a general and abstract 'right to hasten death'" but rather in traditional rights to bodily integrity and freedom from unwanted touching.

Although the passage in Farrell may constitute obiter dictum, the distinction that it articulates is, at the very least, consistent with other common law principles and with the public policy principles embedded in pertinent legislative enactments both in New Jersey and in similar statutes throughout the country.

POINT II

THE ADVANCE DIRECTIVE ACTS PROVIDE GUIDANCE ON THE LIMITATIONS OF PATIENT AUTONOMY AND THE REFUSAL TO PROVIDE MEDICALLY INAPPROPRIATE OR FUTILE CARE. THIS LEGISLATION SUPPORTS THE AUTHORITY OF A PHYSICIAN OR OTHER HEALTH CARE PROVIDER OR INSTITUTION TO WITHDRAW MEDICALLY INAPPROPRIATE OR FUTILE CARE DESPITE THE REQUEST OF PATIENT OR SURROGATE THAT IT BE CONTINUED.

Beginning in 1976, states throughout the country enacted advance directives legislation. To date, virtually all states have enacted statutes authorizing and governing the use of advance

directives. (A survey of the various state statutes is contained in an appendix table to this Brief at Aa-10 to 18.) Moreover, beginning in the early 1990's, a significant number of states adopted legislation that specifically authorizes health care professionals to refuse unilaterally to provide or continue providing LSMT when medically inappropriate or contrary to generally accepted health care standards. Many of these statutes have been based on the Uniform Health care Decisions Act drafted by the National Conference of Commissioners on Uniform State Laws. See Thaddeus Mason Pope, "Medical Futility Statutes: No Safe Harbor to Unilaterally Refuse Life-Sustaining Treatment," 75 Tenn. L. Rev. 1, 53 n.291 (2008). New Jersey's advance directives statute - the New Jersey Advance Directives for Healthcare Act (the "New Jersey Act"), found at N.J.S.A. 26:2H-53 to -91, which went into effect in 1992 - belongs, albeit with a few qualifications discussed below, to a second wave of health care decision-making legislation.

While empowering a patient to provide preferences and instructions in the event of a serious illness or terminal condition, these advance directives/health care decision-making statutes also clearly reject the unfettered ability of a patient or family to demand care. Indeed, all but five states have provided expressly by statute that health care professionals may refuse to comply with a patient's request for treatment on some

ground. See Monica Sethi, "A Patient's Right to Direct Own Health Care vs. a Physician's Right to Decline to Provide Treatment," 29 Bifocal, Dec. 2007, at 21, 27, 32 n.32. These statutorily protected grounds include reasons of conscience or personal beliefs, religious convictions, and conflict with accepted health care professional standards. See generally, Pope, supra; see also Sethi, supra, at 27. The proposition that health professionals have a right to discontinue care when its continuation is contrary to accepted professional standards is well established throughout the country, both as a matter of professional consensus within the national medical community, see, e.g., AMA Council on Ethical and Judicial Affairs, Code of Medical Ethics §§ 2.035, 2.037 (2006-2007); Am. Thoracic Soc'y, Withholding and Withdrawing Life-Sustaining Therapy, 144 Am. Rev. Respiratory Disease 720, 728 (1991), and as a matter of statutory law in a majority of state jurisdictions, see Sethi, supra, at 32-33 n.34 (listing statutory provisions from 29 states authorizing physicians or other health care professionals to decline to take any action contrary to accepted health care standards).

Significantly, fifteen states, including New Jersey, expressly acknowledge that health care professionals have a right to discontinue care when its continuation would be medically "ineffective," "futile," "inappropriate," or contrary to "generally accepted health care standards," "reasonable medical

standards" or, in the case of New Jersey, "accepted professional standards" or "accepted medical standards." See Sethi, supra, at 33 n.38. Furthermore, eleven states, including New Jersey, statutorily prescribe some process by which a health care provider may properly decline to continue providing LSMT over the objections of the patient's proxy. See Lisa L. Dahm, "Medical Futility and the Texas Medical Futility Statute: A Model to Follow or One to Avoid?," 20 No. 6 Health Law 25, 26 (2008). Finally, while eleven other states **require** the health care provider to continue providing LSMT without time limit pending transfer to a facility willing to comply with the request of the patient or patient's proxy to continue LSMT, New Jersey is **not** one of these states. See Maggie Datiles, "The Rising Role of Advance Directives in Protecting the Sanctity of Human Life," in Americans United for Life, Defending Life 2008: A State-by-State Legal Guide to Abortion, Bioethics and the End of Life 511, 513 (2008). In short, New Jersey belongs to a relatively small group of state jurisdictions that have enacted the most explicit legislative measures to safeguard the right of physicians and other health care professionals to refuse to take part in medical interventions that are contrary to accepted health care standards.

While the New Jersey Act is, in most respects, similar to other post-1990 state enactments, its scope is conspicuously narrower than the others in that it expressly limits its

applicability to situations in which the patient has executed an advanced directive. See N.J.S.A. 26:2H-74. Because Mr. Betancourt did not have an advance directive (3T 23:18-20), the New Jersey Act does not control or directly apply to this appeal. Nevertheless, the New Jersey Act enunciates several principles of law and public policy which, for the reasons stated above, should guide the resolution of the instant case. The most relevant of these guiding principles concern: (1) whether the patient's right to self-determination is limited, and if so, the extent to which it is limited; and (2) the circumstances under which New Jersey permits life-sustaining treatment to be withheld or withdrawn from a patient despite the objection of patient or surrogate.

The New Jersey Act clearly articulates the principle that the patient's right to self-determination is limited, inter alia, by the State's interest in safeguarding the ethical integrity of the health care professions, including professionals and institutions providing the medical care. First and foremost, Sections 26:2H-62 and 2H-65 of the Act unambiguously provide that the patient's right to self-determination does not require health care professionals or institutions to continue care that is contrary to accepted health care standards. Subsection (d) of N.J.S.A. 26:2H-62, which describes additional rights and responsibilities of health care professionals, provides in pertinent part in that "[n]othing in this act shall be construed to require a physician,

nurse or other health care professional to … continue … health care in a manner contrary to law or accepted professional standards." Similarly, Subsection (c) of N.J.S.A. 26:2H-65, which describes additional rights and responsibilities of health care institutions, provides that "[n]othing in this act shall be construed to require a health care institution to participate in the … continuing … of health care in a manner contrary to law or accepted medical standards." If one is not required to continue the care, this necessarily presumes a right to withdraw the care.

Additional support for this principle is found in the legislative findings section of the New Jersey Act. In particular, Subsection (d) of N.J.S.A. 26:2H-54 states, in pertinent part, that "[t]he right of individuals to forego life-sustaining measures is not absolute and is subject to certain interests of society," and that one of these interests "encompasses safeguarding the ethical integrity of the health care professions, individual professionals, and health care institutions, and maintaining public confidence and trust in the integrity and caring role of health care professionals and institutions." N.J.S.A. 26:2H-54(d). Given New Jersey's long-settled position since the Quinlan decision in 1976 that compliance with an individual patient's request to forego LSMT does not, in itself, violate the ethical integrity of the health care professions, and given that none of the leading end-of-life cases in New Jersey

since then have ever found this interest to outweigh the patient's interests, the Legislature's having nevertheless expressly identified this interest in its legislative findings strongly suggests that it contemplated situations in addition to that of a patient's refusal of LSMT. It is consistent with the Farrell dicta that a patient has no right to compel a physician or health care provider to continue treatment and thereby violate either generally accepted standards or ethics by continuing care. Considered both separately as well as together, these three provisions make clear that the patient's right to self-determination is limited by the right of health care professionals and institutions to decline to continue or participate in care that they believe is contrary to accepted professional and medical standards.

In contemplation of the second guiding principle, the New Jersey Act provides that in New Jersey, "life-sustaining treatment" may be withheld or withdrawn from a patient in six circumstances, all six of which are circumstances in which the patient's demand for continued treatment may conflict with accepted professional and medical standards. They are:

(1) When the life-sustaining treatment is experimental and not a proven therapy, N.J.S.A. 26:2H-67(a)(1);

(2) When the life-sustaining treatment is likely to be "ineffective" or "futile in prolonging life," N.J.S.A. 26:2H-67(a)(1);

(3) When the life-sustaining treatment is likely to merely prolong an imminent dying process, N.J.S.A. 26:2H-67(a)(1);

(4) When the patient is permanently unconscious, N.J.S.A. 26:2H-67(a)(2);

(5) When the patient is in a terminal condition, N.J.S.A. 26:2H-67(a)(3); and

(6) In the event none of the above circumstances applies, when the patient has a serious irreversible illness or condition, and the likely risks and burdens associated with the medical intervention to be withheld or withdrawn may reasonably be judged to outweigh the likely benefits to the patient from such intervention, or imposition of the medical intervention on an unwilling patient would be inhumane, N.J.S.A. 26:2H-67(a)(4).

In short, as the Act makes clear, even where the patient has executed a directive to the contrary, a health care professional and/or institution may refuse to continue providing LSMT if its continuation is contrary to accepted professional and medical standards and if the circumstances fall within one of the six categories noted above. Had a directive been in place in Mr. Betancourt's situation, the statutory provisions regarding treatment that is "futile in prolonging life" and merely prolonging an imminent dying process in a patient who is permanently unconscious and in a terminal condition would have precluded the result reached by the court below. Where as here no directive is present, health care professionals and institutions

ought to be as entitled to this same right because the underlying principle has already been adopted as a matter of public policy in New Jersey.

POINT III

THE DECISION-MAKING POWER OF THE PATIENT OR THE PATIENT'S SURRROGATE DOES NOT INCLUDE THE POWER TO COMPEL CARE TO BE PROVIDED, ESPECIALLY WHEN CONTRARY TO ACCEPTED STANDARDS OR MEDICAL ETHICS

As already discussed, in large part the question presented on this appeal is whether the patient's family can compel physicians and health care providers to provide continued medical care to a patient in a permanent vegetative state who is actively dying or whether the health care providers can seek to terminate the continued care in such circumstances. In A. Meisel & K.L. Cerminara, The Right To Die: The Law of End-of-Life Decisionmaking (3d ed. 2004), the authors observe that:

> The fundamental legal question in the futility debate is whether the right of self-determination encompasses a "positive" legal right to compel the provision of treatment or whether it is limited to the long-standing "negative" right to be free from unwanted interferences with bodily integrity. It is now relatively clear that there is no broad constitutional basis for such a claim and that the general common law and statutory precedents for positive rights range from mixed to weak. [Id. § 13.01[C] at 13-5.]

While the lower court in this matter made reference to Quinlan, Conroy, and Jobes, it did so only to identify the principle of a patient's right of self-determination and the

general paradigm that a court should not ordinarily be involved in whether treatment should be removed. [Da48 to 50]. It failed to appreciate that those cases involved a request and consent by the patient or surrogate for the termination of care. Those cases do not deal with situations in which the patient's surrogate wants care to continue and the health care professionals disagree, taking the position that further care is medically inappropriate or futile.

