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*1197 CHOOSING LIFE AFTER DEATH: RESPECTING RELIGIOUS BELIEFS AND MORAL CONVICTIONS IN NEAR DEATH DECISIONS

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I've looked at life from both sides now

From win and lose and still somehow

It's life's illusions I recall.

I really don't know life at all. [FN1]

Though I walk in the valley overshadowed by death, I will fear no evil, for You are with me. Your rod and Your staff, they comfort me. [FN2]

INTRODUCTION

When a family first visits a medical Intensive Care Unit to see a family member who is brain dead, they cannot help but notice the tubes and the machines that sustain the patient. The sounds are the 'quiet 'whoosh' of air from a mechanical respirator and the rhythmic beeping of a cardiac monitor.' [FN3] The patient is silent; she does not move or talk or see. [FN4] Yet, when the physician speaks to the family and explains that the patient is brain dead, it is difficult ***1198** for the family to comprehend that she is actually dead. [FN5] At that time, however, important decisions must be made. There is the question of donating the patient's organs, and most difficult emotionally, there is the question of withdrawing the mechanical devices that sustain the patient in her current state.

Legally, most states permit the donation of organs and the discontinuation of mechanical devices, [FN6] sustaining respiration and heartbeat upon a determination of brain death. [FN7] Some recent developments indicate that the mechanical devices should be discontinued expeditiously and automatically once the brain death determination is made. [FN8] Such a procedure, however, raises serious questions regarding the role of personal choice in the decisionmaking process. If an individual has moral convictions or religious beliefs that conflict with the current brain death definition and the resulting automatic procedure, the question is how those individual preferences should be accommodated.

In medical decisionmaking, the individual's right to self-determination is paramount. That right, based either on the common law right of self-determination or the constitutional rights of privacy [FN9] or free exercise of religion, [FN10] should be respected when an individual wishes to continue living after society considers her dead. Currently, an individual's previously stated wish controls the decision to withdraw nutrition and hydration when she had almost totally lost brain function and is in a persistent vegetative state. [FN11] Also, an individu-

al's wish controls when she refuses specific treatment based on religious belief, such as a Jehovah's Witness' refusal to have blood transfusions. [FN12] The individual's preference will be overridden only if there is a sufficiently compelling state interest. In almost all cases, [FN13] the individual's right to choose outweighs any ***1199** countervailing state interest.

This Article presents the argument that this right of choice extends beyond a brain death determination. If an individual's moral convictions or religious beliefs dictate that she should continue living beyond society's definition of death, that preference should be respected. An individual has the right to continue treatment even after brain death. The right of personal choice extends until traditional criteria of death, cessation of heartbeat and respiration, are met. [FN14] Alternatively, the right of personal choice continues after legal death in the form of a right to direct the disposition of one's own body after death. [FN15] This right is embodied in several statutory provisions which protect individual preferences in decisions after death, but before burial, such as organ donation and autopsy. The right to choose to continue treatment after a brain death determination would prevail despite countervailing state interests. [FN16]

There are basically two ways to protect an individual's preferences in the decision to discontinue mechanical devices. The more preferable method is to enact statutes which provide exemptions from brain death definitions based on individuals' moral convictions or religious beliefs. Such statutes would provide clear guidance to hospitals and physicians concerning their obligation to respect the individual's preferences. It is also possible to regulate the decisionmaking process in a less formal way by requiring hospitals to develop policies which would reasonably accommodate an individual's moral convictions or religious beliefs. In either case, respect for individual choice would be protected as it is in other decisions made before and after a determination of death.

Part I of this Article explains the evolution of the current legal definition of death which uses brain death criteria and how this definition impacts on the medical decisionmaking process. [FN17] Part II discusses the basis for the right to choose to continue treatment ***1200** after a brain death determination. [FN18] The basic premise is that an individual's preferences should control the decision to continue maintenance of respiration and heartbeat beyond a brain death determination, just as it controls medical decisions before death and the disposition of one's own body after death. First, the development of the right of an individual's preferences in medical decisionmaking is examined in two specific near death situations: withdrawal of nutrition and hydration from those in a persistent vegetative state based on the rights of self-determination and privacy [FN19] and refusal of blood transfusions based on religious beliefs. [FN20] Second, extension of the right of personal choice beyond brain death is examined as part of the individual's right to control decisions such as autopsy and organ donation after death. [FN21]

The remainder of the Article deals with the consequences of recognizing such a right. PART III discusses whether the countervailing state interests in withdrawal and refusal cases are relevant to the continuation of treatment situation. [FN22] It also examines whether other state interests are sufficiently compelling to override the right to continuing treatment. [FN23] Particular attention is given to the religious beliefs of Orthodox Jews who do not accept a brain death definition. Finally, in Part IV, statutory and regulatory provisions to protect individual preferences based on religious beliefs or moral convictions are proposed and discussed. [FN24]

I. EVOLUTION OF THE CURRENT BRAIN DEATH DEFINITION

A. The Traditional Process of Determining Death

The evolution of the current brain death definition is best understood by first examining the traditional pro-

cess of determining death. That process has three components: 1) the medical criteria used to determine the signs of death, 2) the legal demarcation of the category of individuals who will be considered dead, and 3) the consequences of meeting the medical criteria and falling within the legal category. Traditionally, the medical criteria of cessation of ***1201** heartbeat and respiration were also used to establish the legal category or definition of death. If an individual was found by a physician to have no heartbeat and respiration, she fell within the legal category of those considered dead.

After the medical and legal criteria were met, the physician took two steps before releasing the individual's body for burial. First, it was necessary to make a treatment decision. In most cases when an individual was no longer breathing and had no heartbeat, [FN25] treatment was not initiated or else treatment was discontinued. Before the advent of technology which could sustain respiration and heartbeat by mechanical devices, that decision did not involve an actual choice but was an automatic response to the situation. It was obvious that treatment beyond that point was useless. Second, the physician declared or pronounced the individual dead. She then recorded the declaration of death in the death certificate indicating time and cause of death and documenting the legal fact that the individual had died.

Death signified a major change in status. Medically, instead of being a patient, she became a dead body or corpse. The responsibility for the dead body passed to the next of kin for the purpose of burial. [FN26] The next of kin's consent was required to authorize an ***1202** autopsy. [FN27] Legally, after death, she was referred to as the decedent or a deceased person rather than as a person. [FN28] The decedent's marriage was ended by death. The financial responsibility for any unpaid hospital bills was shifted to the decedent's estate. Life insurance benefits were triggered by death. The decedent's property was transferred either by operation of a deed, [FN29] will, [FN30] or intestate succession. [FN31] Criminal liability for homicide and civil liability for medical malpractice ceased at death. [FN32] The legal definition and medical determination of death provided the critical line for deciding***1203** to initiate or continue medical treatment as well as for determining the legal status of an individual.

