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JACQUELINE BETANCOURT, on behalf of RUBEN BETANCOURT, *Plaintiff-Respondent,*		SUPERIOR COURT OF NEW JERSEY APPELLATE DIVISION
v.	}	Docket No. A-3849-08T2
TRINITAS HOSPITAL, *Defendant-Appellant*		CIVIL ACTION

On Appeal From: Final Order
Sat Below: Hon. John F. Malone, P.J.Ch., Union County

BRIEF OF AMICI CURIÆ
AGUDATH ISRAEL OF AMERICA
AND
RABBINICAL COUNCIL OF AMERICA,
IN SUPPORT OF PLAINTIFF-RESPONDENT

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INTEREST OF THE AMICI CURIÆ

Agudath Israel of America is an eighty-seven year old national grassroots Orthodox Jewish movement with constituents and branches across the United States, including New Jersey. It is a tax-exempt nonprofit organization under section 501(c)(3) of the Internal Revenue Code. Its local affiliate in New Jersey is Agudath Israel of New Jersey, which advocates for the interests of its members in this State. Agudath Israel has a long history of submitting *amicus curiæ* briefs in cases involving religious liberty in general, and the rights of Orthodox Jews to practice their religion in particular.

The Rabbinical Council of America, established in 1935, is the largest Orthodox Jewish rabbinical organization in the world. Its membership exceeds one thousand rabbis, and it is deeply concerned with issues related to religious freedom.

The instant case is of great interest and concern to Agudath Israel and the Rabbinical Council of America and their respective members. The central issue in the case is whether a patient's right to self-determination should continue to be the guiding principle in New Jersey law when disputes arise between the patient and his or her family, and health care facility personnel, or within a patient's family. The Appellant's position, should it prevail, would enable a medical provider to terminate life support services for a patient even when that decision would be diametrically

counter to the patient’s and his family’s personal, moral, or religious beliefs.

The organizations and their constituents, as a matter of deeply held religious conviction, believe that the decision to withdraw or withhold life-sustaining treatment from an incapacitated patient is a profoundly serious moral, ethical, and religious decision, and not, as the Appellant attempts to construe it, a purely medical decision. The organizations contend that physicians should not have the right to impose their ethical or moral views on a patient, in the face of clear wishes of the patient or his or her proxy to the contrary.

Agudath Israel has considerable expertise in dealing with legal disputes in precisely this area of law. For example, Agudath Israel has been called upon from time to time by its constituents throughout the country for assistance in defending the rights of individual patients and their families to continue to receive medical treatment in the face of opposition from doctors and hospital officials, or other relatives of the patient, who sought to terminate such treatment. On many occasions, Agudath Israel has engaged the services of members of its pro bono national network of attorneys to secure formal legal representation for such patient’s families. With such assistance, families have often successfully obtained court injunctions to prevent the withdrawal, or compel the application, of life-sustaining treatment.

Members of the Rabbinical Council of America also have substantial experience in this field. Its congregational rabbis are frequently called upon to advise and counsel members of the Jewish faith who are dealing with end-of-life issues affecting themselves or their family members.

In this matter, the Court's decision affirming the lower court's ruling would promote the principles which the organizations seek to advance. It would strengthen the protections available to those confronted with challenges to their religious beliefs in end-of-life circumstances.

On the other hand, a decision by this court overturning the trial court decision would have a severe adverse impact on the organizations' ability to continue to uphold their constituents' religious and legal rights in disputes with hospital personnel. Furthermore, it might send a disturbing message throughout the country, that the personal ethical views of individual doctors should supersede the religious, moral and personal beliefs of patients and their families as to whether a patient's life is "worthy" of continuing to receive medical treatment.

The Jewish perspective on these issues, guided by *halacha*, the corpus of Jewish law, is complex and fact-sensitive; each situation must be evaluated by a qualified rabbinic decisor. Nonetheless, certain guiding principles can be briefly stated. Judaism considers life precious, indeed holy, even when its "quality" is severely diminished.