More relevant to this situation is Causey v. St. Francis Medical Center, 719 So.2d 1072 (La. App. 1998), which the lower court failed to consider properly. The facts in Causey are strikingly similar to the facts of this case with the principal difference being a younger patient. In Causey, a comatose quadriplegic patient with ESRD was at the hospital in renal failure. The patient's treating physicians believed that continued dialysis would be of no benefit and over the family's objection and contrary demand, dialysis was discontinued, the ventilator was removed, and the patient died soon thereafter of respiratory and cardiac failure. Id. at 1073-74.

The holding in Causey simply involved a pleading issue and the need for the claim to first go through that state's medical malpractice review panel procedure before the tort claim could be filed. The court stated that if not obtaining consent in this

situation was below the appropriate standard of care, then the hospital would be liable for medical malpractice. Id. at 1076. However, "[a] finding that treatment is 'medically inappropriate' by a consensus of physicians practicing in that specialty translates into a standard of care." Id.

Rideout v. Hershey Medical Center, 30 Pa. D. & C.4th 57 (CP Dauphin County, Pa. 1995) (heard en banc) is another case which carefully analyzes the issues involved here. Although Rideout is a trial court's ruling on a motion to dismiss, the motion was heard en banc and the opinion is carefully thought out and well reasoned. The plaintiffs in Rideout brought 11 causes of action seeking damages from defendant hospital for withdrawing their child's respirator without their consent. Id. at 59-63. In deciding the defendant's motions to dismiss each claim, the Pennsylvania court discussed the principles of self-determination, as well as potential tortious and statutory grounds for the action.

The Rideouts' claims that are most relevant to this appeal were the claims that disconnecting their child's respirator without the parent's consent violated their child's right to privacy under the Pennsylvania Constitution, and the right to liberty under the U.S. Constitution as recognized in Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990). Id. at 74. After stating that the state's interest in "the integrity

of the medical profession" was implicated by these facts, Id. at 77, the court held that the right to privacy and the right to liberty do not confer a right to **demand** medical care or treatment, only a right to **refuse** treatment. Id. at 80. The court thus dismissed the claims based on a right to privacy and a right to liberty. Id. at 82.

The analysis of the issues presented here revolves around the existence or non-existence of a duty to provide care and the determination of who, as between the patient or patient's surrogate and the medical provider - whether physician or hospital - has the legal right to decide. Guidance can be drawn from the end-of-life jurisprudence as well as tort cases and constitutional principles. In addition, an examination of statutory provisions demonstrates that only in a very limited context is there a positive right to demand treatment, and that context does not embrace the right to demand treatment that is deemed to be contrary to medical standards.

A. THERE IS NO CONSTITUTIONAL RIGHT TO DEMAND END-OF-LIFE HEALTH CARE

Neither the United States Constitution nor the New Jersey Constitution of 1947 provides a basis for compelling a hospital or physician to furnish health care. Apart from the probable lack of state action in the facts of this case, the United States Supreme Court has consistently refused to recognize entitlement to such

services as education or health care as within the ambit of the Due Process Clause. In DeShaney v. Winnegao County Dep't of Social Servs., 489 U.S. 189 (1989), the Court stated:

> [T]he Due Process Clause generally confers no affirmative right to governmental aid, even where such aid may be necessary to secure life, liberty, or property interests of which the government itself may not deprive the individual. [Id. at 196.]

Similarly, denial of such services does not invoke the Equal Protection Clause unless the service is "fundamental" or the unequal distribution is the result of a suspect classification. See also Right to Choose v. Byrne, 91 N.J. 287, 304 (1982)(rejecting Chancery Division declaration that the New Jersey Constitution guarantees a fundamental right to health.)

B. TORT PRINCIPLES DO NOT SUPPORT A RIGHT TO DEMAND HEALTH CARE

The common law did not require physicians to provide emergency care at the scene of an accident. There is no common law duty to rescue another person. Rather, a duty of care emerges from what is essentially a contractual relationship between a health care provider and a patient. The common law then provides protection in the form of "negative" rights to be free from injury as a result of negligence or breach of duty.

When a physician-patient relationship is created, a duty emerges to provide the degree of care that is ordinarily provided by practitioners in the same field of medicine, or what is

commonly known as compliance with accepted standards of care. However, this obligation to avoid malpractice does not support the leap to a right of a patient or their surrogate to compel treatment. Neither does the doctrine of informed consent.

The common law doctrine of informed consent - which governs an essential aspect of the decision-making process regarding end-of-life care - includes a limitation on the patient's positive rights that parallels the very limitation suggested in Farrell, supra, 108 N.J. at 351-52. Under the informed consent doctrine, a physician has a clear duty not only to inform a patient or family of the patient's condition and recommended treatment along with accompanying risks and benefits, but also to disclose alternative treatments. See Largey v. Rothman, 110 N.J. 204, 208 (1988). However, alternative treatment choices must be in accordance with accepted standard medical practice. A physician is not required to administer any course of treatment which the physician regards as medically inappropriate. Matthies v. Mastromonaco, 310 N.J. Super. 572, 598 (App. Div. 1998), aff'd, 160 N.J. 26 (1999).

Although a physician may be required to provide information regarding medical options, the right of informed choice has never been held to empower a patient to require a physician to provide a particular form of treatment to a patient, but merely to choose from among those that the physician is qualified to offer or that

other qualified physicians might offer. As summarized in Meisel & Cerminara, it is still "essentially a negative right - a right to say no to a recommended treatment, a right to be free from unwanted interferences with one's bodily integrity" and the contention that these principles of self-determination create a right by patient or family to dictate what treatment is to be administered "is to read the common law precedents both out of context and far too broadly." A. Meisel & K.L. Cerminara, The Right to Die, supra, § 13.04[E][1] at 13-20.

Likewise, the doctrine of abandonment also provides no foundation for a duty to treat. Abandonment of a patient involves the failure of a physician to continue to provide treatment when it is still needed where the physician had assumed a responsibility to treat and has not been properly relieved with a resulting injury. Clark v. Wichman, 72 N.J. Super. 486, 491-92 (App. Div. 1962). Abandonment does not occur when there has been sufficient notice of termination of services. See Marshall v. Klebanov, 182 N.J. 23, 34 (2006); Brandt v. Grubin, 131 N.J. Super. 182, 192-93 (Law Div. 1974). Indeed, the New Jersey State Board of Medical Examiners adopted a regulation that permits a physician to terminate a physician-patient relationship and discontinue care after giving notice in accordance with the regulation and a period of 30 days during which the patient has an opportunity to transfer care to another provider. N.J.A.C. 13:35-

6.22. This element of "transfer" of care is an important component of the analysis necessary here. As discussed further in Point IV infra, transfer of patient responsibility is a mechanism for resolving the ethical problem of demanding that a physician or health care provider continue to provide treatment considered medically inappropriate. See Couch v. Visiting Home Care Services, 329 N.J. Super. 47, 53 (App. Div. 2000). The court noted with approval the comments that had been in Matthies v. Mastromonaco, supra, that a physician was not required to administer a course of treatment regarded as medically inappropriate and directed the transfer of the patient.

Moreover, it is not just the failure to treat that is involved in an abandonment claim; the essential prerequisite is failure to treat the patient when treatment is medically appropriate. A. Meisel & K.L. Cerminara, supra, § 11.03[D] at 11-46. More fundamentally, the inability to transfer provides a strong indication that the requested treatment is indeed outside accepted medical practice and the standard of care. Pope, supra, "Medical Futility Statutes: No Safe Harbor to Unilaterally Refuse Life-Sustaining Treatment," 75 Tenn. L. Rev. at 61.

C. THE CIRCUMSTANCES OF THIS CASE DO NOT INVOLVE ANY STATUTORY BASIS FOR COMPELLING CARE TO BE PROVIDED.

The common law rule that there is no duty to provide medical care in an emergency has been modified by statute. Pursuant to

N.J.S.A. 26:2H-18.64, no hospital shall deny admission or appropriate service to a patient on the basis of that patient's ability to pay or source of payment. This mandate is tempered, however, by N.J.S.A. 26:2H-18.63 which provides that the obligation to treat does not apply to elective procedures. Cf. St. Barnabas Medical Center v. County of Essex, 111 N.J. 67, 75-76 (1988). There have not been any end-of-life cases involving the New Jersey statute. However, decisions involving related federal legislation offer instructive guidance.

The Federal Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C.A. § 1395dd requires a hospital to provide "appropriate medical screening" and to either stabilize or transfer a patient who presents with an "emergency medical condition." EMTALA was found to be source of a positive right to treatment in In re Baby "K," 823 F.Supp. 1022 (E.D. Va. 1993), aff'd, 16 F.3d 590 (4th Cir.), cert. denied, 513 U.S. 825 (1994). This was an end-of-life case involving a hospital's refusal to resuscitate and provide ventilatory support for an anencephalic infant. Anencephalic infants are born without a forebrain and the absence of portion of the skull.

After birth the infant had been living in a nursing home but was brought to the hospital's emergency room because of respiratory distress. The second time this occurred the hospital

filed an action seeking declaratory judgment that the care could be withheld over the mother's objection. The Fourth Circuit Court of Appeals upheld the District Court's determination that the care had to be provided and could not be withheld. However, this holding was based on the narrow grounds of the EMTALA requirement as to a hospital's obligation to a patient arriving with an emergency condition. After stabilization has occurred, EMTALA does not require continuing care.

The Fourth Circuit made this clear in its decision in Bryan v. Rectors & Visitors of the Univ. of Va., 95 F.3d 349 (4th Cir. 1996). In that case, a patient had been brought to the hospital in an "emergency medical condition" of respiratory distress and was stabilized. The patient remained in the hospital for some 12 days when the hospital determined according to its internal procedures that a "DNR" order would be entered on the chart contrary to the wishes of the family. The patient died. The family brought an action for damages under EMTALA.

The Court of Appeals affirmed the dismissal of the complaint. It emphasized that EMTALA sought to achieve a "limited purpose" and that the stabilization requirement did not involve the patient's "longer-term full treatment." The statute could not "plausibly be interpreted to regulate medical and ethical decisions outside that narrow context." Id. at 352. It

distinguished its Baby "K" holding, stating that it had relied entirely on the stabilizing nature of the care there and the decision "did not present the issue of the temporal duration of that obligation, and certainly did not hold that it was of indefinite duration." Id.

The conclusion that EMTALA did not prohibit termination of care was noted by the court in Causey v. St. Francis Med. Center, supra, 719 So.2d at 1075 n.2.

The applicability of EMTALA to the termination of ventilator support over a family's objection was similarly rejected in Rideout v. Hershey Med. Ctr., supra, 30 Pa. D & C. 4th 57 (C.P. Dauphin Ct. 1995). This Pennsylvania decision by an en banc panel of the Court of Common Pleas also considered whether the termination of the ventilator support violated the Federal Rehabilitation Act of 1973, 29 U.S.C.A. § 794. It rejected this statute as source of a duty to treat a "handicapped" individual or that the failure to treat was a form of discrimination prohibited by the Rehabilitation Act. The court accepted the hospital's contention that the patient was not "otherwise qualified" for the treatment but for her brain cancer since it was her brain cancer that necessitated the use of the ventilator.