B. Addition of Brain Death Definition

The process of determining death was developed in the nineteenth century. It remained stable until the 1970's, when there was a move to add or substitute a ‘brain death’ definition for the traditional legal category. [FN33] This development can be traced to several changes in medical technology and practice. [FN34] First, mechanical devices [FN35] were invented which could sustain respiration and heartbeat for those who in prior years would have rapidly died. [FN36] Second, sophisticated techniques [FN37] were developed to determine when an individual had permanently lost all brain function. This is called ‘brain death.’ [FN38] Finally, with the increasing success of ***1204** transplantation surgery, [FN39] the concomitant need for ‘viable, intact’ organs surfaced. [FN40] The best candidates for organ donations are those ‘otherwise healthy individuals who have died following traumatic head injuries and whose breathing and blood flow are being artificially maintained.’ [FN41]

Although the need for viable, intact organs does not account totally for the development of brain death legislation, [FN42] medical practitioners' doubts concerning their criminal [FN43] and civil [FN44] liability for transplanting organs from individuals not legally dead provided the main impetus for establishing a brain death definition. [FN45] In addition, brain death was viewed by some as death itself. [FN46] Depending on the situation, death was manifested in two ways: through cessation of heartbeat and respiration or irreversible cessation of all brain function. [FN47] Because the use of a brain death definition ***1205** marked a major shift in medical practice and prior law, there was considerable uncertainty about the consequences of the change. [FN48] After all, adding this definition meant that individuals, who by traditional standards were considered alive, would now

be considered dead. [FN49]

The difficulty of the transition to a brain death definition is reflected in the tentative language of the first brain death statutes. These early formulations reflected the general understanding at that time: 1) brain dead individuals were not dead by traditional criteria, but there were reasons for considering or pronouncing them dead, such as facilitating organ transplants, and 2) brain death criteria applied only when an individual's heartbeat and respiration were sustained by mechanical devices. Early model legislation suggested that those who had experienced irreversible cessation of total brain function 'shall or will be considered dead.' [FN50] In other words, the individual was not dead by traditional criteria, but would be considered legally dead in order to remove her organs for transplantation without risking criminal liability. Alternatively, some legislation provided that these individuals 'may or shall be pronounced dead.' [FN51] This language indicated both that the brain death definition was applicable when organ transplantation was contemplated and that there was some discretion in using the definition to pronounce an individual dead.

***1206** Another approach was to say that a brain dead individual 'is dead' but to qualify that language with the phrase 'for legal and medical purposes.' [FN52] The National Conference of Commissioners on Uniform State Laws originally adopted this approach in 1978 in approving the Uniform Brain Death Act. [FN53] In 1980, The National Conference of Commissioners on Uniform State Laws deleted the 'for legal and medical purposes' language [FN54] and approved the Uniform Determination of Death Act (UDDA). [FN55] Section 1, entitled 'Determination of Death,' provides that ' a n individual who has sustained either 1) irreversible cessation of circulatory and respiratory functions, or 2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead.' [FN56] In 1981, this definition was also endorsed by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research [FN57] and has now been adopted by all twenty-four ***1207** states that have since adopted statutory definitions of death. [FN58] Currently, forty-six states have recognized a brain death definition, either through legislation [FN59] or court decisions. [FN60]

***1208** This particular language, 'is dead,' was chosen for the purpose of establishing brain death as the legal definition of death for use in all medical decisionmaking; it was not specifically limited to organ transplantation. [FN61] The UDDA however, did not describe specific tests for determining brain death other than stating that the medical 'determination of death must be made in accordance with accepted medical standards.' [FN62] Also, it did not directly address how treatment decisions should be made after the medical and legal determination of brain death was completed. [FN63]

C. Impact of Brain Death Definition on Decisionmaking

The proponents of a brain death definition had two purposes: 1) facilitating organ transplantation and 2) encouraging acceptance of brain death as a new category of death. The procedures for implementing organ transplantation and for removing mechanical devices sustaining heartbeat and respiration were not addressed in the UDDA. [FN64] The procedures for organ transplantation have become standardized now that the Uniform Anatomical Gift Act has been adopted in all fifty states and the District of Columbia. [FN65] There is still some confusion, however, concerning procedures for removing mechanical devices from those determined to be brain dead.

This confusion has resulted because the timing of death differs when an individual suffers brain death and her heartbeat and respiration are sustained by mechanical devices. First, the use of mechanical devices extends the time period between brain death and actual cessation of heartbeat and respiration. Second, before actual ces-

sation of heartbeat and respiration, the physician must ***1209** act; she must turn off the machines. Third, the death certificate is not executed and the body is not released for burial until the individual's heartbeat and respiration actually stop. This change in timing provides an opportunity to decide whether an individual's organs should be harvested for transplantation. There is also an opportunity to consult with the family before turning off the machines. If there is a decision not to donate the individual's organs, a question remains, however, whether the decision to turn off the machines should be as automatic as discontinuation of treatment was in the traditional process. If so, once an individual is determined to be brain dead, turning off the machines would be part of the formalities of declaring the individual dead, completing the death certificate, and releasing the body for burial.

It now seems clear that the decision to turn off the machines may be treated as an automatic response after a brain death determination is made. The New Jersey Supreme Court, in the recent case of *Strachan v. John F. Kennedy Memorial Hospital*, [FN66] indicated that once a determination of brain death is made, mechanical devices sustaining heartbeat and respiration should be expeditiously removed in order to minimize suffering for the individual's family. [FN67] In that case, there was considerable confusion on the part of the physicians and the hospital administration about how to proceed after an initial determination of brain death was made. [FN68]

The case began when the Strachans' twenty-year-old son, Jeffrey, shot himself in the head on Friday, April 25, 1980, in an apparent suicide attempt and was rushed to Kennedy Hospital. He initially had spontaneous respiration, but soon after his arrival he was placed on a respirator when spontaneous respiration ceased. [FN69] At that time, two doctors made the determination that Jeffrey was brain dead. The Strachans were informed and asked to consider donating his organs for transplantation. They decided against donating***1210** Jeffrey's organs and requested that he be taken off the respirator. Although the physicians involved were familiar with the procedures for organ transplantation, they were unsure how to comply with the parents' request. [FN70] The matter was referred to the hospital administrator who consulted with the hospital's general counsel. [FN71] It was not until Monday, April 28, 1980, that the physicians officially determined that Jeffrey was brain dead, disconnected him from the respirator, and pronounced him dead. After that, the death certificate was executed and Jeffrey's body released to his parents for burial. [FN72]

The suit brought by Jeffrey's parents was pursued on the basis that Jeffrey was dead on Friday when it was first determined that he was brain dead. The theory was that the hospital had a duty to have procedures in place for removal of life-support systems and a duty to release the dead body to the parents. [FN73] The New Jersey Supreme Court was unwilling to impose a duty on hospitals ‘to have in place *procedures* for the removal of a dead body from a life-support mechanism on the request of the next of kin,’ [FN74] but suggested that procedures should have been developed by physicians and hospitals to deal with this situation. [FN75] The court concluded that the hospital did have a duty ‘to act reasonably in honoring the family's legitimate request to turn over their son's body.’ [FN76] The court then determined that the hospital's conduct had violated this duty, and the parents were entitled to damages ***1211** for their emotional distress. [FN77]

It is important to note that the case was not resolved by the New Jersey Supreme Court until eight years after the original incident. It is not surprising that the hospital did not have procedures in place in 1980 before the National Commissioners had even approved the UDDA, even though the New Jersey Supreme Court had approved the brain death definition in dicta in *In re Quinlan* [FN78] in 1976. [FN79] But the New Jersey Supreme Court took the approach in 1988 that the determination of brain death is the major determinant in the decision to withdraw mechanical devices sustaining heartbeat and respiration. [FN80] According to the court's reasoning, once the physician determines the patient is brain dead, [FN81] the patient then becomes a dead body, and a duty arises to respect the wishes of the next of kin regarding the care of that body. The implication is that the procedures following a determination of brain death should be just as automatic as they were under the traditional

definition. The delay in expeditiously removing the respirator, pronouncing death, and executing the death certificate after the brain death determination was considered negligent and the Strachans were to be compensated for the resulting emotional distress they suffered. [FN82]

The guidelines developed for physicians facing this situation also indicate that the procedures for turning off the machines sustaining***1212** brain dead individuals should be similar to traditional procedures. For instance, the Los Angeles County Medical Association and Bar Association Guidelines (Guidelines), approved in 1986, stated that after a determination and pronouncement of death, '[t]here is *no* legal or ethical issue involved in discontinuing all treatment, including ventilatory support . . ..' [FN83] As in the traditional procedures, the physician determines death, decides to discontinue all treatment, and then declares the patient's death. [FN84] 'Once the patient is pronounced dead and the time of death has been established, the disconnection of the respirator has no greater medical or legal significance than the removal of any other modality . . . from the body of a dead patient.' [FN85] There are some dissimilarities in procedure. For instance, the Guidelines recommended that the patient's family be informed of the medical determination of brain death. [FN86] They should be given the opportunity to have the medical determination confirmed and to decide whether to donate the individual's organs according to the Uniform Anatomical Gift Act. [FN87] Nevertheless, in essence, the Guidelines viewed the decision to discontinue use of the mechanical devices as an automatic response to brain death. Just as all treatment was discontinued for those determined to be dead under traditional criteria, so should all treatment be discontinued for those determined to be dead under brain death criteria.