Jewish religious law does not always insist that life be maintained; in some cases of seriously ill patients, *halacha* forbids intercessions that will prolong suffering. Each patient's situation must be dealt with in consultation with a knowledgeable expert in this area of Jewish law, and those experts can and do differ, but there is a general consensus that the active removal of connected life-support systems or withholding of nourishment is usually prohibited. As a general rule, Jewish law does not permit any action that might hasten the demise of a person *in extremis*. As explained eloquently by Rabbi J. David Bleich,

> Judaism regards human life as being of infinite and inestimable value. Not only is life in general of infinite value, but every moment of life is of inestimable value as well. The quality of life which is preserved is thus never a factor to be taken into consideration. Neither is the length of the patient's life expectancy a controlling factor. . . .
>
> Judaism does not perceive the overriding obligation to preserve life to be in any way antithetical to "death with dignity." It is Judaism which teaches that the human body must be accorded every sign of dignity in death as well as in life. But the struggle for life is never an indignity. The attempt to sustain life, by whatever means, is naught but the expression of the highest regard for the precious nature of the gift of life and of the dignity in which it is held.

Bleich, *Judaism and Healing*, pp. 22, 140. Medical information is a component in the decision-making process, but certainly not the only factor to be considered.

These are the values which amici seek to uphold through their participation in this appeal.

LEGAL ARGUMENT

POINT I.
THE TRIAL COURT CORRECTLY APPLIED WELL-ESTABLISHED PRECEDENT THAT A PATIENT HAS THE RIGHT TO DETERMINE THE COURSE OF HIS MEDICAL TREATMENT.

A. The Common Law and Well-Established New Jersey Precedent Have Long Recognized A Patient's Right to Self Determination.

Improvements in medical technology and knowledge have enabled physicians to help cure patients previously deemed incurable, and to sustain life in situations in which life had previously been deemed unsustainable. But while the technological knowledge has changed, the basic concepts and ideals that our society holds sacred have remained constant, forever intertwined in the basic Anglo-American traditions upon which this country was founded.

One concept derived from those sacred traditions is that of patient autonomy. The right of an individual to determine his own fate and the course of his medical treatment has been an accepted right at common law dating back to the nineteenth century. As the Supreme Court of the United States stated in *Union Pac. Ry. Co. v. Botsford*, 141 *U.S.* 250 (1891): "No right is more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and

unquestionable authority of law." This basic right to self determination has been consistently recognized by the federal and state courts. *See Cruzan v. Director, Missouri Dept. of Health*, 497 *U.S.* 261, 281 (1990)("The choice between life and death is a deeply personal decision of obvious and overwhelming finality"); *In the Matter of Karen Quinlan*, 70 *N.J.* 10 (1976); *In the Matter of Claire C. Conroy*, 98 *N.J.* 321 (1985) ("The right of a person to control his own body is a basic societal concept, long recognized in the common law"); *In re Jobes*, 108 *N.J.* 394, 398 (1987); *Schloendorf v. Society of N.Y. Hos.*, 211 *N.Y.* 125 (1914) (in which Justice Cardozo stated, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body"); *See also In the Matter of Farrell*, 108 *N.J.* 335 (1987); *Satz v. Perlmutter*, 362 *So*.2d 160 (Fla.App. 1978); *In the Matter of Westchester County Medical Center*, 72 *N.Y.*2d 517 (1988); *In the Matter of Storar*, 52 *N.Y.*2d 363 (1981); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728 (1977); *Brophy v. New England Sinai Hospital, Inc.*, 398 Mass. 417 (1986); *In re Gardner*, 534 *A.*2d 947 (Me. 1987); *Rasmussen v. Fleming*, 154 Ariz. 207 (1987).

In applying this fundamental right of self determination, the New Jersey Supreme Court has concluded that a patient has the legal right to forego medical treatment and be the final arbiter of his medical care, even where the patient's decision is at variance with the medical opinion of the attending physician. *Quinlan* concerned a patient in a comatose state whose father sought the legal right to remove

his daughter from her respirator, thereby effectuating his daughter's death. Although the doctors stated that such actions would "conflict with their medical judgment," the court held that as surrogate of the patient, the father possessed the legal right to terminate his daughter's treatment, despite the medical opinion of the physicians; *Quinlan*, *supra*, at 40-42.

Conroy concerned an 84-year-old nursing home resident with alleged irreversible physical and mental impairments and limited life expectancy, whose guardian ad litem wished to remove her nasogastric feeding tube, a life terminating act. Observing that the "right of a person to control his own body is a basic societal concept, long recognized in the common law," the court held that so long as the guardian followed certain criteria necessary to determine the patient's wishes, the guardian had the legal right to cease medical treatment; *Conroy*, *supra*, at 346, 364-366.