While the question of whether the related Americans with Disabilities Act (ADA) creates a duty to treat has received

limited attention in the case law, a recent law review comment offers a compelling arguments as to why it should not.

> [I]f the ADA prohibits the withdrawal of treatment from permanently unconscious patients, it follows that it is discriminatory to withhold treatment from anyone. From this line of reasoning, one might conclude that Congress must have intended to create a system of unlimited universal access to health care when it enacted the ADA. This conclusion is obviously incorrect; interpreting the ADA to require the lives of those who are permanently unconscious to be sustained endlessly is not only unfeasible, it is also contrary to the wishes of many people with disabilities who desire beneficial, as opposed to extended, treatment. The crucial difference is "between discriminating judgment and discriminatory judgment." [Kristi E. Schrode, Comment, "Revising Policies For Permanently Unconscious Patients," 31 Hous. L. Rev. 1609, 1662 (1995).]

See also Schiavo ex rel. Schindler v. Schiavo, 403 F.3d 1289, 1293 (11th Cir. 2005)("The Rehabilitation Act, like the ADA, was never intended to apply to decisions involving the termination of life support or medical treatment.")

Other New Jersey statutory and regulatory provisions regarding long-term care facilities are also lend support to Trinitas' position on this appeal.

In Gleason v. Abrams, 250 N.J. Super. 265 (App. Div. 1991), the court noted that until enactment of the New Jersey Advance Directives for Health Care Act (discussed in detail in Point II of this Brief), the legislature had not set forth any policy recognizing or rejecting the right of a person to refuse LSMT. Gleason involved the statute establishing the Office of the

Ombudsman for the Institutionalized Elderly and authorizing the promulgation of regulations to implement N.J.S.A. 52:27G-1 et seq. was at issue in Gleason. The Ombudsman was charged with protecting the institutionalized elderly from "abuse" which was defined and proscribed by the statute. The Ombudsman had promulgated regulations that excluded certain instances of withdrawing or withholding LSMT from required reporting of "abuse." But "providing to a resident medical treatment that is not medically indicated" was within the scope of "abuse". N.J.A.C. 5:100-1.2 (now found at N.J.A.C. 15A:3-1.2). The Appellate Division noted that the term "medically indicated" was defined as "'treatment that will improve the medical condition of the resident or is necessary to provide palliative care to the resident.'" 250 N.J. Super. at 273 (quoting N.J.A.C. 5:100-2.2 (now found at N.J.A.C. 15A:3-2.2)). Consequently, providing a patient with treatment that does not improve the patient's medical condition would be a violation of this regulatory provision. Certainly, it does not support a family's demand for treatment that would not improve the patient's condition but simply prolong the dying process.

Accordingly, if Mr. Betancourt were in a facility subject to these statutes and regulations and his health care professionals had not attempted to discontinue dialysis, the mechanical

ventilation, and effectuate a DNR process, they arguably would be subject to sanctions under the Act.

POINT IV

THE TRANSFER OF PATIENTS WHOSE FAMILY SEEK MEDICALLY INAPPROPRIATE OR FUTILE LIFE-SUSTAINING MEDICAL TREATMENT SHOULD BE PERMITTED TO ACCOMMODATE THE ETHICAL OBLIGATIONS OF PHYSICIANS AND HEALTH CARE PROVIDERS AND THE DUTY HOSPITALS OWE TO THE PUBLIC TO MAKE THEIR LIMITED BEDS AND RESOURCES AVAILABLE TO PATIENTS WHO ARE IN NEED OF ACUTE CARE

While the families of terminally ill patients in situations such as Mr. Betancourt's usually reach consensus agreement with health care professionals regarding the discontinuation of LSMT, Mr. Betancourt's family wanted the caregivers at Trinitas to keep Mr. Betancourt alive, even though he had no prognosis for recovery. While the wishes of the family concerning health care decisions should be respected, as substantiated in Points I through III of this Brief, the family does not have the absolute power to direct treatment. Acquiescence to the wishes of the family should not be required when to do so would require health care professionals and institutions to provide unethical and medically inappropriate or futile treatment to a moribund patient.

In end-of-life situations, a patient's right of self determination must always be balanced by four state interests: the state interest in preserving life, the state interest in preventing suicide, the state interest in safeguarding the integrity of the medical profession, and the state interest in

protecting third parties who may be harmed by the treatment decision. In re Conroy, 98 N.J. 321, 348-349 (1985); see also N.J.S.A. 26:2H-54(d). In this case, the wishes of Mr. Betancourt's family impermissibly violate New Jersey's interest in preserving the integrity of the medical profession.

Conroy and N.J.S.A. 26:2H-54(d) both declare that a patient's interest in self-determination must be balanced by a state's interest in preserving the integrity of the medical profession. Id. If this judicial and legislative principle is to have any effect, there must be some point at which the request of a patient or the patient's proxy goes beyond the tolerable bounds of professional ethics, after which point a physician is no longer required to honor those requests. Ethical publications by medical associations can provide useful guidance in these circumstances.

In short, resolution of the ethical conflict can be accomplished with a transfer of care to either a different physician or different health care facility and continuing care until the transfer is completed. The lower court in Jobes ordered just such a transfer. The Supreme Court reversed that part of the order only "under the circumstances of this case" and primarily because the nursing home patient in Jobes had not been informed of a policy precluding removal of a feeding tube and indeed, the record did not indicate that any such policy had ever been formalized. 108 N.J. at 424-25. Under these circumstances, the

Court concluded that the resident and her family "were entitled to rely on the nursing home's willingness to defer to their choice among courses of medical treatment." Id. The record indicated that it would be difficult, if not impossible, to locate another facility that would accept Mrs. Jobes and the Court concluded that allowing the discharge "would essentially frustrate Mrs. Jobes' right of self-determination" since it would deprive her of all care, including palliative care, not simply the LSMT that the family wanted discontinued. Id. at 425-26. Accordingly, it imposed on the nursing home the burden of complying with the request to withdraw LSMT despite its ethical and policy-based misgivings.

On the other hand, in Couch v. Visiting Home Care Services, supra, the Appellate Division reversed an order requiring home nursing care for an indefinite period of time where the nursing professionals were of the view that the continued care was medically inappropriate. After summarizing the contentions of the parties, the court stated: "the real issue is the right of these medical providers to withdraw from a case when in their professional opinion it would be improper and unsafe to continue." 329 N.J. Super. at 52. Relying on Matthies v. Mastromonico, supra Judge Bilder wrote:

> If the patient selects a course, even from among reasonable alternatives, which the physician regards as inappropriate or disagreeable, the physician is free to refuse to participate

> and to withdraw from the case upon providing reasonable assurances that basic treatment and care will continue. [Id.]

The court authorized the transfer to another facility.

Moreover, as previously set forth in this Brief, the right of self-determination is not absolute. In connection with an advance directive, the mechanism of transfer is widely employed. Furthermore, in the context of the appropriateness of the demanded care, the fact that another physician or another health care facility is unwilling to provide the demanded care is corroborative of the inappropriateness of the care and the reason for its termination.

> If the patient is transferred, then she will receive the requested treatment. If the patient is not transferred, the inability to transfer should serve as confirming evidence that the requested treatment was outside the standard of care and that the provider's refusal to comply with the request was appropriate. To the extent there is variability among providers' judgments of medical appropriateness, transfer thereby serves as an important safety valve function. [Pope, supra, 75 Tenn. L. Rev. at 61.]

In discussing the discontinuation of dialysis for the patient in Causey, that court had noted with approval a procedure of attempting to transfer the patient. 719 So.2d at 1076 n.3.

An additional interest of the public which the trial court below failed to consider is the duty that a hospital, like Trinitas, owes to the public which it serves to take all steps necessary to ensure that adequate acute care is available to those in need of it. N.J.S.A. 26:2H-18.64 provides that a hospital shall

not "deny any admission or appropriate service to a patient on the basis of the patient's ability to pay or source of payment." (Emphasis added.) However, once this duty has been fulfilled, as it was here and the provision of this service is no longer "appropriate," the hospital must also take into account its duty to the public at large, with which it has a fiduciary relationship. This duty includes the removal of patients from a hospital who are no longer in need of acute medical care. There is no question on this trial record that Trinitas has provided all the care to which the patient is entitled - and more.

Trinitas is a quasi-public trust and has a fiduciary relationship with the public. Zoneraich v. Overlook Hospital, 212 N.J. Super. 83, 90 (App. Div.), certif. denied, 107 N.J. 32 (1986); Berman v. Valley Hospital, 103 N.J. 100, 106 (1986). As such, Trinitas operates "for the benefit of the public" and "in aid of service to the public." Greisman v. Newcomb Hospital, 40 N.J. 403-04 (1963). In appropriate circumstances, courts have ordered the removal of a patient who is no longer in need of acute care so that the hospital may make its bed available to another patient who is.

The leading case in New Jersey is Jersey City Medical Center v. Halstead, 169 N.J. Super. 22 (Ch. Div. 1979). In that case, the court dealt with the issue of the removal of a patient from a hospital where the patient's medical condition no longer required

hospitalization. The court noted that the record revealed a lack of bed space at the hospital and that this presented difficulty for the hospital and "a potential of serious prejudice to patients requiring hospital care." Id. at 24. Judge Kentz noted with approval that there were other facilities such as nursing homes or extended care facilities which were better utilized for persons who did not have acute medical problems. He further wrote:

> The overcrowding which has already been discussed poses a real danger in that those patients actually in need of emergency medical care might receive less than optimal care if the overcrowding persists. **[The Medical Center] owes a duty to the public which it serves to take all steps necessary to insure that adequate care is available to those in need of it, and this includes the removal of patients no longer in need of medical care.**
>
> Equity will in proper cases enjoin a continuing trespass or series of trespasses if an action for damages would provide an inadequate remedy. ... It is clear that an action by [the Medical Center] for damages would be adequate compensation for services already rendered ... but would be inadequate to remedy the damage done to [The Medical Center's] ability to carry out its public duty by her continued occupancy of bed space. [Id. at 25 (emphasis added).]

Similarly, and more recently, in 2000, the Chancery Court in Bergen County removed an incapacitated, undocumented alien who was occupying an acute care bed but who was no longer in need of acute care. In In re Orlando Flores,[7] the patient was in need of

[7] While there is no formal opinion, pursuant to R. 1:36-3, a copy of pertinent pleadings from this unreported decision are included in the Appendix to this Brief at Aa-1 to 9. Counsel is unaware of any other relevant unpublished opinions within the scope of the rule, including those adverse to the position advanced here.

skilled nursing care and had been cleared for discharge by his physician; however, his family refused to cooperate with the hospital to effectuate the discharge. (Aa-1 to 2). The hospital had been on divert and bypass status over the preceding months leading to the court action.