The most striking aspect of both the *Strachan* case and the Guidelines is the almost total disappearance of the brain dead individual after a determination of brain death. In *Strachan*, the issue was how the physicians and hospital administrators should have responded to the family's request. Under the Guidelines, the decision is viewed as a medical one to be reached by a physician in consultation with the family. There is no reference to how the brain dead individual's preferences should influence this decision. Once the patient becomes a dead body, the decision is left in the hands of the physicians and the families.

***1213** *D. Impact on Personal Choice*

Although these procedural guidelines provide clarity where physicians and hospitals may be confused, the recommended automatic response may impinge on the right of the brain dead individual to control decisions regarding her death. Although most people may view maintenance on machines as an occurrence that should be avoided if one is close to death, [FN88] an individual for various reasons***1214** may wish to continue heartbeat and respiration beyond the point which physicians and society consider death. [FN89]

First, brain death may not be an acceptable definition according to the patient's religious or cultural belief. For instance, according to some Orthodox Jewish legal scholars [FN90] 'brain death and ***1215** irreversible coma are not acceptable definitions of death . . ..' [FN91] Similarly, other cultures such as Native American [FN92] and some Japanese [FN93] do not recognize brain death.

Second, the patient may be convinced that permitting withdrawal of mechanical devices from brain dead individuals may lead to the morally objectionable withdrawal of those devices from others who have less serious forms of brain damage. Recently, there have been recommendations that less than total cessation of all brain function be considered the legal definition of death. [FN94] Also ***1216** several courts have permitted the withdrawal of mechanical devices providing nutrition and hydration from those not legally dead but in a persistent vegetative state. [FN95] An individual may conclude that this could lead to active euthanasia which she opposes on moral grounds, [FN96] and therefore, opposes the automatic withdrawal of mechanical devices and wants to

avoid it in her own case.

Third, she may fear that the mechanical devices would be ***1217** withdrawn prematurely in order to harvest her organs. Despite the procedures and safeguards provided by the Uniform Anatomical Gift Act, [FN97] she may prefer to have mechanical devices sustain her even though spontaneous respiration has ceased.

For whatever reasons, if an individual has indicated that she wants her heartbeat and respiration sustained by mechanical devices even after a brain death determination, how should physicians and hospitals respond? More fundamentally, the question is whether and to what extent society should recognize and accommodate individuals' objections to the imposition of the current brain death definition in a manner which results in the automatic response of withdrawing mechanical devices which sustain heartbeat and respiration. In short, should an individual be allowed to choose to live after society considers her dead?

II. THE RIGHT TO CHOOSE LIFE AFTER DEATH

Particular choices regarding medical treatment in near death decisions may be based on an individual's religious beliefs or personal philosophy about the meaning of life and death. They may also be based on an individual's personal experiences or fears about how her life will end. The right of each individual to control the course of her medical treatment should encompass a right to continue treatment after a brain death determination in accordance with her religious beliefs, moral convictions, or personal experiences. If her personal definition of death extends beyond the legal definition, she should be treated as if she were alive. She would have the same right to exercise choice concerning medical decisions as any living individual. This right may be impaired only if there is a sufficiently compelling state interest. [FN98] Before examining possible justifications a state might have for overriding the individual's right to choose, it is necessary to consider that right ***1218** more closely.

A. Respect for Personal Choice In Medical Decisionmaking While Alive

The right to have an individual's religious beliefs or moral convictions respected after a brain death determination is based on respect for an individual's autonomy in medical decisionmaking. Under current law, control of medical decisionmaking rests primarily with the individual patient, [FN99] and includes decisions at the end of one's life. Not only have legislatures acted to protect this right, [FN100] but courts have expanded existing legal doctrines with the aim of protecting individual autonomy in deciding the course of medical treatment. These doctrines include the common law right to self-determination [FN101] and the constitutional rights of privacy [FN102] and free exercise of religion. [FN103] Even in the most difficult cases, the ***1219** individual's right to choose her own course of treatment has been honored. [FN104] The degree of respect accorded to the individual's choices is illustrated by those cases which allow the withdrawal of treatment at the end of an individual's life or refusal of treatment in potentially life-threatening situations. Two examples will be examined here: 1) the discontinuation of nutrition and hydration from those in a persistent vegetative state and 2) the refusal of blood transfusions by Jehovah's Witnesses.

1. The Choice to Withdraw Nutrition and Hydration from Those in a Persistent Vegetative State

a. The Common Law Right to Self-Determination

In the recent New York case of *Delio v. Westchester County Medical Center*, [FN105] the court struggled

with ‘the controversial and profoundly difficult question of whether the common law right to decline medical treatment . . . encompasses a right to remove or withhold artificial means of nourishment and hydration to an individual in a persistent vegetative state with no hope of recovery.’ [FN106] The court held that where there is clear and convincing evidence that the individual would have chosen to discontinue the life-sustaining treatment, including nutrition and hydration, those wishes will be honored. [FN107]

Daniel Delio, a thirty-three-year-old exercise physiologist, had routine surgery in May, 1986. During the operation, he suffered cardiac arrest which resulted in brain damage. Daniel was diagnosed as ‘being neocortically dead,’ but not brain dead as he retained***1220** part of his brain functions. [FN108] Daniel had lapsed into what is called a ‘persistent vegetative state.’ [FN109] In June, 1986, two feeding tubes were inserted into Daniel's stomach and intestines. In August, 1986, Daniel's wife Julianne sought appointment as conservator to discontinue all medical treatment including removal of the feeding tubes. The Medical Center opposed Julianne's appointment on the ethical ground that removal of the tubes ‘would constitute a deliberate act which would cause Daniel's death contrary to its mission as a hospital to preserve life.’ [FN110] Although Julianne's appointment as conservator was approved, her request to withdraw the feeding tubes was not. The lower court judge, Justice Cerrato, concluded ‘that while ‘his personal sympathies in this human tragedy were with the anguished wife, mother and relatives of Daniel Delio,’ he believed that ‘placing a judicial imprimatur on a decision to terminate the care in this case, in absence of clear legislative or judicial guidance, is fraught with danger’ . . ..' [FN111]

The Appellate Division, however, found that because there was clear and convincing evidence of the patient's wishes, Julianne was entitled to act according to his wishes. [FN112] The evidence of Daniel's wishes included detailed and specific discussions with relatives. [FN113] Because of his professional training as an exercise physiologist and his personal experiences when his father suffered a severe heart attack, Daniel believed ‘that the destruction of the cortex was the equivalent to the cessation of life itself because the functions originating in the cortex provided the human qualities of an individual.’ [FN114] Daniel believed, therefore, that neocortical death rather than brain death should be the controlling definition of death. [FN115] On several occasions and with strong conviction, Daniel had expressed that ‘he did not want to be maintained artificially if ***1221** he were to lapse into a chronic vegetative state.’ [FN116]

The court allowed Daniel's beliefs about death and choices about continued medical treatment to be carried out. It based that decision squarely on the common law right to self-determination. [FN117] That right was established in the 1914 case of *Schloendorff v. Society of New York Hospital*, [FN118] where Justice Benjamin Cardozo stated that ‘ e very human being of adult years and sound mind has a right to determine what shall be done with his own body.’ [FN119]

That right could not be overcome in *Delio* simply because Daniel was incompetent at the time the decision had to be made. [FN120] It did not matter that the mechanical devices provided nutrition and hydration rather than respiration and heartbeat, [FN121] nor were any state interests compelling enough to override Daniel's right to self-determination with respect to his body. [FN122] The only countervailing interests that could overcome such a right are 1) the preservation of life, 2) the prevention of suicide, 3) the protection of innocent third parties and 4) maintenance of the ethical integrity of the medical profession. [FN123] In *Delio*, as in all other cases concerning ***1222** patients in a persistent vegetative state, [FN124] none of these interests was found sufficient to override the right of self-determination.