It is therefore a matter of well established precedent that whether or not the physicians are in agreement with the patient's decision is of no legal consequence. The patient or his surrogate is to be the final decision maker with regard to his or her medical care. Even where a physician advises a patient that his condition is medically treatable and the patient may likely benefit from treatment, the patient has the legal right to elect to refuse treatment, even if the failure to receive such treatment will result in

the patient's death.[1] *See Thor v. The Superior Court of Solano County*, 5 Cal.4th 725, 734 (1993) ("While the physician has the professional and ethical responsibility to provide the medical evaluation upon which informed consent is predicated, the *patient still retains the sole prerogative to make the subjective treatment decision based upon an understanding of the circumstances*." (citing *Conroy*)(emphasis added)). Simply stated, a physician has a duty to inform his patient of the medical options available. Ultimately, though, the patient is the final arbiter of his own medical care.

Appellant argues that this status quo should be overturned in cases where the patient's right to self determination conflicts with what appellant artfully describes as the current medical standard of care. In such cases, argues appellant and its supporters, the physician's recommended course of treatment should prevail over a patient's unambiguous wishes. Such a position would eviscerate the patient's right to self determination. If the right to self determination carries any practical meaning—something New Jersey State precedent clearly establishes—it means that patient autonomy must be protected regardless of whether the physician is in disagreement. *See Conroy*, at 352-353 ("Indeed, if the patient's right to

[1] Amici, as a matter of religious belief, do not agree that individuals should have the unlimited autonomy to make medical decisions that could have the effect of shortening their lives. The state, as well, as evidenced by laws prohibiting suicide and euthanasia, holds that there are circumstances in which the state's interest in preserving life should supersede an individual's right to personal autonomy.

informed consent is to have any meaning at all, it must be accorded respect even when it conflicts with the doctor or the values of the medical profession as a whole"); *See also Lane v. Candura*, 6 Mass.App.Ct. 377 (1978); *Natanson v. Kline*, 186 Kan. 393, 406-407 (1960) ("A doctor might well believe that an operation or treatment is desirable or necessary, but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception").

In fact, unlike the above-cited cases in which the court's upheld a patient's right to refuse treatment, there is a much greater state interest in upholding a patient's right to continue to receive treatment over the objections of the patient's physicians. Unlike the decision to terminate one's life, which potentially conflicts with several state interests and yet has been upheld by the courts, the desire to continue one's life is in fact supported by those same state interests. In New Jersey, the state interests that a court must consider in such cases include the interest in preserving life, preventing suicide, and protecting innocent third parties. *See Conroy*, 98 *N.J.* at 348-349. In cases such as this one, where the patient wished to live, the state's interest in preserving life, the most significant of the four, *id.* at 349, is clearly furthered by deferring to the patient's choice to keep living. The state's interest in preventing suicide is furthered by allowing the patient to remain alive. And the state interest in protecting innocent third parties would be furthered by giving the patient's

dependents and other family members the comfort of knowing that the patient's wishes are being respected.

B. The Issue Before This Court is Not One of First Impression.

Contrary to Appellant's argument, the issue before this court is not one of first impression. Well established New Jersey precedent recognizes the patient's right to determine his or her own medical fate. Appellant attempts to distinguish the case at bar from precedent by arguing that prior cases concerned patients who wished to refuse medical treatment, while the patient in this matter elected to forego the physician's advice and continue treatment. However, the court's reasoning in *Quinlan* and *Conroy* did not turn on the specific course of treatment in those cases. *Quinlan* and *Conroy* held, quite simply, that the patient's right to self determination outweighs the wishes of the physician.

Nowhere in New Jersey jurisprudence is there any authority for limiting the patient's right to self determination to cases in which he agrees with the physician's advice. Were this Court to adopt the Appellant's argument, it would effectively confer upon the medical profession the unfettered right to decide when to terminate medical treatment. Appellant's position, in effect, is that a patient should only have the right to self-determination when he wishes to terminate his life, but he should not have the right to decide to continue to live. Such an argument

effectively abrogates the entire principle of patient autonomy, and makes no logical or moral sense. The New Jersey Supreme Court anticipated arguments of this sort when it stated that "[a] significant problem in any discussion of sensitive medical-legal issues is the marked, perhaps unconscious, tendency of many to distort what the law is, in pursuit of an exposition of what they would like the law to be," *Quinlan,* at 42.