In granting the relief requested by the hospital, the Court appointed a Temporary Guardian for the patient who was directed to cooperate with the hospital and complete any documentation necessary to effectuate the discharge and transfer of the patient. (Aa-2). The court also ordered the discharge and transfer of the patient (who was from El Salvador, and who was in a persistent vegetative state) from the hospital to a charity care hospital in San Salvador, noting that the hospital "has paid or given free care to [the patient] for one year" and had made every effort to find a suitable facility in the United States which would take the patient. (Id.)

The family brought a motion for a stay pending appeal which the Chancery Court denied. (Aa-5 to 6). The Appellate Division granted an emergent stay pending appeal, (Aa-7); however, the New Jersey Supreme Court heard the hospital's emergent motion to vacate the Appellate Division's stay and vacated the stay in a 7-0 decision, clearing the way for the immediate transfer of the patient to El Salvador. See In re Flores, N.J. Supreme Court Docket No. M-159 (September 7, 2000); (Aa-8 to 9). The hospital

successfully argued to the Supreme Court that, given the difficulty in securing a long-term care bed for the patient and the delay in ability to transfer the patient, and because there was no assurance that the hospital in San Salvador would continue to hold the available bed, immediate transfer was necessary to avoid irreparable harm, as that bed may have been the patient's only meaningful hope for long-term care.

Although the record in this case does not indicate that Mr. Betancourt was using resources that Trinitas then needed for some other patient, a judicial precedent compelling a hospital and its treating physicians to provide a patient with medically inappropriate or futile treatment for an indefinite period could, in other situations, force a hospital to violate its public trust.

POINT V

NEITHER CATHOLIC TEACHING NOR THE ETHICAL AND RELIGIOUS DIRECTIVES GOVERNING CATHOLIC HEALTH CARE INSTITUTIONS REQUIRE A HEALTH CARE PROFESSIONAL OR HOSPITAL TO ADMINISTER CARE THAT IS MEDICALLY, ETHICALLY, AND MORALLY INAPPROPRIATE

In Quinlan, the Supreme Court took note of the teachings of the Catholic Church in considering the appropriateness of Mr. Quinlan to serve as the guardian for his comatose daughter. 70 N.J. at 32-34. The Court did not view the teachings of the Catholic Church as being precedential in resolving a civil law question. However, the Court did find it significant that the Roman Catholic Church did not consider it immoral to discontinue

respirator treatment and that treatment termination would probably not "be at all discordant with the whole of Judeo-Christian tradition, considering its central respect and reverence for the sanctity of human life." Id. at 47. Subsequently in Conroy, the Court considered the testimony of a Roman Catholic priest in that proceeding who explained the ethical and moral tests involving the benefits and burdens of continuing treatment and end-of-life decision-making. 98 N.J. at 340.

The Catholic teaching does not require that a Catholic hospital or a health care professional working in such a hospital to provide end-of-life medical treatment that such hospital or professional believes is medically, ethically, and morally improper. The Ethical and Religious Directives for Catholic Health Care Institutions (2001) (the "Directives"), (available at http://www.usccb.org/bishops/directives.shtml) which govern the activity within all Catholic health care institutions in the United States, are not inconsistent with the development of the secular common law and statutory law of New Jersey on end-of-life medical interventions. Directive 56 states: "a person has a moral obligation to use ordinary or proportionate means of preserving his or her life." The phrase "ordinary and proportionate means" are defined as those that, in the patient's view, offer a reasonable hope of benefit, and are not excessively burdensome or expensive. Directive 56.

Similarly, Directive 57 permits the withdrawal of extraordinary or disproportionate means of sustaining life. The phrase "extraordinary or disproportionate means" are similarly defined as those that do not offer a reasonable hope of benefit or are excessively burdensome or expensive. Directive 57. Accordingly, while the Directives oblige people to use ordinary and proportionate means to preserve life, they do not require a person to sustain life through extraordinary or disproportionate means.

While the Directives, like New Jersey case law, respect patient autonomy and self-determination, see e.g., Directives 24-26, 59, the Directives similarly recognize that this right is not absolute, and, more specifically, that it is limited by concepts of morality and ethics. For example, Directives 59 clearly states that:

> The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, **unless it is contrary to Catholic moral teaching**. (Emphasis supplied).

Catholic ethicists who have written on this topic have observed:

> Viewed from a Christian and Catholic perspective, however, autonomy is not absolute. The Christian is obliged to use his or her God-given freedom wisely and well . . . the patient and his or her family have an obligation in charity to respect the autonomy of the health professional or institution. The patient cannot, in the name of the absoluteness of autonomy, demand that the physician become the unquestioning instrument of the patient's will. The conscience of the religious physician or hospital cannot be

overridden . . . . [Edmund D. Pellegrino & David C. Thomasma, The Christian Virtues in Medical Practice 123 (1996).]

On the record of this case, where the patient from whom treatment is being withheld is in a permanent vegetative state and is actively and palpably dying, neither dialysis nor resuscitation offers any reasonable hope of benefit; indeed, such treatments go against the weight of Catholic and secular professional medical ethics and morals.[8] Thus, in the present case, the application of the Directives would lead to the conclusion that it is permissible to withhold life sustaining treatment - i.e., to withhold dialysis for ESRD and to permit the imposition of a DNR Order - even if a patient's surrogate would rather continue the treatment.

POINT VI

THE PUBLIC INTEREST REQUIRES THAT THE COURT ADOPT A PROCESS UNDER WHICH A PHYSICIAN, HEALTH CARE PROVIDER OR INSTITUTION MAY DECLINE TO CONTINUE PROVIDING LIFE-SUSTAINING TREATMENT TO A PATIENT IN CIRCUMSTANCES WHERE CONTINUATION IS CONTRARY TO ACCEPTED PROFESSIONAL AND MEDICAL STANDARDS

Should this court find that a patient's rights of autonomy and decision-making regarding end-of-life care do not require a hospital or its physicians to continue providing LSMT when its continuation is contrary to accepted ethical, moral, or

[8] It should be noted that this is not a case involving the issue of nutrition and hydration and thus, Pope John Paul II's allocution entitled To the Participants in the International Congress on "Life Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas" (Mar. 20, 2004) is not implicated.

professional medical standards, then the court should adopt a set of procedural guidelines which, if properly followed, would enable physicians, hospitals and other health care providers to affirmatively withhold and/or withdraw LSMT without fear of incurring legal liability. NJHA, CHCPNJ, and MSNJ propose the guidelines set forth below, which can be adopted by the court. In 2005 MSNJ had promulgated for its physician members a non-binding set of guidelines regarding medically futile therapy. These are included in the Appendix to this Brief at Aa-19 to 21 and have informed, in part, the suggestions set forth below. Beyond the recommendation to "seek legal opinion," the MSNJ guidelines did not present a mechanism to resolve the conflict of a patient or patient's surrogate demanding the continuation of care found to be medically inappropriate. That opportunity is presented here.

As discussed supra, New Jersey has authorized health care professionals and institutions to decline to implement measures that are contrary to generally accepted health care standards, and has provided a statutorily prescribed process for the resolution of this type of dispute. To do so, the physician, provider or institution must: (1) promptly inform the patient (if possible) and/or the patient's proxy of the refusal; and (2) immediately make reasonable efforts to assist in locating and transferring the patient to the other health care facility.

This discussion is informed by other state statutes which require, either expressly or impliedly, that the treatment continue, including LSMT, for some duration. In some states, such as Alaska, this duration is the period until the patient has been transferred to another facility willing to accept the patient and comply with the patient's instruction or the proxy's decision - i.e., a duration without time limit pending actual transfer. See Datiles, supra, at 513 (listing eleven states with statutory requirements to continue treatment pending transfer). The New Jersey Act, N.J.S.A. 26:2H-62(b), provides that:

> [a] physician may decline to participate in the withholding or withdrawing of measures utilized to sustain life, in accordance with his sincerely held personal or professional convictions. In such circumstances, the physician shall act in good faith to inform the patient and the health care representative, and the chief of the medical staff or other designated institutional official, of this decision as soon as practicable, to effect an appropriate, respectful and timely transfer of care, and to assure that the patient is not abandoned or treated disrespectfully.

Subsection (c) sets forth essentially the same process for nurses and other health care professionals. See N.J.S.A. 26:2H-62(c). Finally, Section 26:2H-65(a)(4), which applies to health care institutions, states:

> In situations in which a transfer of care is necessary, including a transfer for the purpose of effectuating a patient's wishes pursuant to an advance directive, a health care institution shall, in consultation with the attending physician, take all reasonable steps to effect the appropriate, respectful and timely transfer of the patient to the care of an alternative health care professional or institution, as necessary, and shall assure that the patient

> is not abandoned or treated disrespectfully. In such circumstances, a health care institution shall assure the timely transfer of the patient's medical records, including a copy of the patient's advance directive. [N.J.S.A. 26:2H-65(a)(4).]

There is no express requirement under the New Jersey Act to continue LSMT while the institution attempts to effect the transfer, and other than the implied period of time required to "take all reasonable steps" to effect the transfer, no other duration is indicated.[9] As a result, some have suggested that health care providers continue LSMT, even when it is contrary to accepted professional standards, because of the fear of potential legal liability. In addition, writers have documented a trend in outcomes between ex ante cases, i.e., those in which health care providers seek prior judicial approval to discontinue LSMT, and ex post cases, in which the provider discontinues LSMT without

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[9] Two legal commentators suggest that the lack of a specified time duration to continue treatment while a transfer is effected means that the statute is a comprehensive, unilateral decision-making statute which permits the provider to discontinue LSMT under the circumstances permitted by the state's statute after taking "all reasonable steps" to effect the transfer. See Pope, supra, at 60-62; see also, Kathleen M. Boozang, "Deciding the Fate of Religious Hospitals in the Emerging Health Care Market," 31 Hous. L. Rev. 1429, 1454, n.100 (1995). In contrast, one commentator states that New Jersey's statute is like all other state statutes except for Texas in requiring the continuation of treatment pending transfer. Jon D. Feldhammer, "Medical Torture: End of Life Decision-Making in the United Kingdom and United States," 14 Cardozo J. Int'l & Comp. L. 511, 527 (2006). One commentator even suggests that while most states require that LSMT be continued pending transfer, the New Jersey statute does not contain such a requirement. Dahm, supra, at 26 n.47.

judicial permission and then defends the decision in court. Health care providers are much less likely to prevail in ex ante cases than ex post cases.[10] The anomaly of subjecting providers to two considerably different consequences depending on which temporal side of the legal proceeding one is on, suggests that health care providers have a genuine incentive to discontinue LSMT before the possibility of being enjoined from doing so.

Amici NJHA, CHCPNJ, and MSNJ are mindful of the court's reluctance to be perceived as legislating from the bench; however, the principle which was true some 25 years ago is equally true today:

> [P]atients and their families and physicians are increasingly being faced with these difficult and complex decisions without legislative guidelines and under the threat of civil and criminal liability. Until the Legislature acts, it is to the courts that the public must look for the guidelines and procedures under which life-sustaining medical treatment may be withdrawn or withheld. Sensitive to the patients' rights to self-determination, but cognizant of the vulnerability of the sick, we strive to protect all the relevant interests. Conroy, supra, 98 N.J. at 343; Farrell, supra, 108 N.J. at 341-344.