The right of a patient to refuse medical treatment is paramount when the patient's wish has been clearly expressed while competent. In essence, unless there is a compelling state interest, the individual's right of self-determination controls both the definition of death and the treatment decision. Applying this reasoning to an individual's wish to be sustained after a brain death determination, an individual should have the right to control

the decisions to continue treatment according to her own personal views absent any contrary compelling state interests.

b. The Constitutional Right of Privacy

In cases concerning the right to withdraw medical treatment, courts will often rely not only on the common law right to self-determination but also on the federal and state constitutional rights of privacy. The right of privacy was first extended to the right to decline medical treatment in 1976 by the New Jersey Supreme Court in *In re Quinlan*. [FN125] Today, although the common law right is considered the primary protection for the individual's right to refuse medical treatment, the right of privacy provides additional protection. [FN126] These rights extend to an individual in a persistent***1223** vegetative state in two situations: 1) where she has authorized a surrogate to make all medical decisions on her behalf but has not specifically mentioned withdrawal of treatment and 2) where she has not clearly expressed her opinion regarding treatment.

In the first situation, in *In re Peter*, [FN127] Hilda Peter had executed a power of attorney authorizing her close friend Eberhard Johanning 'to make all decisions with respect to her health, as if he were next of kin' and 'to be given full and complete authority to manage and direct her medical care.' [FN128] After Hilda lapsed into a persistent vegetative state and was being sustained by a nasogastric tube in a nursing home, Eberhard Johanning sought appointment as her guardian for the purpose of removing her nasogastric tube. Because there was clear and convincing evidence, including the power of attorney, that Hilda would have chosen to withdraw the nasogastric tube, the court found no sufficiently strong state interest to override her right to discontinue feeding by mechanical devices. [FN129] Indeed, the court concluded that 'we find it difficult to conceive of a case in which the state could have an interest strong enough to subordinate a patient's right to choose not to be artificially sustained in a persistent vegetative state.' [FN130]

The New Jersey Supreme Court explained that medical choices are private in the sense that 'it is the patient's preferences-formed by his or her unique personal experiences-that should control.' [FN131] These choices control even if they are executed by a surrogate and even if they differ from 'societal standards of reasonableness or normalcy.' [FN132] The privacy given to these decisions***1224** 'does not vary with the patient's condition or prognosis.' [FN133] As in the cases resting on the common law right to self-determination, the constitutional right of privacy includes the individual's right to determine her own treatment close to death. The logical implication of this reasoning is that the right to privacy would also include respect for an individual's decision to be sustained on mechanical devices after a brain death determination.

In the second situation, in *In re Jobes*, [FN134] there was insufficient evidence to determine Nancy Ellen Jobes' attitude toward the withdrawal of mechanical feeding devices. [FN135] At the time the case was decided, Nancy Ellen, a young woman who had lapsed into a persistent vegetative state after an operation, [FN136] had been fed and hydrated through mechanical devices for over seven years. In 1985, her husband and parents had requested that the nursing home withdraw her jejunostomy tube which provided her nutrition and hydration. When the nursing home refused on moral grounds, Mr. Jobes asked the court to authorize the withdrawal.

As in *In re Peter*, the New Jersey Supreme Court held that this case was controlled by their earlier decision in *In re Quinlan*. [FN137] Actually, *Jobes* was an updated version of *Quinlan*; the only major difference was that the family in *Jobes* requested withdrawal of feeding tubes rather than a respirator. [FN138] As in *Quinlan*, the court in *Jobes* concluded that Nancy Ellen's 'right to choose whether to consent or to refuse life-support outweighed any relevant state interests.' [FN139] The major questions then became who should decide and what the standards and safeguards should be for ***1225** protecting the individual's rights. [FN140]

When an individual's wishes are not clearly expressed, the court held that the surrogate decisionmaker must consider the ‘patient's personal value system.’ [FN141] This includes not only the patient's prior statements and reactions to medical issues but also the patient's personality, with ‘particular reference to his or her relevant philosophical, theological, and ethical values.’ [FN142] The court concluded that the ‘patient's family members were the proper parties to make a substituted medical judgment on her behalf.’ [FN143] The rationale is that the patient's family has the best knowledge of the individual's view and attitudes and is generally most concerned about her welfare. [FN144]

The court then found that Nancy Ellen's family was the ‘best qualified to determine the medical decisions she would [have] made’ and would not disturb its decision to remove the feeding tube. [FN145] The additional procedural guidelines established by the court in *Quinlan*, such as an appointment of a guardian and reference***1226** to a hospital prognosis committee, were not necessary in this case. [FN146] The court's final decision was to allow removal of Nancy Ellen's feeding tube. This was done and she died on August 7, 1987. [FN147]

The right to consent to or decline medical treatment has been extended to those individuals who have not specifically or clearly expressed their preferences. In such situations, it is the role of the family to make decisions in accordance with the value system of that individual. Applied to the situation where an individual's value system mandates sustaining mechanical devices beyond the legal definition of death, the reasoning of *Jobes* implies that the family should have the right to make that request and have it respected. [FN148]

2. The Choice to Refuse Blood Transfusions Based on Religious Beliefs

Jehovah's Witnesses refuse a specific kind of medical treatment, blood transfusions, based on their religious beliefs. [FN149] Ordinarily, these individuals express their wishes whenever they are under the care of a doctor or when emergency care is necessary. The courts enter the picture when a physician or hospital seeks to impose a blood transfusion against the individual's expressed desires.

***1227** The constitutional right of free exercise of religion encompasses a refusal of medical treatment based on religious belief unless there is a sufficiently compelling state interest to override the individual's decision. [FN150] This right applies whether or not the individual is competent at the time the decision is made. [FN151] The state interests balanced against this right to refuse medical care based on religious beliefs are identical to those considered when the right of self-determination or privacy is at stake. [FN152] This free exercise right represents an additional basis for controlling medical decisionmaking. Ordinarily it would be asserted with the rights of self-determination or privacy which are not necessarily supported by any type of religious belief. [FN153]

***1228** In treatment decisions involving religious belief, deference is the norm. When an individual is competent, the courts will often uphold the individual's refusal of treatment despite the state's interests in preserving life, preventing suicide, protecting innocent third parties, and maintaining the ethical integrity of the medical profession. A recent Florida case, *Wons v. Public Health Trust of Dade County*, [FN154] shows the extent of deference to the competent individual's religious belief. Mrs. Norma Wons, a thirty-eight-year-old woman and mother of two children, ages twelve and fourteen, sought treatment for uterine bleeding at Jackson Memorial Hospital. Norma, who was found to be competent, refused a blood transfusion based on her religious belief as a Jehovah's Witness. The hospital sought a court order authorizing its medical staff to administer life-saving blood transfusions. According to the lower court, the protection of innocent third parties (i.e., her minor children) was sufficient to override Norma's refusal of blood transfusions. [FN155]

The Florida District Court of Appeal concluded, however, that Norma's belief should not be overridden because her possible death from refusal of a blood transfusion would not 'result in an abandonment of her two minor children.' [FN156] Because the father and extended family would provide financial and emotional support for the children, the court reasoned that the children 'will be reared by a loving religious family; and they will no doubt cherish the memory of a courageous mother who in time of peril stood by her religious convictions.' [FN157]

There is some precedent for overriding a refusal of a blood transfusion in an emergency situation based on the need to protect innocent third parties such as minors or even the unborn [FN158] or to ***1229** preserve the patient's life. [FN159] In these situations, without a transfusion, it is highly likely that the individual will die; with the transfusion, the individual will most probably live. [FN160] Judges override the individual's religious belief knowing that 'a life hung in the balance . . . and death could have mooted the cause in a matter of minutes . . ..' [FN161] The rationale comes later.