Appellants argue that physicians should not be compelled to administer treatments which are contrary to what they describe as medical standards of care. As stated in their brief, "The matter before this Court is not whether treatment should be withheld or withdrawn from a patient." They claim that instead the issue is whether a physician should be compelled to administer treatments that are against the current standard of medical care and which they consider to be inhumane. This attempt to "reframe" the issue is but a semantic subterfuge that seeks to divert the Court from the central issue in this case. Allowing doctors to elect not to administer patient-requested treatment if they feel such treatment violates what they describe as medical standards of care is the same thing as deciding whether treatment should be withheld or withdrawn from a patient. A doctor's interest in insisting on a certain standard of medical care cannot and should not trump the patient's legal right to self-determination.

With regard to the issue of standards of medical care, it is important to note that within the medical profession itself there is a dispute as to what doctors should do when patient autonomy conflicts with professional standards of care. In *Thor*, for example, an *amicus curiae* brief filed by the California Medical Association, representing over 30,000 physicians, stated that they were in "full [support] of the 'primacy of patient autonomy.'" *Thor*, at 743. The California Supreme Court concluded that respecting patient autonomy does not result in disregarding professional standards of care. As the Court stated:

> Our conclusion that the patient's choice must be respected regardless of the doctor's judgment *does not denigrate professional standards of care*. Rather, it attests to their continuing and critical importance in maximizing the broader precept of self-determination that transcends a particular course of treatment. Patient autonomy and medical ethics are not reciprocals; one does not come at the expense of the other. The latter is a necessary component and complement of the former *and should serve to enhance rather than constrict the individual's ability to resolve a medical decision in his or her best overall interest.*

Thor, at 743 (emphasis added).

But to the extent that in individual cases there may be a conflict between what doctors see as the appropriate standard of care and the patient's wishes, the courts of New Jersey have already spoken as to which side should prevail in such a dispute. The patient's right to self determination clearly takes precedence, and gives him the right to choose

to continue treatment and preserve his life, just as the law recognizes his right to refuse treatment in certain circumstances.

C. Adopting Appellant's Position Would Deprive Patients of the Right to Make Their Own Health Care Decisions.

Adopting the arguments of Appellant would have serious adverse consequences. The entire concept of patient autonomy would largely cease to exist; if doctors can make life-and-death decisions regardless of the wishes of their patients, why should patients have the autonomy to make lesser health care decisions for themselves? The entire foundation of the current patient-doctor relationship would be permanently transformed. Physicians, based solely on their own moral and ethical views, would have the legal ability to halt treatment to patients of all ages, diagnosed with various illnesses and conditions, whenever the physician believed that such treatment would not conform to the acceptable standard of care. Doctors in New Jersey would henceforth be able to decide, on their own, that whole groups of patients should no longer be treated because they are simply, in the view of their doctors, no longer worth keeping alive. This position has already been adopted by at least one physician's organization in North America (the Manitoba College of Physicians and Surgeons), which last year voted to adopt a policy that mandates that it would be appropriate to end a patient's life despite opposition from the patient or his or her legal representatives whenever a patient, in the doctor's

view, no longer has the prospect of having a level of brain activity that enables him or her to "achieve awareness of self . . . awareness of environment . . . and . . . experience his/her own existence." Only the doctrine of personal autonomy has prevented such disregard for the rights of patients from becoming the norm in the United States. Should this Court adopt appellant's position, that doctrine would, at least in New Jersey, cease to exist.

POINT II.

APPELLANT'S POSITION, IF ADOPTED BY THE COURT, WOULD LEAD TO THE VIOLATION OF PATIENTS' CONSTITUTIONAL RIGHTS.