Accordingly, this is a case which requires the court's intervention, consistent with pertinent precedent and the policy

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[10] See Thaddeus Mason Pope, "Involuntary Passive Euthanasia in U.S. Courts: Reassessing the Judicial Treatment of Medical Futility Cases," 9 Marq. Elder's Advisor 229, 238-266 (2008) (providing a comprehensive review of futility cases from 1983 to 2008).

choices reflected in the relevant provisions of New Jersey statutes discussed elsewhere in this Brief.

Thus, even without invoking issues surrounding medical "ineffectiveness" or "futility," health care professionals and institutions should be permitted to exercise their right to discontinue LSMT if LSMT would be unethical, immoral, or not in accordance with accepted professional and medical standards under the following guidelines:[11]

(1) Earnest attempts should be made in advance to deliberate over and negotiate prior understandings between the patient, if possible, the patient's health care representative, and the attending physician on what constitutes appropriate care for the patient, and what falls outside acceptable limits for the physician, family, and possibly also the institution.[12]

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[11] The AMA CEJA guidelines begin with the proposal that "health care institutions, whether large or small, adopt a policy on medical futility." AMA Council on Ethical and Judicial Affairs, Code of Medical Ethics Opinion 2.037 (2008). While it would be well within the authority of the legislature to enact such a broadly applicable proposition into law, it is neither appropriate nor necessary for the court to include such a proposition in issuing guidelines for the instant case. Rather, the court should set forth guidelines that provide clear directions for health care providers and institutions to follow and a clear indication of when and after what actions their responsibilities to continue LSMT end in cases like Betancourt. In this regard, part (2) of the AMA CEJA guidelines serves as a good model upon which to fashion such guidelines. These guidelines are included in the CEJA Report found at Da-38 to 39.

[12] Dervied from AMA CEJA Opinion 2.037(2)(a) except that the term "proxy" was substituted with "patient's health care

(2) To the extent possible, health care decisions should be made jointly between the patient or patient's health care representative and the patient's attending physician(s).[13]

(3) Attempts should be made to negotiate disagreements if they arise, and to reach resolution within all parties' acceptable limits, with the assistance of the institutional ethics committee and consultants as appropriate.[14]

(4) If, however, the disagreements are irresolvable, and the attending physician or the health care institution refuses to comply with a request by the patient or patient's health care representative to continue LSMT because the continuation would be contrary to accepted professional standards (or in the case of an institution, contrary to accepted medical standards),[15] then the physician or institution shall promptly inform the patient, if possible, and the patient's health care representative of the

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representative," which is the term used in New Jersey's advance directives statute. See N.J.S.A. 26:2H-55.

[13] Substantially the same language as in AMA CEJA Opinion 2.037(2)(b), again with "patient's health care representative" substituted for "proxy."

[14] Derived from AMA CEJA Opinion 2.037(2)(c).

[15] While the grounds for the physician's or institution's refusal to continue LSMT are not expressly written into the procedures of any of the statutory procedural requirements or in the AMA CEJA opinion, they are included in these guidelines to limit their scope as much as possible.

refusal[16] and of the right of the patient or patient's health care representative to seek review by an institutional or regional reviewing body as referred to in N.J.S.A 26:2H-69, such as the institution's prognosis committee.

(5) Upon being informed of the physician's or institution's refusal, the patient or patient's health care representative may request review by an institutional or regional reviewing body as referred to in N.J.S.A 26:2H-69, such as the institution's prognosis committee which shall review the case and take into account the recommendations of the ethics committee, testimony of the family and others involved in the care of the patient, and other independent clinical considerations which bear on the patient's care. If such request is made to an institutional body, the request shall be granted.[17] During this review period, the

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[16] See, e.g., Cal. Prob. Code § 4736(a); Tenn. Code Ann. § 68-11-1808(f)(1); but cf. Va. Code Ann. § 54.1-2990(A)

[17] The Texas statute requires institutional review in these situations. Texas Health & Safety Code § 166.046(a) ("If an attending physician refuses to honor a patient's advance directive or a health care or treatment decision made by or on behalf of a patient, the physician's refusal shall be reviewed by an ethics or medical committee.") (emphasis added). However, none of the other ten statutes, including New Jersey, mandates institutional review. On the one hand, the benefits of institutional review are clear, see, e.g., Clin. J. Am. Soc. Nephrol. 3: 587-593, 591 (2008); on the other hand, the New Jersey statute appears does not mandate such review. This proposed guideline strikes the balance of these interests; i.e., while no review is required, review will be granted if the patient or patient's health care representative requests it.

health care providers shall continue to provide LSMT. If such request is not made, or is made to a regional reviewing body but declined, then the procedural requirements of guideline (8) apply.

(6) The institutional or regional review body will issue a decision on the case as soon as reasonably practicable after it completes its review.

(7) If the institutional or regional body's review and decision supports the position of the patient or patient's health care representative and the physician remains unpersuaded, then the health care institution shall, in consultation with the attending physician, take all reasonable steps to effect the appropriate, respectful and timely transfer of the patient to another physician within the institution who is willing to comply with the patient's instruction or the decision of the patient's health care representative.[18]

(8) If the institutional or regional body review and decision support the physician's position and the patient or patient's health care representative remains unpersuaded, or if the review supports the position of the patient or patient's health care representative but no physician within the institution is willing to comply with the patient's instruction or health care representative's decision, then the health care institution shall,

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[18] This guideline is a hybrid of AMA CEJA Opinion 2.037(2)(e) and pertinent language from N.J.S.A. 26:2H-65(a)(4)

in consultation with the attending physician, take all reasonable steps to effect the appropriate, respectful and timely transfer of the patient to another institution that is willing to comply with the instruction or decision. In such cases, the transfer should be supported both by the transferring and receiving institutions. The physician shall provide the patient or patient's health care representative a reasonable period of not less than 14 days and no more than 28 days after the reviewing body's decision to effect such transfer.[19] During this period, the physician shall continue to provide any life-sustaining treatment to the patient which is reasonably available to such physician, as requested by the patient or patient's health care representative.[20]

---

[19] Texas' required duration of continued treatment is uniquely unambiguous, with a fixed number of 10 days except for the possibility of a court-ordered extension. See Texas Health & Safety Code § 166.046(e). Virginia's statute describes the duration as a "reasonable time of not less than fourteen days." Va. Code Ann. § 54.1-2990(A) Texas' 10-day period has been criticized as inflexible or simply too short; in fact, there have been recent legislative attempts to expand the length of the duration. See Hearing on S.B. 439 Before the S. Comm. on Health and Human Servs., 80th Leg. (Tex. 2007). Accordingly, perhaps the approach taken by Virginia may be more prudent.

[20] An express provision like this is found in ten of the eleven statutes that statutorily prescribe some process for situations in which the health care provider or institution declines to continue LSMT on the grounds of conflict with accepted professional and medical standards; New Jersey's statute is the outlier. Providing an express statement like this would do much to clear the statutory ambiguity.

(9) If transfer cannot be effected within the time period set forth above after the reviewing body's decision, the physician and institution shall no longer be obligated to continue providing LSMT. In all cases, however, appropriate pain relief and other palliative care shall be continued in accordance with accepted medical and nursing standards.[21]

This proposed process should also be accompanied by a declaration of immunity to any health care professional or institution that acts, in good faith and in accordance with the process outlined herein, as follows:

> A health care professional shall not be subject to criminal or civil liability, or to discipline by the health care institution or the respective State licensing board for professional misconduct for any actions performed in good faith and in accordance with accepted professional standards to carry out the cessation of life sustaining medical treatment in accordance with these guidelines.[22]

> A health care institution shall not be subject to criminal or civil liability for any actions performed in good faith and in accordance with accepted professional standards to carry out the cessation of life sustaining medical treatment in accordance with these guidelines.[23]

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[21] See Cal. Prob. Code § 4736(c). See also N.J.S.A. 26:2H-67(b) ("Nothing in this section shall be construed to impair the obligations of physicians, nurses and other health care professionals to provide for the care and comfort of the patient and to alleviate pain, in accordance with accepted medical and nursing standards.").

[22] See, e.g., N.J.S.A. 26:2H-73b.

[23] See. e.g., N.J.S.A. 26:2H-73c.

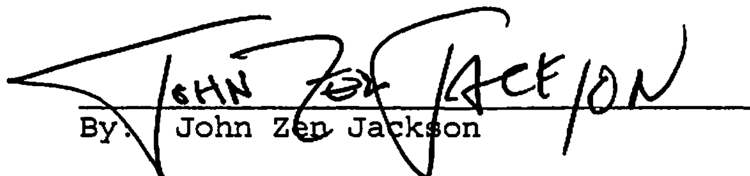
CONCLUSION

Accordingly, the court should reverse the trial court and hold that under these circumstances, and after following the procedures being proposed in Point VI, a hospital such as Trinitas should be permitted to discontinue LSMT.

Respectfully submitted,

KALISON, MCBRIDE, JACKSON & HETZEL, P.C.

Attorneys for *AMICI CURIAE*
New Jersey Hospital Association,
Catholic HealthCare Partnership
of New Jersey, and
Medical Society of New Jersey



By: John Zen Jackson

Dated: August 7, 2009

On the Brief:

John Zen Jackson, Esq.
James A. Robertson, Esq.

APPENDIX

IF THIS IS A MONEY JUDGMENT, IT WILL NOT BE AUTOMATICALLY RECORDED AS A STATEWIDE LIEN. TO DO SO, FORWARD IT DIRECTLY TO THE CLERK OF THE SUPERIOR COURT IN TRENTON ALONG WITH A $25.00 FEE.

FILED
AUG 17 2000
Superior Court, Chancery Division
Probate Part

KALISON, McBRIDE & JACKSON, P.A.
Attorneys at Law
Liberty Corner Executive Center
645 Martinsville Road
P.O. Box 814
Liberty Corner, New Jersey 07938
(908) 647-4600
Attorneys for Petitioner, Hackensack University Medical Center

In The Matter Of ORLANDO FLORES, An Alleged Incapacitated Person.	: SUPERIOR COURT OF NEW JERSEY : CHANCERY DIVISION: PROBATE PART : BERGEN COUNTY : : DOCKET NO.: : : FINAL JUDGMENT FOR : APPOINTMENT OF A : TEMPORARY GUARDIAN : AND THE TRANSFER OF : PATIENT

This matter having come before the Court upon the application of Kalison, McBride & Jackson, P.A., attorneys for Petitioner, Hackensack University Medical Center, by way of Verified Complaint for preliminary injunctive relief and for a determination of the incapacity of, and for appointment of a legal guardian for Orlando Flores, the alleged incapacitated person; and the Court having previously ordered that Carol Personette, Esq., be appointed to act as counsel for Orlando Flores in this proceeding and that Oilda M. Salazar Picinich, Esq. be appointed to act as the guardian *ad litem* of Orlando Flores in this proceeding; and the Court having considered the Verified Complaint and the Certifications of Hans Schmidt, M.D., Mark Flood, M.D., and the Certifications of Carol Kulkens; and the reports of the Court-appointed attorney and guardian *ad litem* for Orlando Flores and the independent medical examination report of Susan P. Molinari, M.D.; and the Court having held hearings and heard oral arguments on April 7, 2000, April 14, 2000, June 30, 2000, July 14, 2000 and August 11, 2000 at which appearances were entered by James A. Robertson, Esq., attorney for the Petitioner, and the aforesaid Court-appointed attorney

and guardian *ad litem* for Orlando Flores and Regino Delacruz, Esq., the attorney for the family of Orlando Flores; and the Court having heard testimony; and it appearing that Orlando Flores is unfit and unable to govern himself and manage his affairs; and for good cause shown;

IT IS ON THIS 17 day of August, 2000.