In an emergency, an individual's express wishes may be overridden if the court is concerned about innocent third parties including very young children [FN162] and even the unborn. [FN163] In *In re Application of Jamaica Hospital*, [FN164] Justice Lonschein's Saturday evening dinner arrangements were interrupted by the need to authorize a blood transfusion for a pregnant patient whose condition was critical from loss of blood. The patient refused to consent to a blood transfusion based on her religious belief. She was eighteen weeks pregnant and the mother of ten children. Her only next of kin was a sister who was unavailable. In authorizing the transfusion,***1230** the judge based his decision to order treatment primarily on the state's interest in the unborn fetus as well as on the mother's responsibility to her minor children. [FN165] Preservation of the life of the individual predominated in order to protect innocent third parties.

When an individual has not clearly expressed her beliefs but the family refuses to consent on her behalf, judges will sometimes authorize an emergency blood transfusion based on the state's interest in preservation of life. Two recent cases, *In re Estate of Dorone* [FN166] and *University of Cincinnati Hospital v. Edmond*, [FN167] involved adults who were brought to the hospital after serious injuries and who were incapable of expressing their own wishes. In each case, objections were voiced by a family member. In *Dorone*, the father refused to consent to a blood transfusion for his son because they were Jehovah's Witnesses. [FN168] In *Edmond*, four adult children represented their mother's opposition to receiving either blood or plasma based on their religious beliefs as Jehovah's Witnesses. [FN169] In both cases, the courts chose to override the individuals' beliefs, as expressed by the families, based on the overarching concern with preserving life. [FN170] Both courts reiterated the need 'to give weight to the known instinct for survival,' [FN171] and 'to err on the side of life.' [FN172]

Commentators have criticized those cases which permit blood transfusions contrary to an individual's religious beliefs. [FN173] The ***1231** major criticism is that the decisions are not supported by the state interests invoked but instead reflect the decisionmakers' views that the patient's reasons are 'silly or inconsequential' or that the patient's decision is personally distasteful. [FN174] It is doubtful that cases permitting the overriding of an individual's beliefs would be directly relevant where there is neither urgency [FN175] nor a question about restoring the brain dead individual to normal life. The refusal of treatment cases, however, do stand for the proposition that an individual's free exercise rights also serve as a basis for respecting an individual's choice concerning medical treatment. The choice would be to continue maintenance on a respirator beyond a brain death determination not to refuse a blood transfusion. They also indicate that the free exercise right is not absolute and may yield when the state interest is sufficiently compelling.

B. Respect for Personal Choice in Decisions After a Brain Death Determination

The individual's right to control the course of her medical treatment in accordance with her own religious beliefs and moral convictions is broad enough to encompass a right to continue treatment after a brain death determination. The argument may be raised, however, that after death, the right to control medical decisionmaking is extinguished. [FN176] If death is defined as brain death, the individual no longer has the right to control the decision to continue mechanical devices sustaining respiration and heartbeat. There are two ways to resolve this question.

First, the individual's subjective definition of death may control, not the brain death definition. Because death does not occur ***1232** according to the individual's religious beliefs or moral convictions until respiration and heartbeat cease, the individual is not legally dead even after a brain death determination. Therefore, until that time, the individual would have the same rights as any living person to make choices regarding her medical care. The brain dead individual would have the same common law right of self-determination and the constitutional rights of privacy and free exercise of religion as previously discussed. [FN177] She would have the same right to have people carry out her wishes. From the individual's point of view, the right of choice would continue until the traditional legal definition of death is met.

The second way to resolve this issue is to recognize that the right to choose continues after death. If the legal definition controls and an individual is dead after a brain death determination, the right of personal choice is not extinguished but continues in a different form. The right changes to a right to control the disposition of one's own body. This represents an extension of the common law right to self-determination and the constitutional right of privacy after death. This right of disposition of the body after death is found in various statutory provisions. For instance, the individual's wishes control her burial. The next of kin has the responsibility to ‘faithfully carry out directions of the decedent’ concerning ‘the preparation for, type or place of interment of his remains.’ [FN178] The decedent's directions may be given before death either orally or in writing. [FN179] If contained in a will, the directions must be carried out regardless of the validity of the will. [FN180]

1. The Individual's Right to Control Disposition of the Body

This right to control the disposition of one's own body is currently protected in two situations involving decisions made after death but before burial: 1) the donation of organs and 2) the authorization***1233** of autopsy. The decisionmaking process regarding donation of organs is found in the Uniform Anatomical Gift Act, now enacted in various forms in all fifty states and the District of Columbia. [FN181] The Act provides that ‘ a ny individual of sound mind and 18 years of age or more may give all or part of his body . . . the gift to take effect upon death.’ [FN182] Prior to death, an individual may make the gift by will or by other gift document. [FN183] If the decedent does not authorize a gift and there is no ‘actual notice of contrary indications by the decedent,’ the next of kin may donate all or part of a decedent's body. [FN184] Similarly, autopsies must be authorized either by the decedent prior to death or the next of kin after death. [FN185] Performance of an autopsy without authorization is considered a misdemeanor. [FN186]

These statutory provisions implicitly recognize an individual's right to control the decisions regarding disposition of one's body after death. This same right should exist regarding the discontinuation of mechanical devices after a brain death determination. If there are no indications of the individual's preferences, the choice would then fall to the family. [FN187]

Yet there is a marked difference between the decisionmaking process for organ donation and autopsy author-

ization, and the currently suggested decisionmaking process for discontinuing treatment***1234** after a brain death determination. According to the procedures suggested by *Strachan v. John F. Kennedy Memorial Hospital*, [FN188] and the Los Angeles County Guidelines, [FN189] consideration of the individual's preferences regarding the decision is not even mentioned. Although those preferences may surface in consultation with the family, there is no recognition that the individual's wishes should be the primary determinant in the decisionmaking process.

To ensure that an individual's right of choice is protected in the decisionmaking process for discontinuation of treatment after a brain death determination, it would be necessary for the physician to ascertain and follow the individual's preference regarding that decision. In most cases, that preference will not differ from the physician's own judgment that the treatment should be discontinued. Where the individual may have expressed her preference, however, this requirement will protect her right to dispose of her own body.

2. Respect for Religious Beliefs in Disposition of the Body

Personal choices based on an individual's religious beliefs are also respected in decisions made after a determination of death but before burial. For instance, the California Uniform Anatomical Gift Act specifically protects those individuals who may not wish to donate their organs because of their religious beliefs. [FN190] If it is known that the decedent belongs to a faith healing sect or has religious tenets that would be violated by organ donation, no other individual has the authority to make a donation. [FN191] Similarly, there are restrictions on the authorization of an autopsy if it would violate***1235** the deceased's beliefs. [FN192]

The most significant protection of an individual's religious beliefs in these types of decisions is found in statutes which limit the powers of the coroner to perform autopsies when an objection is based on religious belief. [FN193] If the coroner is informed of the decedent's religious belief or there is some reason for believing that the autopsy is contrary to the decedent's belief, [FN194] she is prohibited from performing an autopsy or other procedure, [FN195] with only limited***1236** exceptions. [FN196] Because of the need to do autopsies quickly, these statutes usually provide a forty-eight-hour waiting period for deciding whether action by the coroner is appropriate. [FN197] Either the family or the coroner may initiate court action to determine whether an autopsy should by performed despite the religious objection. [FN198] If the family or a friend [FN199] voices an objection, the autopsy***1237** will not be performed unless there is either a compelling public necessity, [FN200] or an interest outweighing the decedent's right to fully exercise her religious convictions. [FN201] ‘Compelling public necessity’ in this context means that the autopsy is essential for a criminal investigation or that there is an immediate and substantial threat to public health. [FN202] If the coroner's court petition is denied, the body is released to the family or other person authorized to control its disposition. [FN203]

The main protection for the individual's choice provided by these statutes is that the decision to perform an autopsy is no longer within the sole discretion of the coroner. To protect the choice of an individual based on religious belief, this type of procedure could also be used in the decisionmaking process for discontinuing mechanical devices after a brain death determination. If the family objected on behalf of the individual or the physician had some reason to believe that the individual's religious beliefs would be violated, the individual's beliefs would control the decision.