A. Upholding Appellant's Position Would Lead to the Violation of Patients' First Amendment Rights.

Under the First Amendment to the United States Constitution, patients have the right to refuse medical treatment when such care violates their religious beliefs. *See In re Milton*, 29 Ohio St.3d 20 (1987); *In re Osborne*, 294 *A.*2d 372 (D.C.Ct.App., 1972) (patient had the right to refuse a blood transfusion due to religious beliefs even where such refusal risked death); *In re Brooks' Estate*, 32 Ill.2d 361, 373 (1965). Significantly, the only time the State may override the patient's religious wishes and compel medical treatment is where the State's interest in prolonging life is at stake. *See Milton* at 24 (freedom of religion may be infringed 'only to prevent grave and immediate danger to interests in which the State may lawfully protect' (quoting

West Virginia State Bd. of Edu. v. Barnette, 319 *U.S.* 624, 639 (1943)); *Thomas v. Collins*, 323 *U.S.* 516, 530 (1945) ("Only the gravest abuses, endangering paramount interests, give occasion to permissible limitation"). A patient thus has the constitutional right to stipulate that medical care be in accord with his religious beliefs. Where the patient's interest is in accord with the state's interest in preserving life, as here, the patient's constitutional right to insist that the course of his own medical treatment accords with his religious beliefs is even stronger. One of the few courts to consider a case of alleged "medical futility" ruled that a mother's desire to keep her permanently unconscious baby alive through ventilator treatment outweighed the opinions of the hospital, natural father, and the guardian *ad litem*, who wished to terminate the treatment. *In re Baby K*, 832 *F. Supp.* 1022 (E.D.Va. 1993), *aff'd*, 16 *F.*3d 590 (4th Cir. 1994), *cert. denied*, 513 *U.S.* 825 (1994). Denying the hospital declaratory judgment that it would not violate state or federal law by terminating treatment, the court based its holding in part on the protection of the First Amendment rights of the mother, who believed that "all life is sacred and must be protected". 832 *F. Supp.* at 1030.

A great many of members of amici's constituents have executed living wills or advance care directives in which they have stipulated that, should they become incapacitated, the health care decisions made on their behalf must be in accordance with their religious beliefs. Both Agudath Israel of America and the Rabbinical Council of America have

developed their own living will and health care proxy forms for their members, precisely to insure that the religious views of these prospective patients are faithfully followed by their health care providers. Should the Court adopt appellant's argument, such written living wills and health care proxies might be rendered meaningless. Even where the patient stipulated that he wished to continue treatment for deeply-held religious reasons, a physician would still have the legal right to ignore the patient's wishes and terminate treatment, in violation of the patient's religious beliefs, and in violation of the patient's First Amendment free exercise rights to practice their religion.

B. Upholding Appellant's Position Would Lead to the Violation of Patients' Right to Privacy.

In addition to the right to self determination at common law, the patient's right to determine his own medical fate is protected under the United States Constitution. *See Roe v. Wade*, 410 *U.S.* 113, 151 (1973); *Eisenstadt v. Baird*, 405 *U.S.* 438 (1972). *Roe* held that all persons have a constitutional right to privacy with regard to any personal right that may be "'fundamental' or 'implicit in the concept of ordered liberty,'" *Roe,* at 151 (internal citations omitted). At issue in this appeal is whether a patient has a right to choose to remain on various forms of life support, thereby remaining alive, even when the physician advises the patient's surrogate that such treatment would be medically

futile. The right to elect not to terminate one's own life is certainly at least as "fundamental" as the right conferred by the Supreme Court in *Roe* upon a mother who wishes to terminate her pregnancy.[2]

As observed in *Quinlan*, the New Jersey State Constitution, Art. I, Par. 1, explicitly recognizes the individual's inherent right to preserve his life, *Quinlan* at 19. The Constitution states that "All persons are by nature free and independent, and have certain natural and unalienable rights, among which are those of enjoying and defending life . . ." *N.J.Const.(1947)*, *Art. I, Par. 1*. Patient autonomy, particularly in instances where the patient is attempting to continue to live, is thus a fundamental right under both the United States and New Jersey constitutions. Appellant's argument, if adopted by this Court, would deprive patients of these fundamental constitutional rights.

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[2] Amici do not agree on religious or legal grounds with the decision in *Roe*. But the principle of a constitutional right to privacy enunciated in *Roe* remains the law of the land and is very much applicable in the instant case.

POINT III
THE DECISION TO WITHDRAW LIFE-SUSTAINING TREATMENT FROM A PATIENT IS AN ETHICAL DECISION, NOT A MEDICAL ONE, AND THUS SHOULD NOT BE MADE UNILATERALLY BY A PHYSICIAN.