ORDERED that Orlando Flores is hereby declared to be in incapacitated person by reason of him being unfit and unable to govern himself and manage his affairs; and it is further

ORDERED that Oilda Picinich, Esq. be discharged as the guardian *ad litem*; and it is further

ORDERED that Steven Klein Esq. be and hereby is appointed as the Temporary Guardian of the person ~~and property~~ of Orlando Flores until the discharge and transfer of Mr. Flores from Hackensack University Medical Center and/or Wellington Hall Nursing Home is effectuated and until Mr. Flores is no longer within the jurisdiction of the United States; and it is further

ORDERED that Orlando Flores ~~shall~~ may immediately be discharged from Hackensack University Medical Center and/or Wellington Hall Nursing Home and transferred to the care and custody of Hospital de Ilobasco at 4° Calle Poniente, Ilobasco, Departmento de Cuscatlan, El Salvador or any other El Salvadorian hospital with an available bed;* and it is further

ORDERED that the Temporary Guardian shall cooperate with Hackensack University Medical Center and/or Wellington Hall Nursing Home and complete any and all documentation necessary to effectuate the ~~immediate~~ discharge and transfer of Orlando Flores from Hackensack University Medical Center and/or Wellington Hall Nursing Home to Hospital de Ilbasco or any other El Salvadorian hospital with an available bed; and it is further

* as the Court notes that plaintiff has paid or given free care to Mr. Flores for one year, efforts have been made to obtain other care in the U.S. but to no avail as Mr. Flores is here illegally. The Court notes that his mother resides in El Salvador.

ORDERED that the Court recognizes Orlando Flores' mother to be the natural and appropriate guardian of Mr. Flores, and as such, Mr. Flores' mother shall assume the responsibility over his person and property upon Mr. Flores' arrival in El Salvador; and it is further

ORDERED that Orlando Flores and his estate, including but not limited to his attorneys, representatives, agents, guardians, executors, trustees and/or administrators shall indemnify and pay Hackensack University Medical Center and/or Wellington Hall Nursing Home for any and all costs of medical care incurred as a result of Mr. Flores' stay at Hackensack University Medical Center and/or Wellington Hall Nursing Home from August 21, 1999 to the day of transfer to El Salvador and all attorney's fees, costs and expenses incurred as a result of bringing the within action, and shall pay such costs, fees and expenses out of any monetary award or recovery entered in Mr. Flores' favor in any pending worker's compensation, personal injury or Dram Shop case or any other case in which he is awarded money for personal injuries sustained which led to his admission to Hackensack University Medical Center and/or Wellington Hall Nursing Home commencing on August 21, 1999; and it is further

ORDERED that reasonable attorneys' fees and expenses shall be paid to the Court-appointed attorney for Orlando Flores, Carol Personette, Esq. for the services rendered in connection with these proceedings in the amount of $5,350 -, said fee to be paid from the estate of Orlando Flores and if insufficient funds exist therein, by the petitioner herein or as directed by the Court; and it is further

ORDERED that reasonable fees and expenses shall be paid to the guardian *ad litem*, Oilda M. Salazar Picinich, Esq., for services rendered in connection with these proceedings in the amount of $4,007.50, said fee to be paid from the estate of Orlando Flores, and if

insufficient funds exist therein by the Petitioner herein or as directed by the Court; and it is further

ORDERED that the Temporary Guardian be permitted to serve without a bond; and it is further

ORDERED that a copy of this Order be served on all parties and all counsel within 7 days from the date hereof.

Hon. Marguerite T. Simon, P.J. Ch.

Order Denying Stay Of The Provision Of The Court's Order of August 11, 2000 Allowing Discharge and Transfer of Defendant Orlando Flores Pending Appeal entered August 18, 2000

FILED
SUPERIOR COURT OF NEW JERSEY

AUG 18 2000

MARGUERITE T. SIMON
P.J.S.C.

DE LA CRUZ & ASSOCIATES
6135 Bergenline Avenue, Suite 3
West New York, NJ 07093
(201) 662-0406
File No.: 99230
Attorneys for Defendant, Orlando Flores, and Applicant for Guardianship, Mario Flores

In the Matter of ORLANDO FLORES, An ~~Alleged~~ Incapacited Person Alternatively captioned as HACKENSACK UNIVERSITY MEDICAL CENTER vs. ORLANDO FLORES	:SUPERIOR COURT OF NEW JERSEY CHANCERY DIVISION BERGEN COUNTY PROBATE PART DOCKET NO. CIVIL ACTION

ORDER

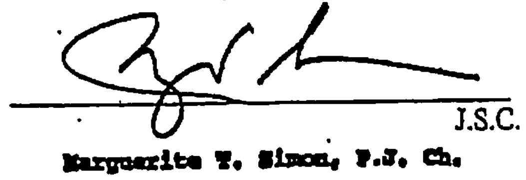
THIS MATTER having been brought before the Court on ~~Order to Show Cause~~ application of DELACRUZ & ASSOCIATES, attorneys for Plaintiff Orlando Flores and Applicant for Guardianship Mario Flores,* for an Order staying the discharge and transfer of Orlando Flores during appeal to the Appellate Division, and the Court having considered the matter and having read all argument and good cause appearing;

IT IS on this 18 day of August, 2000,

ORDERED, that ~~the~~ a stay of the provision of the Court's Order of August 11, 2000 allowing the discharge and transfer of Defendant Orlando Flores to El Salvador ~~shall be and is hereby stayed pending appeal until further Order of the Court~~ is denied for the reasons specified in the record; and it is,

in the presence of James Robertson Esq, Orlando Salazar Pacienca Esq. and Steven Klein Esq.

FURTHER ORDERED, that a copy of this Order be served on all counsel within 7 days of the signing of this Order.



J.S.C.

Marguerite T. Simon, P.J. Ch.

Papers filed with the Court:
( ) Answering papers
( ) Reply papers

-6739-99T5

Appellate Division Order on Emergent Application
Granting Emergent Application for Stay

ORDER ON EMERGENT APPLICATION

IN THE MATTER OF ORLANDO FLORES, An Incapacitated Person.

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-6739-99T5
MOTION NO. M-0004
PART: U
JUDGE (S): LESEMANN
CIANCIA

EMERGENT APPLICATION
FILED: AUGUST 22, 2000

BY: REGINO DE LA CRUZ, ESQ.
for ORLANDO FLORES

ANSWER(S) FILED:
APPEARANCE ONLY:

BY: JAMES A. ROBERTSON, ESQ.
for HACKENSACK UNIVERSITY
MEDICAL CENTER

ORDER

THIS MATTER HAVING BEEN THE COURT, IT IS ON THIS 31st DAY OF AUGUST, 2000, HEREBY ORDERED AS FOLLOWS:

	GRANTED	DENIED	OTHER
EMERGENT APPLICATION FOR STAY	(X)	()	()

SUPPLEMENTAL:

The Chancery Division judgment dated August 17, 2000, is stayed pending final resolution of the appeal filed with the court, or further order of this court. The Clerk's office shall establish an expedited briefing and calendaring schedule, to facilitate resolution of the appeal as promptly as possible.

FOR THE COURT:

ARTHUR J. LESEMANN, J.A.D.

FILED
APPELLATE DIVISION
AUG 31 2000
Clerk

I hereby certify that the foregoing is a true copy of the original on file in my office.
Clerk

New Jersey Supreme Court Order Entered
September 7, 2000 Vacating Stay entered by
New Jersey Superior Court, Appellate Division

SUPREME COURT OF NEW JERSEY
M-159 September Term 2000

IN THE MATTER OF ORLANDO FLORES,
An Incapacitated Person,

FILED
SEP 07 2000
CLERK

ORDER

This matter having been duly presented to the Court, it is ORDERED that the motion of Hackensack University Medical Center to vacate the stay entered by the Superior Court of New Jersey, Appellate Division, is granted.

WITNESS, the Honorable Deborah T. Poritz, Chief Justice, at Trenton, this 7th day of September, 2000.

I hereby certify that the foregoing is a true copy of the original on file in my office.

CLERK OF THE SUPREME COURT
OF NEW JERSEY

CLERK OF THE SUPREME COURT

SUPREME COURT OF NEW JERSEY

NO. M-159 SEPTEMBER TERM 2000

ON CERTIFICATION TO

MOTION to vacate a stay

IN THE MATTER CF ORLANDO FLORES,
An Incapacitated Person,

DECIDED September 7, 2000

CHECKLIST	GRANT	DENY	MOOT	
CHIEF JUSTICE PORITZ	X			
JUSTICE STEIN	X			
JUSTICE COLEMAN	X			
JUSTICE LONG	X			
JUSTICE VERNIERO	X			
JUSTICE LAVECCHIA	X			
JUSTICE ZAZZALI	X			
TOTALS	7			

-535- (6/00)

Statutes Authorizing Refusal by Health-Care Providers and/or Institutions to Take Action Contrary to Generally Accepted Health Care Standards and Specifically (if Stated) Action Deemed Medically "Ineffective," "Futile," or "Inappropriate"

STATE	CITATION(S)	LANGUAGE OF CITED PROVISION(S)
Alabama		
Alaska	Alaska Stat. § 13.52.060(f)	"A health care provider, health care institution, or health care facility may decline to comply with an individual instruction or a health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the provider, institution, or facility. In this subsection, 'medically ineffective health care' means health care that according to reasonable medical judgment cannot cure the patient's illness, cannot diminish its progressive course, and cannot effectively alleviate severe discomfort and distress."
Arizona		
Arkansas	Ark. Code Ann. §§ 20-17-208(b), -210(f)	"A physician or other health care provider, whose actions under this subchapter are in accord with reasonable medical standards, is not subject to criminal or civil liability or discipline for unprofessional conduct with respect to those actions." Ark. Code Ann. § 20-17-208(b). "This subchapter does not require any physician or other health care provider to take any action contrary to reasonable medical standards." Ark. Code Ann. § 20-17-210(f).
California	Cal. Prob. Code §§ 4654, 4735	"This division does not authorize or require a health care provider or health care institution to provide health care contrary to generally accepted health care standards applicable to the health care provider or health care institution." Cal. Prob. Code § 4654. "A health care provider or health care institution may decline to comply with an individual health care instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution." Cal. Prob. Code § 4735.
Colorado		
Connecticut		
Delaware	Del. Code Ann. tit. 16, §§ 2501(m), 2508(f)	"'Medically ineffective treatment' means that, to a reasonable degree of medical certainty, a medical procedure will not: (1) Prevent or reduce the deterioration of the health of an individual; or (2) Prevent the impending death of an individual." Del. Code Ann. tit. 16, § 2501(m). "A health-care provider or institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective treatment or health care contrary to generally accepted health-care standards applicable to the health-care provider or institution." "" Del. Code Ann. tit. 16, § 2508(f).