There is a difference, however, between a decision made by a physician as opposed to one made by a coroner. [FN204] The coroner has ***1238** broad powers entrusted to her by the state; [FN205] the physician's power to make decisions regarding treatment is already subject to the individual's preference. For instance, a coroner does not need authorization to perform an autopsy, [FN206] but a physician does. In this respect, if the coroner is re-

quired to defer to an individual's religious belief in the autopsy decision, the physician, a fortiori, should defer to an individual's religious belief in the decision to discontinue the use of mechanical devices.

III. COUNTERVAILING STATE INTERESTS

Although deference to an individual's preferences is appropriate in the decisionmaking process for discontinuing treatment after a brain death determination, these preferences may still be overridden if there is a compelling state interest in doing so. It is first necessary to determine whether any of the state interests relevant to the withdrawal or refusal of treatment are also relevant to the continuation of treatment after a brain death determination. Those interests include preservation of life, prevention of suicide, protection of innocent third parties, and the ethical integrity of the medical profession. It is also necessary to examine whether other state interests, such as preservation of another individual's life, uniformity, or control of the cost of medical care, could be considered sufficiently compelling to override an individual's preference to continue treatment.

A. Preservation of Life and Prevention of Suicide

The state interests in preservation of life and prevention of suicide, if interpreted narrowly, would not apply to the decision to continue use of mechanical devices after a brain death determination. Preservation of life and prevention of suicide usually refer to ***1239** protection of the particular individual from premature death at the hands of others or herself. [FN207] Here the issue is the individual's wish to extend, rather than shorten, her life. Therefore, the state's interests in preservation of life and prevention of suicide are promoted, rather than diminished, by allowing an individual to choose to live beyond a brain death determination.

Preservation of life can be interpreted more broadly, however, to mean respect for life in general. The underlying premise is that treating some individuals' lives as less valuable than others' demeans society's overall respect for life. [FN208] The argument is that by allowing some brain dead individuals to be sustained longer than others, those individuals are somehow ‘less dead’ than those who are sustained for a shorter period of time. [FN209] That situation would diminish respect for life in general. The major fallacy in that reasoning is that respect for life in general stems from treating each individual as a unique individual. [FN210] If instead, a whole group is treated in one way without respecting the preferences of each individual within that group, then respect for life would be diminished. The continuation of treatment in accordance with the wishes of the individual generally promotes respect for life by treating each individual as unique with preferences that should be followed. Hence, the interest in preservation of life in the broad sense is also ***1240** promoted by respecting an individual's wish to continue treatment.

B. Ethical Integrity of the Medical Profession

Another state interest relevant in withdrawal or refusal of treatment cases is the ethical integrity of the medical profession. Most cases involving withdrawal or refusal of treatment are brought by physicians and hospitals whose values are in conflict with the treatment decisions of the patient. [FN211] In the continuation of treatment situation, the medical profession's ethics may be offended because they feel their mission is to save life, not to care for dead bodies. [FN212] Yet, the state interest in the medical profession's ethical integrity has not been sufficient to override a particular individual's wishes in withdrawal or refusal of treatment cases. [FN213] Instead, the courts have suggested that if a physician or hospital is unwilling to carry out the wishes of the patient, the patient should be transferred to the care of another physician or hospital or facility that will. [FN214] In the treatment continuation situation, the physicians and hospitals would not have to take any action other than

to continue care of the brain dead individual. Although this is difficult for the health care professional, it is still part of humane treatment in accordance with the wishes of the patient and that ***1241** reasoning may ease the burden for the care giver of continuing treatment.

C. Protection of Innocent Third Parties

The final state interest relevant in refusal of treatment is the protection of innocent third parties. This ordinarily refers to minors or even the unborn [FN215] who would become the responsibility of the state if the individual who was refusing treatment died. This interest is not directly applicable where an individual wishes to continue treatment after a brain death determination. [FN216] Although continuing treatment may use state financial resources to pay for the care given, [FN217] that does not directly affect innocent third parties who are relatives of the individual.

D. Preservation of Another's Life

The state interest in preservation of life in withdrawal or refusal cases refers to the individual's own life. [FN218] The state interest in preservation of life in continuation of treatment cases refers to the life of another individual. The situation would arise if there was insufficient room in an intensive care unit for all patients who were sustained on mechanical respirators. If there was only one ‘bed’ or space available in the intensive care unit and there were two patients who needed intensive care, one brain dead and the other only temporarily unable to sustain respiration, the physician would have to choose who would have that bed and who would receive ordinary ward care. In such a case, the individual who would probably recover would have priority over the brain dead individual. The brain dead individual would receive care but not in the intensive care unit. This decision is a difficult part of the triage process of medicine, and the preservation of another's life is sufficient in an emergency [FN219] to override an individual's preference.

A far more difficult question is raised when dealing with two brain dead individuals, one sustained because of the need to preserve***1242** her organs for transplantation and the other sustained because of the individual's religious beliefs. Imagine an emergency situation where a third patient who is temporarily unable to sustain respiration needs to be cared for in an intensive care unit and no beds are available except those sustaining the brain dead individuals. The dilemma facing the physician is which brain dead individual to relegate to ward care. To resolve the dilemma, it is helpful to examine the purposes and values involved in sustaining the two brain dead individuals. First, it is considered acceptable and desirable to sustain individuals after a brain death determination if it is necessary to preserve their organs for transplantation. [FN220] That exception to automatic discontinuation of treatment is permitted because of the possibility of saving another's life. It is considered desirable because the brain dead individual's life cannot be saved and because there is value in her death if it can give life to another. [FN221] Second, sustaining a brain dead individual because of her moral convictions or religious beliefs also has value. This value is related to respect for the individual herself but arguably must yield when other lives can be saved. In this hypothetical situation then, it would be the individual sustained because of her religious beliefs who would be transferred to ward care. Therefore, the state interest in preservation of another individual's life would be sufficiently compelling in this emergency situation to override an individual's preference in continuing treatment at the intensive care level.