A. The Decision to Terminate Treatment Is Not a Medical Decision.

Underlying Appellant's argument that doctors should have the right to terminate medical care based on accepted standards of care is the premise that the decision to terminate treatment is fundamentally a medical decision. Amici's position rejects that assumption. The decision as to which course of medical treatment would best address a patient's particular condition is a medical decision, but the decision to withhold treatment is not a medical decision. Rather, it is an ethical decision; a doctor does not have any superior ethical wisdom when it comes to making such life and death ethical decisions. Very simply, these organizations do not agree with the unstated presumption of Appellants, and their supporting amici, that graduating from medical school somehow confers upon a doctor a better ability to make ethical decisions of life and death. Rather, in a multi-cultural society in which individuals and groups hold vastly different views on such fundamental issues as when human life should be preserved and when not, such decisions best belong to the patients themselves.

Appellants' contention is that doctors should have the right to impose their personal ethical or moral views on a

patient in the face of clear wishes of the patient or his or her proxy to the contrary. This is not current law, and there is no logical or moral reason why it should be the law.

The issue in this case is not whether a patient, through his surrogate, has the right to insist on receiving medical care that serves no medical purpose (what the commentators call "physiological" or "quantitative" futility). See Daniel Robert Mordarski, Note, *Medical Futility: Has Ending Life Support Become the Next "Pro-Choice/Right to Life" Debate?*, 41 Clev.St.L.Rev. 751, 755 (1993); Mark Strasser, *The Futility of Futility?: On Life, Death, and Reasoned Public Policy*, 57 Md.L.Rev. 505, 526-531 (1998); Keith Shiner, Note, *Medical Futility: A Futile Concept?*, 53 Wash. & Lee L.Rev. 803, 826-832 (1996).

Rather, the question here involves treatment that would help keep the patient alive, but the patient's physicians question whether that outcome is in fact beneficial to the patient. *Shiner*, at 830. The determination as to whether to prolong the life of a patient who is incapacitated is simply not within the realm of medicine, but rather is instead a deeply personal philosophical, ethical, and religious issue. What is the value of human life for someone who is severely incapacitated or even in a "persistent vegetative state"? The answer has nothing to do with medical knowledge and technology, which is the doctor's sphere of expertise, but everything to do with religious and moral values. See David M. Smolin, *Praying for Baby Rena: Religious Liberty, Medical*

Futility, and Miracles, 25 Seton Hall L.Rev. 960, 971 (1995). Several days or even months of living in pain or in a vegetative state may have no value to a doctor or hospital concerned with costs, an excess of patients, and scarcity of medical resources. But to patients and their families, those days may provide an invaluable opportunity to participate in important familial or religious events. Mordarski, 41 Clev.St.L.Rev. at 759-760. And to patients with deeply held religious beliefs regarding the sanctity of human life, such as in the Jewish tradition, those days in which the patient clings to life are of inestimable worth.

B. New Jersey's Public Policy Recognizes the Distinct Religious Sensibilities of Patients.

New Jersey's public policy, as formulated by statute, recognizes that patients' distinct religious sensibilities are to be respected. For example, the New Jersey Declaration of Death Act states that a person who experiences irreversible cessation of all functions of the entire brain, including the brain-stem, should be declared dead, N.J.S.A. 26:6A-3. However, some New Jersey citizens – including some constituents of amici – maintain the religious belief that death does not occur until the heart also permanently ceases to function. To accommodate such belief, the Legislature enacted an "exemption to accommodate personal religious beliefs," based on the work of the New Jersey Commission on

Legal and Ethical Problems in the Delivery of Health Care. Thus, N.J.S.A. 26:6A-5 now provides,

> The death of an individual shall not be declared upon the basis of neurological criteria pursuant to sections 3 and 4 of this act when the licensed physician authorized to declare death, has reason to believe, on the basis of information in the individual's available medical records, or information provided by a member of the individual's family or any other person knowledgeable about the individual's personal religious beliefs that such a declaration would violate the personal religious beliefs of the individual. In these cases, death shall be declared, and the time of death fixed, solely upon the basis of cardio-respiratory criteria pursuant to section 2 of this act.

This statute clearly establishes a public policy of accommodating a patient's religious beliefs. A physician is proscribed from declaring a person dead, and cannot impose the statutory definition of death, even in a case where such person is considered clinically dead pursuant to N.J.S.A. 26:6A-3. See Boyle, *Religious Reasoning in Health Care Resource Management: The Case Of Baby K.*, 25 Seton Hall L. Rev. 949 (1995).