Statutes Authorizing Refusal by Health-Care Providers and/or Institutions to Take Action Contrary to Generally Accepted Health Care Standards and Specifically (if Stated) Action Deemed Medically "Ineffective," "Futile," or "Inappropriate"

STATE	CITATION(S)	LANGUAGE OF CITED PROVISION(S)
District of Columbia	D.C. Code § 7-627(a)	"No physician, licensed health care professional, health facility, or employee thereof who in good faith and pursuant to reasonable medical standards causes or participates in the withholding or withdrawing of life sustaining procedures from a qualified patient pursuant to a declaration made in accordance with this subchapter shall, as a result thereof, be subject to criminal or civil liability, or be found to have committed an act of unprofessional conduct."
Florida		
Georgia		
Hawaii	Haw. Rev. Stat. § 327E-7(f)	"A health-care provider or institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care or health care contrary to generally accepted health-care standards applicable to the health-care provider or institution."
Idaho		
Illinois	755 Ill. Comp. Stat. Ann. 35/7, 45/4-8(c)	"No physician, health care provider or employee thereof who in good faith and pursuant to reasonable medical standards causes or participates in the withholding or withdrawing of death delaying procedures from a qualified patient pursuant to a declaration which purports to have been made in accordance with this Act shall as a result thereof, be subject to criminal or civil liability, or be found to have committed an act of unprofessional conduct." 755 Ill. Comp. Stat. Ann. 35/7. "If the actions of a health care provider who fails to comply with any direction or decision by the agent are substantially in accord with reasonable medical standards at the time of reference and the provider cooperates in the transfer of the patient pursuant to subsection (b) of Section 4-7 of this Act, the provider shall not be subject to any type of civil or criminal liability or discipline for unprofessional conduct for failure to comply with the agent."
Indiana		
Iowa	Iowa Code Ann. § 144A.9(2)	"A physician is not subject to civil or criminal liability for actions under this chapter which are in accord with reasonable medical standards."
Kansas	Kan. Stat. Ann. § 65-28,106	"No physician, licensed health care professional, medical care facility or employee thereof who in good faith and pursuant to reasonable medical standards causes or participates in the withholding or withdrawing of life-sustaining procedures from a qualified patient pursuant to a declaration made in accordance with this act shall, as a result thereof, be subject to criminal or civil liability, or be found to have committed an act of unprofessional conduct."

Statutes Authorizing Refusal by Health-Care Providers and/or Institutions to Take Action Contrary to Generally Accepted Health Care Standards and Specifically (if Stated) Action Deemed Medically "Ineffective," "Futile," or "Inappropriate"

STATE	CITATION(S)	LANGUAGE OF CITED PROVISION(S)
Kentucky		
Louisiana		
Maine	Me. Rev. Stat. Ann. tit. 18-A, § 5-807(f)	"A health-care provider or institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care or health care contrary to generally accepted health-care standards applicable to the health-care provider or institution."
Maryland	Md. Code Ann., Health-Gen. §§ 5-601(o), 5-611(a)-(b)	"'Medically ineffective treatment' means that, to a reasonable degree of medical certainty, a medical procedure will not: (1) Prevent or reduce the deterioration of the health of an individual; or (2) Prevent the impending death of an individual." Md. Code Ann., Health-Gen. § 5-601(o). "Except as provided in § 5-613(a)(3) of this subtitle, nothing in this subtitle may be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be ethically inappropriate." Md. Code Ann., Health-Gen. § 5-611(a). "Except as provided in § 5-613(a)(3) of this subtitle, nothing in this subtitle may be construed to require a physician to prescribe or render medically ineffective treatment." Md. Code Ann., Health-Gen. § 5-611(b)(1). "Except as provided in subparagraph (ii) of this paragraph, a patient's attending physician may withhold or withdraw as medically ineffective a treatment that under generally accepted medical practices is life-sustaining in nature only if the patient's attending physician and a second physician ce
Massachusetts		
Michigan	Mich. Comp. Laws Ann. §§ 333.5653(d), 700.5511(3)	"'Medical treatment' means a treatment including, but not limited to, palliative care treatment, or a procedure, medication, surgery, a diagnostic test, or a hospice plan of care that may be ordered, provided, or withheld or withdrawn by a health professional or a health facility under generally accepted standards of medical practice and that is not prohibited by law." Mich. Comp. Laws Ann. § 333.5653(d). "A person providing care, custody, or medical or mental health treatment to a patient is bound by sound medical or, if applicable, mental health treatment practice and by a patient advocate's instructions if the patient advocate complies with sections 5506 to 5515, but is not bound by the patient advocate's instructions if the patient advocate does not comply with these sections." Mich. Comp. Laws Ann. § 700.5511(3).

Statutes Authorizing Refusal by Health-Care Providers and/or Institutions to Take Action Contrary to Generally Accepted Health Care Standards and Specifically (if Stated) Action Deemed Medically "Ineffective," "Futile," or "Inappropriate"

STATE	CITATION(S)	LANGUAGE OF CITED PROVISION(S)
Minnesota	Minn. Stat. Ann. § 145C.11(2)(a)	"With respect to health care provided to a patient with a health care directive, a health care provider is not subject to criminal prosecution, civil liability, or professional disciplinary action if the health care provider acts in good faith and in accordance with applicable standards of care."
Mississippi	Miss. Code Ann. § 41-41-215(6)	"A health-care provider or institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care or health care contrary to generally accepted health-care standards applicable to the health-care provider or institution."
Missouri	Mo. Ann. Stat. § 459.040	"A physician, licensed health care professional, medical care facility or employee thereof or other person who, in good faith and pursuant to usual and customary medical standards, causes or participates in the withholding or withdrawal of death-prolonging procedures, which acts are not otherwise unlawful, from a patient pursuant to a declaration made in accordance with sections 459.010 to 459.055 shall not, as a result thereof, be subject to criminal or civil liability or be found to have committed an act of unprofessional conduct."
Montana	Mont. Code Ann. §§ 50-9-204(2), -205(6)	"A health care provider whose action under this chapter is in accord with reasonable medical standards is not subject to civil or criminal liability or discipline for unprofessional conduct with respect to that decision." Mont. Code Ann. § 50-9-204(2). "This chapter does not require a health care provider to take action contrary to reasonable medical standards." Mont. Code Ann. § 50-9-205(6).
Nebraska	Neb. Rev. Stat. Ann. §§ 20-410(2), 412(6)	"A physician or other health care provider whose action under the Rights of the Terminally Ill Act is in accord with reasonable medical standards shall not be subject to criminal or civil liability, or discipline for unprofessional conduct, with respect to that action. Neb. Rev. Stat. Ann. § 20-410(2). "The act shall not require a physician or other health care provider to take action contrary to reasonable medical standards." Neb. Rev. Stat. Ann. § 20-412(6).
Nevada	Nev. Rev. Stat. Ann. §§ 449.630(2), 449.670(1)	"A physician or other provider of health care, whose action pursuant to NRS 449.535 to 449.690, inclusive, is in accord with reasonable medical standards, is not subject to civil or criminal liability, or discipline for unprofessional conduct, with respect to that action." Nev. Rev. Stat. Ann. § 449.630(2). "NRS 449.535 to 449.690, inclusive, do not require a physician or other provider of health care to take action contrary to reasonable medical standards." Nev. Rev. Stat. Ann. § 449.670(1).
NEW		

Statutes Authorizing Refusal by Health-Care Providers and/or Institutions to Take Action Contrary to Generally Accepted Health Care Standards and Specifically (if Stated) Action Deemed Medically "Ineffective," "Futile," or "Inappropriate"

STATE	CITATION(S)	LANGUAGE OF CITED PROVISION(S)
New Jersey	N.J.S.A. §§ 26:2H-62(d), -65(c), -67(a)(1)	"Nothing in this act shall be construed to require a physician, nurse or other health care professional to begin, continue, withhold, or withdraw health care in a manner contrary to law or accepted professional standards." N.J.S.A. § 26:2H-62(d). "Nothing in this act shall be construed to require a health care institution to participate in the beginning, continuing, withholding or withdrawing of health care in a manner contrary to law or accepted medical standards." N.J.S.A. § 26:2H:65(c). "Consistent with the terms of an advance directive and the provisions of this act, life-sustaining treatment may be withheld or withdrawn from a patient ... [w]hen the life-sustaining treatment ... is likely to be ineffective or futile in prolonging life." N.J.S.A. § 26:2H-67(a)(1)
New Mexico	N.M. Stat. Ann. § 24-7A-7(F)	"A health-care provider or health-care institution may decline to comply with an individual instruction or health-care decision that requires medically ineffective health care or health care contrary to generally accepted health-care standards applicable to the health-care provider or health-care institution. 'Medically ineffective health care' means treatment that would not offer the patient any significant benefit, as determined by a physician."
New York		
North		
North Dakota	N.D. Cent. Code §§ 23-06.5-09(3), -12(3)	"This chapter does not require any physician or other health care provider to take any action contrary to reasonable medical standards. N.D. Cent. Code § 23-06.5-09(3). "A health care provider who administers health care necessary to keep the principal alive, despite a health care decision of the agent to withhold or withdraw that health care, or a health care provider who withholds health care that the provider has determined to be contrary to reasonable medical standards, despite a health care decision of the agent to provide the health care, may not be subjected to civil or criminal liability or be deemed to have engaged in unprofessional conduct if that health care provider promptly took all reasonable steps to: a. Notify the agent of the health care provider's unwillingness to comply; b. Document the notification in the principal's medical record; and c. Arrange to transfer care of the principal to another health care provider willing to comply with the decision of the agent." N.D. Cent. Code § 23-06.5-12(3).