E. Uniformity

The state interest in uniformity is the major reason given for rejecting an exemption from a brain death

definition for religious beliefs or moral convictions. [FN222] Without such uniformity, the argument***1243** goes, confusion and abuse are likely. [FN223] Advocates of uniform definitions still recommend respect and accommodation of the personal or religious beliefs, but not through the use of exemptions from definitions of death. [FN224]

Uniformity, however, may be necessary for only two components of the determination of death process: the medical criteria used to determine brain death and determination of the time of legal death. Medically, the criteria used by physicians must be uniform so that their determinations can be made by reference to objective physical signs not subjective judgments. [FN225] Legally, the time of death must be clear for several reasons, such as knowing exactly when a physician's civil or criminal liability for withholding or withdrawing treatment ceases, when health insurance benefits cease and when life insurance benefits arise, or when an estate will pass to a decedent's heirs. [FN226]

Although uniform definitions are desirable, it does not follow that the brain death definition must be the only definition or that it must be applied uniformity in all contexts. [FN227] In fact, the exact opposite is true when the decision is to withdraw treatment from an individual who does not yet meet the legal definition of death but is in a persistent vegetative state. In those cases, despite the need for a uniform definition of death, the patients are permitted to choose how to end their own lives. [FN228] Similarly, the individual's preferences, not uniformity, should predominate in treatment decisions and decisions for disposition of one's own body. It is clear that the individual's preferences should be followed despite the current legal definition of death. [FN229]

***1244** The real question is whether traditional criteria of cessation of respiration and heartbeat can be used in the same situation when brain death criteria are applicable. The concern is that death will become subject to individual preference thus producing intolerable confusion. [FN230] Some people will be dead by one person's definition, but alive by another's. [FN231] The danger of confusion for the medical and legal professions, however, has a very hollow ring. Both the medical and legal profession seem equipped to apply different definitions in different contexts. As long as there is certainty as to what definitions and procedures are appropriate in each situation, exemptions from current definitions do not run afoul of the state interest in uniformity.

The case of a brother and sister who are injured in an automobile accident illustrates that differing definitions can work without jeopardizing any state interest. Both are brought to the hospital, put on respirators, and determined medically to be brain dead. Although both were raised in a traditional Orthodox Jewish home, the sister but not the brother has continued to follow the beliefs and practices of the religion. Add the fact that both are potential candidates for organ donation. There are two decisions that need to be made: 1) whether to donate either individual's organs and 2) when to discontinue treatment. For organ donation, if the brother indicated that he wished to have his organs donated, those wishes would be carried out. If the sister indicated that she did not want her organs donated because of her religious beliefs, again those wishes would be carried out. The brother and sister both meet the medical criteria of brain death, but as far as the organ donation decision is concerned they would not be treated the same. Although both would be considered legally dead, the brother might in fact be sustained on mechanical devices longer than the sister.

Concerning the decision to discontinue treatment, the brother's respirator may be turned off before the sister's. If the sister did not believe in a brain death definition because of her religion, her definition would control and she would continue to be sustained until she died from other complications. [FN232] The decision ***1245** to discontinue the brother's treatment could be made sooner at the request of his family [FN233] or because he desired to donate his organs. [FN234] These differing treatment decisions can be carried out without interfering with the legal definition of death.

Legally, there are problems with the time of death for insurance benefits, both for medical care and for life insurance, and for inheritance rights. Concerning time of death for insurance benefits, exemptions from brain death definitions for religious beliefs or moral convictions will result in differing times of death for different people. For instance, in the brother and sister example, strict uniformity would require that both individuals' health insurance ended at the determination of brain death and that the right to life insurance benefits would then arise. If the sister's definition of death controlled-cessation of respiration and heartbeat-her health insurance benefits would continue longer than her brother's and her life insurance benefits would arise later. This lack of uniformity is not a great obstacle, as long as it is made clear in the policies when coverage would end in the case of health insurance and when the benefits would arise in the case of life insurance. [FN235]

There may also be a problem concerning inheritance rights if the brother is considered dead before the sister and there was a contingency in a will concerning one dying before the other. [FN236] The likelihood of such an occurrence is quite small and could be resolved on a case-by-case basis [FN237] or by statutory provision. [FN238] Although***1246** there may be a lack of uniformity and some uncertainty, it does not seem sufficiently compelling to interfere with an individual's right to choose treatment in accordance with her religious beliefs or moral convictions.

F. Controlling the Cost of Medical Care

The final state interest that is relevant in deciding whether an individual's preference should be overridden in the continuation of treatment situation is the concern for controlling the cost of medical care. [FN239] The concern arises because continuation of treatment after a brain death determination is very costly, [FN240] even though after brain death, individuals can usually be sustained only for two to ten days. [FN241] The simplest answer is that the individual who desires the continued care should bear the burden of paying for it. But that answer involves new questions about whether private insurance or governmental programs would provide that kind of coverage. [FN242] This is particularly pertinent because denial of insurance benefits puts a tremendous burden on the family's finances and possibly precludes exercising the option of continuing treatment. [FN243]

***1247** To protect against this possibility, a state can require insurers to provide coverage for those who choose treatment after a brain death determination. [FN244] The right to choose to continue treatment after a brain death determination should not be an illusory one. [FN245] If that choice can be denied merely by lack of funding, the state interest would be compelling in any case involving scarce resources. The balance, although costly to the families and the state, should tip toward individual choice.

In conclusion, the only countervailing state interest which should override the individual's preference to continue treatment after brain death is the need to provide the emergency care to another whose life can be saved. The need for uniformity and containing the cost of health care are insufficiently compelling to override the individual's right to choose.

IV. RECOMMENDED STATUTORY PROVISIONS FOR RESPECTING RELIGIOUS BELIEFS AND MORAL OBJECTIONS

Statutory protection of religious beliefs or moral convictions which conflict with a brain death definition takes two forms: 1) providing a religious or personal belief exemption from a brain death definition, and 2) requiring reasonable accommodation of religious or personal beliefs in treatment decisions. Bills to provide a religious belief exemption have been introduced or recommended in several states, [FN246] but have not been enacted. [FN247] Reasonable accommodation***1248** provisions have been adopted through the regulatory process

in New York. [FN248]

A. Exemptions from a Brain Death Definition

Religious belief exemptions prohibit the use of definitions of death that would be contrary to an individual's religious or moral beliefs. [FN249] In the New York bill, the prohibition applied to all 'life sustaining decision,' while in the California bill, an exception applied to 'an individual whose heartbeat and respiration are maintained by mechanical means.' Neither bill met with success, although New York has provided protection for individual preferences through a regulation requiring reasonable accommodation in the determination of death. [FN250]

The major reason for rejecting religious belief exemptions has been the claimed need for uniformity. [FN251] It was recently concluded that:

> [s]ociety's general interests in uniformity in this area may yield, to a limited degree, in order to respect more fully the religious and moral convictions of those individuals who desire that their deaths be declared solely in accordance with long-accepted traditional criteria based on the irreversible cessation of cardiac and respiratory activity. [FN252]

The New Jersey Commission has proposed new legislation, [FN253] the ***1249** New Jersey Declaration of Death Act, which would be both recognize legislatively [FN254] a brain death definition and provide an exemption to accommodate personal religious beliefs or moral convictions.

This proposal is the most extensive of its kind and attempts to resolve many of the problems presented by a personal belief exemption. The New Jersey proposal does not take the approach of the UDDA which uses a 'definition' of death, [FN255] but instead recognizes categories of individuals who 'shall be declared dead.' [FN256] This emphasizes the procedures that follow a medical determination of brain death: an individual 'whose circulatory and respiratory functions can be maintained solely by artificial means, and who has sustained irreversible cessation of all function of the entire brain, including the brain stem, shall be declared dead.' [FN257] That provision, however, is subject to an exemption which accommodates differing personal religious beliefs or moral convictions.