Here, it is undisputed that Mr. Betancourt was alive according to all clinical definitions. Yet Appellant's position is that physicians should have the right to override the patient's wishes and direct the cessation of all treatment, thereby causing the patient to die. Appellants advocate for a result which would likely strike any fair

minded person as nothing short of perverse: When a person is considered to be clinically dead pursuant to the definition promulgated by the New Jersey State Legislature, the law mandates that treatment should continue where the person's religious beliefs are in conflict with the statutory definition of death. However, should the person be indisputably alive – according to any definition – the physician should be allowed to terminate treatment, thereby inevitably leading to the patient's death. Such a position is neither logical nor consistent with the public policy of this State.

C. Allowing Physicians to Make Such Ethical Decisions Would Adversely Affect the Health Care of Many Patients.

Allowing physicians to terminate life-sustaining treatment unilaterally will likely result in a number of additional undesirable consequences, beyond depriving patients of their right to autonomy. Unscrupulous healthcare providers may take advantage of the vulnerability of terminally ill and unconscious patients and terminate their treatment for economic or other improper motives. It is not farfetched to assume that, should this Court overturn the lower court's decision and abandon the concept of patient autonomy, many elderly, ill patients would be fearful to enter hospitals for needed medical care out of concern that the doctors there will make decisions to terminate their

lives in direct contradiction to their wishes and those of their close family members.

D. Physician's "Rights" Should Not Supersede Patient's Rights.

The hospital asserts that the main point of contention in this case is whether or not a court can compel physicians and hospitals to provide life-sustaining treatment to a patient who desires to live, despite the physicians' alleged moral objection to such treatment. Since this conflict between physician and patient involves a question of the patient's life and death, the patient's right to autonomy, as explained earlier, must prevail. *See* Kathleen M. Boozang, *Death Wish: Resuscitating Self-Determination for the Critically Ill*, 35 Ariz.L.Rev. 23, 66 (1993).

Appellant cites this Court's opinion in *Couch v. Visiting Home Care Services*, 329 *N.J.Super.* 47 (App.Div., 2000) and alleges that medical professionals cannot be forced to provide treatment where they think it is inappropriate. However, *Couch* leads to the opposite conclusion, in the context of this case. *Couch* involved a quadriplegic who was receiving in-home care for treatment of a decubitus ulcer, or pressure sore. Since the patient's condition was worsening, he required 24-hour care, which was beyond the capabilities of the county health department and the private home-care service to provide. It was simply unsafe and improper to attempt to care for the patient while still in his home.

Paraphrasing its opinion in *Matthies v. Mastromonaco*, 310 *N.J.Super.* 572 (App.Div., 1998), *aff'd*, 160 *N.J.* 26 (1999), this Court said, "when the plaintiff selects a course which the professional nurses feel inappropriate or unsafe, they are free to refuse to participate and to withdraw from the case *upon providing reasonable assurances that basic treatment and care will continue,*" *Couch*, *supra,* 329 *N.J.Super.* at 53 (emphasis added). Thus, since the county health department accepted responsibility for arranging for continued care, the county and the private home-care service were not obligated to continue to provide treatment on their own.

In the instant case, however, the hospital and its physicians did not accept responsibility to arrange for continued care of Mr. Betancourt. Instead, they wished simply to abandon the patient, leaving him to die. *Couch* only addresses a case where existing healthcare providers have provided reasonable assurances that necessary care will continue. In such a case they are not required personally to continue caring for the patient. However, implied in *Matthies* and *Couch* is the proposition that when no transfer is available, the healthcare providers must continue treatment, especially if terminating such treatment would cause a patient's death. A similar notion has been codified by the legislatures of other states; see, e.g., M.D. Code Ann., Health-Gen. § 5-613(a)(3).

CONCLUSION

For the foregoing reasons, it is respectfully urged that the decision of the Chancery Division be affirmed.

Respectfully,

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TRINITAS HOSPITAL

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION

A-3849-08T2

CIVIL ACTION

CERTIFICATION OF SERVICE

I do hereby certify that the original and 4 copies of the Brief were sent to the Clerk, Appellate Division, by overnight delivery; with copies to those shown on the attached service list, by first-class mail; on September 15, 2009.

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