Statutes Authorizing Refusal by Health-Care Providers and/or Institutions to Take Action Contrary to Generally Accepted Health Care Standards and Specifically (if Stated) Action Deemed Medically "Ineffective," "Futile," or "Inappropriate"

STATE	CITATION(S)	LANGUAGE OF CITED PROVISION(S)
Ohio	Ohio Rev. Code Ann. §§ 1337.15, 2133.11(A)(5), 2133.11(B)	See, e.g., 1337.15(A)(5)(a)-(b): "Subject to division (H) of this section, an attending physician of a principal is not subject to criminal prosecution or professional disciplinary action and is not liable in damages in a tort or other civil action for actions taken in good faith and in reliance on a health care decision when all of the following are satisfied: ... (5) If the decision is to withhold or withdraw life-sustaining treatment, the attending physician determines, in good faith, to a reasonable degree of medical certainty, and in accordance with reasonable medical standards, that ... : (a) The principal is in a terminal condition or in a permanently unconscious state[; and] (b) There is no reasonable possibility that the principal will regain the capacity to make informed health care decisions for the principal." See also, e.g., 2133.11(A)(5): "Subject to division (D) of this section, an attending physician, consulting physician, health care facility, and health care personnel acting under the direction of an attending physician are not subject to criminal prosecution, are
Oklahoma	Okla. Stat. Ann. tit. 63, § 3101.10(B)	"A physician or other health care provider, whose actions under the Oklahoma Advance Directive Act are in accord with reasonable medical standards, is not subject to criminal or civil liability or discipline for unprofessional conduct with respect to those actions; provided, that this subsection may not be construed to authorize a violation of Section 3101.9 of this title. In making decisions and determinations pursuant to the Oklahoma Advance Directive Act the physician shall use his or her best judgment applying with ordinary care and diligence the knowledge and skill that is possessed and used by members of the physician's profession in good standing engaged in the same field of practice at that time, measured by national standards."
Oregon		

Statutes Authorizing Refusal by Health-Care Providers and/or Institutions to Take Action Contrary to Generally Accepted Health Care Standards and Specifically (if Stated) Action Deemed Medically "Ineffective," "Futile," or "Inappropriate"

STATE	CITATION(S)	LANGUAGE OF CITED PROVISION(S)
Pennsylvania	Pa. Stat. Ann. 20, §§ 5431(a)(6), 5461(g)(2)	"A health care provider or another person may not be subject to criminal or civil liability, discipline for unprofessional conduct or administrative sanctions and may not be found to have committed an act of unprofessional conduct as a result of ... [r]efusing to comply with a direction or decision of an individual based on a good faith belief that compliance with the direction or decision would be unethical or, to a reasonable degree of medical certainty, would result in medical care having no medical basis in addressing any medical need or condition of the individual, provided that the health care provider complies in good faith with sections 5424 (relating to compliance) and 5462(c) (relating to duties of attending physician and health care provider)." Pa. Stat. Ann. 20, § 5431(a)(6). "If the members of the class of health care representatives are evenly divided concerning the health care decision and the attending physician or health care provider is so informed, an individual having a lower priority may not act as a health care representative. So long as the
Rhode Island	R.I. Gen Laws §§ 23-4.10-7(b), 23-4.11-8(b)	"A physician is not subject to civil or criminal liability for actions under this chapter which are in accordance with reasonable medical standards." R.I. Gen Laws §§ 23-4.10-7(b). "A physician is not subject to civil or criminal liability for actions under this chapter which are in accordance with reasonable medical standards." R.I. Gen Laws §§ 23-4.11-8(b).
South Carolina	S. C. Code Ann. § 44-77-90	"Any person who in good faith and in accordance with the provisions of this chapter participates in the withholding or withdrawal of life-sustaining procedures from the patient is not subject to criminal or civil liability on account of the withholding or withdrawal. The immunity from civil liability does not extend to cases in which a physician deviates from standards of reasonable medical care in connection with the decision to withhold or withdraw."
South Dakota		
Tennessee	Tenn. Code Ann. §§ 68-11-1808(e), 1810(a)	"A health care provider or institution may decline to comply with an individual instruction or health care decision that requires medically inappropriate health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution." Tenn. Code Ann. § 68-11-1808(e).

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Texas	Tex. Health & Safety Code Ann. § 166.044(a)-(e)	"A physician or health care facility that causes life-sustaining treatment to be withheld or withdrawn from a qualified patient in accordance with this subchapter is not civilly liable for that action unless the physician or health care facility fails to exercise reasonable care when applying the patient's advance directive." Tex. Health & Safety Code Ann. § 166.044(a). "A health professional, acting under the direction of a physician, who participates in withholding or withdrawing life-sustaining treatment from a qualified patient in accordance with this subchapter is not civilly liable for that action unless the health professional fails to exercise reasonable care when applying the patient's advance directive." Tex. Health & Safety Code Ann. § 166.044(b)). "A physician, or a health care professional acting under the direction of a physician, who participates in withholding or withdrawing life-sustaining treatment from a qualified patient in accordance with this subchapter is not criminally liable or guilty of unprofessional conduct as a result of that action unless the physician or health professio "The standard of care that a physician, health care facility, or health care professional shall exercise under this section is that degree of care that a physician, health care facility, or health care professional, as applicable, of ordinary prudence and skill would have exercised under the same or similar circumstances in the same or a similar community." Tex. Health & Safety Code Ann. § 166.044(d). "If the patient or the person responsible for the health care decisions of the patient is requesting life-sustaining treatment that the attending physician has decided and the review process has affirmed is inappropriate treatment, the patient shall be given available life-sustaining treatment pending transfer under Subsection (d)." Tex. Health & Safety Code Ann. § 166.044(e).
Vermont	Vt. Stat. Ann. tit. 18, § 9707(b)(2)	"A health care provider, health care facility, and residential care facility having knowledge that a principal's advance directive is in effect shall follow the instructions of the person, whether agent or guardian, who has the authority to make health care decisions for the principal, or the instructions contained in the advance directive, unless: ... (2) the instruction would cause the provider to violate any criminal law or the standards of professional conduct required by a professional licensing board or agency."

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Virginia	Va. Code Ann. §§ 54.1-2988, 2990(A)	"A health care facility, physician or other person acting under the direction of a physician shall not be subject to criminal prosecution or civil liability or be deemed to have engaged in unprofessional conduct as a result of issuing a Durable Do Not Resuscitate Order or the withholding or the withdrawal of life-prolonging procedures under authorization or consent obtained in accordance with this article or as the result of the provision, withholding or withdrawal of ongoing life-sustaining care in accordance with § 54.1 2990. No person or facility providing, withholding or withdrawing treatment or physician issuing a Durable Do Not Resuscitate Order under authorization or consent obtained pursuant to this article or otherwise in accordance with § 54.1-2990 shall incur liability arising out of a claim to the extent the claim is based on lack of authorization or consent for such action." Va. Code Ann. § 54.1-2988. "Nothing in this article shall be construed to require a physician to prescribe or render medical treatment to a patient that the physician determines to be medically or ethica
Washington		
West Virginia	W. Va. Code Ann. § 16-30-10(d)	"No health care provider or employee thereof who in good faith and pursuant to reasonable medical standards causes or participates in the withholding or withdrawing of life-prolonging intervention from a person pursuant to a living will made in accordance with this article shall, as a result thereof, be subject to criminal or civil liability."
Wisconsin		
Wyoming	Wyo. Stat Ann. §§ 35-22-408(f), 410(a)(v), 414(d)	"A health care provider or institution may decline to comply with an individual instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution." Wyo. Stat. Ann. § 35-22-408(f). "A health care provider or institution acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider or institution is not subject to civil or criminal liability or to discipline for[] ... [d]eclining to comply with a health care decision or advance health care directive because the instruction is contrary to the conscience or good faith medical judgment of the health care provider, or the written policies of the institution." Wyo. Stat. Ann. § 35-22-410(a)(v). "This act does not authorize or require a health care provider or institution to provide health care contrary to generally accepted health care standards applicable to the health care provider or institution." Wyo. Stat. Ann. § 35-22-414(d).

Clinical Practice Guidelines on Shared Decision-Making in the Appropriate Initiation of and Withdrawal from Dialysis, as developed in the Renal Physicians Association and the American Society of Nephrology clinical practice guideline that advises nephrologists on when it is appropriate to withhold or discontinue dialysis (2000).

MEDICALLY FUTILE THERAPY GUIDELINES

I. PURPOSE

To suggest a set of guidelines and processes for dealing with medically futile therapy.

II. INTRODUCTION

Law and regulation have codified the right of patients to refuse medical intervention. Health institutions have developed processes for resolving conflict in this area. It is now necessary to broaden the discussion to include the reciprocal situation; that is, the circumstance in which a responsible physician is of the professional opinion that a medical intervention is inappropriate and should be withdrawn or withheld, however, the patient (or surrogate decision-maker) feels that the intervention should be pursued. To further this discussion, the Medical Society of New Jersey (MSNJ) proposes a working definition of medically futile therapy and a procedure to be followed in cases where conflict persists between physician and patient/surrogate.

III. DEFINITION

Futile medical therapy can be considered to be any treatment that cannot within reasonable likelihood cure, palliate, ameliorate, or restore a quality of life that would be satisfactory to the patient. This includes any treatment in which the burdens greatly outweigh any chance of success or benefit to the patient.

The above definition is deliberately vague because it is meant to include not only those therapies in which the success rate is nil but also those therapies where the success rate may approach zero or which have a low success rate coupled with a high likelihood of pain or suffering. Futility decisions must result from a shared decision-making process between physician and patient/surrogate. The physician supplies objective data about the effectiveness of the proposed treatment and the patient/surrogate ponders whether the treatment is "worth it" based on the patient's goals for treatment, life values, interest in risk-taking, etc. Because of the pluralism of our society, individuals may differ in their judgment about whether a particular treatment is futile. To honor this pluralism of values we focus on a process that may aid the shared decision-making.

IV. PRINCIPLES

1. Concepts of medical benefit or burden are value-laden; there always is an element of uncertainty; physicians should not substitute their own values for those of the patient.

2. When a surrogate acts on behalf of an incompetent patient it should be in terms of what would be the patient's own choice. This choice is binding if the patient's specific wishes are stated in an advance directive.

3. Apparent conflicts between physician and patient/surrogate over treatment decisions frequently are the result of miscommunication. The patient/surrogate who demands a medically inappropriate treatment may not understand the diagnosis/prognosis. The physician who believes the patient would be accepting great pain/suffering for minimal chance of success may not understand the patient's goals or values. The conflict resolution process must foster clear communication among the parties involved.

4. A trial of treatment should be considered in situations where the chance of success or the amount of burden tolerable is not clear. Withdrawal of treatment after a trial is ethically and legally no different from withholding treatment in the first place and may give all parties the satisfaction of having tried.

5. Any moral obligation to treat diminishes proportionately as medical effectiveness decreases. A physician is not obligated to provide futile treatments or those that compromise personal or professional integrity. At the same time, the physician must not abandon the patient. Transfer to another physician should be facilitated in cases of unresolved conflict.

6. To engender trust, the cornerstone of the doctor-patient relationship, the physician must always advocate for the patient. If the physician has any allegiances (to hospital, third party payers, etc.), which could appear to represent a conflict of interest with the patient, these must be openly acknowledged and set aside.

7. Financial issues concerning treatment should not be mixed with questions of futility. Lack of reimbursement for a treatment should be acknowledged as a monetary decision, which is different from a decision based on futility. Questions of reimbursement should be addressed in the business and political arena, not at the bedside.

V. SUGGESTED PROCESS FOR SHARED DECISION MAKING REGARDING TREATMENTS THAT MAY BE FUTILE (Table)

Table. Attending physician clearly states prognosis and care plan [proposed treatment]