The exemption provides that death shall not be declared on the basis of brain death standards 'when such a declaration would violate the personal religious beliefs or moral convictions of the individual.' [FN258] The exemption also requires that the belief or conviction be 'communicated to, . . . or should reasonably be known by, the physician authorized to declare death.' [FN259] This is significant because the exemption is not only triggered by a communication from a family member or person close to the individual, [FN260] but requires the physician to ascertain whether a declaration of death based on brain death would violate the individual's beliefs or convictions. [FN261]

Under the New Jersey proposal, before declaring an individual ***1250** dead based on brain death, the physician must 'make reasonable efforts, in good faith, to determine whether such a declaration would violate the personal religious beliefs or moral convictions of that individual.' [FN262] The efforts include review of available medical records and reasonable efforts to contact a person or persons 'who maintained a close association with the individual sufficient to render that person knowledgeable concerning the nature and content of the individual's personal religious beliefs or moral convictions.' [FN263] The purpose of the review of medical records as explained in the proposed statute is to find any advance directives. [FN264] The physician is protected from disciplinary proceedings and civil or criminal liability because the efforts must be reasonable and in good faith,

leaving room for what is ‘appropriate under the circumstances.’ [FN265]

If the individual's beliefs or convictions would be violated, [FN266] the physician must refrain not only from declaring the individual dead, [FN267] but must also refrain from discontinuing mechanical devices***1251** that are sustaining respiration and heartbeat. [FN268]

The proposed statute also provides specific guidance concerning legal time of death and the effect on health and life insurance. Time of death would vary depending on the criteria used to declare death. If brain death criteria are used, the time of death would be ‘upon the conclusion of definitive clinical examination(s) and confirmations necessary to determine’ brain death. [FN269] If traditional criteria are used, the time of death shall be ‘fixed, solely upon the basis of traditional cardio-respiratory criteria . . ..’ [FN270] The proposed statute declares that the changes in the act ‘shall not in any manner affect, impair or modify the terms of, or rights or obligations created under any existing policy of health insurance, life insurance or annuity, or governmental benefits program.’ [FN271] Coupled with the time of death provisions, this provision indicates that the insurance benefits will not change because differing criteria are used. But even more important, the proposed statute prohibits insurers from denying coverage or excluding benefits to ‘any individual solely because of that individual's personal religious beliefs or moral convictions regarding the application of neurological criteria for declaring death.’ [FN272] This would financially protect the individual's right to choose to continue treatment beyond a brain death determination.

This proposed statute has not yet been passed by the New Jersey legislature although it was recommended by the almost ***1252** unanimous New Jersey commission. [FN273] Its provisions should serve as a model for those states who are considering legislation in this area. There are two points that require clarification, however, in the present proposal. First, the statute is not clear on how a physician should proceed if the exemption is not raised on the individual's behalf by a family member, personal physician, religious leader or friend, but instead found by the physician in reviewing the medical records. Under the proposed statute, the physician must make ‘reasonable efforts, in good faith, to determine whether . . . a declaration of death would violate the personal religious beliefs or moral convictions of that individual.’ [FN274] Reasonable efforts include what ‘is appropriate under the circumstances, review of available medical records (including advance directives for health care).’ [FN275] It would be appropriate for the physician to review the medical records for any advance directives while trying to reach the family or close associate of the patient. The search, however, may also yield indications that the individual is an Orthodox Jew. For instance, before reaching the stage of brain death, the individual may have ordered kosher meals or had Sabbath observances noted in her records. It is not clear how the physician should proceed upon her own finding that an advance directive or some other information would trigger the exemption.

As presently written, the exemption applies if it ‘is reasonably advanced on the individual's behalf.’ [FN276] It is not clear that the exemption applies if the physician finds the basis for an exemption in a review of medical records [FN277] but has not been able to contact a family member or other close associate of the individual who would reasonably advance the exemption claim. The policy of the proposed statute seems broad enough to cover this situation, because it mentions both: where the claim ‘has been communicated’ to the physician as well as where the claim ‘should have been reasonably known’ by the physician. [FN278] This ambiguity can be remedied by adding language to section 6(B) to the effect that ‘ i f a physician ***1253** finds that a declaration of death on the basis of neurological criteria would violate the individual's personal religious beliefs or moral convictions . . ..’ [FN279] Thus, the physician would be required to apply the exemption and refrain from taking action based either on her own findings that the individual's religious beliefs or moral convictions would be violated or on the claim of an exemption by a family member of a close associate of the individual.

Second, the statute does not provide for dispute resolution if there was a conflict between a family member and a close associate of the individual. For instance, an individual may have adopted Orthodox Judaism and become estranged from her parents. She may, however, have a close friend who knows the 'nature and content of [her] personal religious beliefs or moral convictions.' [FN280] If both the parents and the friend were contacted by the physician, the friend may advance the exemption claim while the parents resist. The proposed statute is silent on this issue. Perhaps the assumption is that this conflict will be handled through normal hospital procedure to resolve such disputes. Ordinarily, the physician tries to resolve the conflict by further talks with the family and the friend. Second, she may involve the hospital ethics committee, or as a last resort, the dispute may be referred to the courts. In these cases it may be advisable to involve a religious leader who is familiar with the individual if one can be reached. The proposed statute could include a clause that would provide that disputes should be resolved, if possible, by the physician and those closest to the individual, but until the dispute is resolved no action should be taken to declare the individual dead or discontinue mechanical devices sustaining respiration or circulation.

The New Jersey proposed statute represents the most complete protection for the individual's personal religious beliefs and moral convictions in the decisions made after a brain death determination. It not only recognizes the legitimacy of definitions of death based on religious beliefs or moral convictions but also clearly states that no actions can be taken, such as declaring an individual dead or discontinuing mechanical devices sustaining respiration or circulation, that are based solely on brain death criteria. This same purpose can be accomplished with 'reasonable accommodation'***1254** legislation or regulations, but without explicitly creating an exemption from the use of brain death criteria. New York has taken this route by adopting regulations which require hospitals to adopt policies to reasonably accommodate the religious beliefs or moral objections to a brain death determination.

B. Reasonable Accommodation in Decisionmaking

In New York, reasonable accommodation of religious or moral beliefs is required before completing a determination of death using brain death criteria. [FN281] This requirement is found in regulations recently promulgated by the Department of Health. First, hospitals are required to make reasonable efforts to notify the individual's next of kin or other person closest to the individual that a determination of death based on brain death will soon be completed. [FN282] Second, hospitals are required to establish a written policy including 'a procedure for the reasonable accommodation of the individual's religious or moral objections to the determination as expressed by the individual, or by the next of kin or other person closest to the individual.' [FN283] The hospital's obligation is to notify and accommodate. It remains the responsibility of the individual or her next of kin or her close friend to raise the religious or moral objection. [FN284]

***1255** A hospital administrator who is attempting to draft the required written policy must first define 'reasonable accommodation.' [FN285] 'Accommodation' means respect for the individual's religious beliefs or moral convictions. Specifically, it applies to those who may not accept brain death as an acceptable criterion for defining death and would thus desire continued treatment. Accommodating that belief would mean maintaining the individual on a respirator until cessation of her heartbeat and respiration. It would be wise to advise health care personnel that some Orthodox Jews and other groups do not adhere to a brain death definition.

'Reasonable' means that respect for the religious belief or moral objection is not absolute. Where the accommodation of the individual's religious belief would 'cause harm or death to another patient who was not potentially brain dead,' it would be reasonable to override the individual's religious belief. [FN286] The question remains whether the cost of continued maintenance of the individual should be a consideration in determining

what is reasonable. The Department of Health regulations did not address that question. Presumably, in this context, the only factor outweighing the religious belief is the welfare of another patient. Thus accommodation is, in almost all cases, mandated.

***1256** Next it is necessary to define a 'religious or moral objection.' Constitutionally, religious belief is defined from the 'believer's own perspective.' [FN287] Similarly, according to the Department of Health, the religious objection must be that of the individual, not 'an objection personal to the relative who was notified.' [FN288] A moral objection would be functionally equivalent to a religious belief even if it is not based on any particular religion. [FN289] One important question arises about the depth of the inquiry into the religious or moral convictions of a potentially brain dead individual. It is helpful to examine some hypothetical situations.

For instance, in Case #1, assume that the brain dead individual has recently embraced the tenets of Orthodox Judaism, [FN290] but the family, although Jewish, is not Orthodox. The physician managing the case would be required by the new regulation to make reasonable efforts to notify the next of kin of an imminent brain death determination. If the family were already involved, it would be simply a matter of discussing that there was a possibility of determining death and withdrawing the respirator which was sustaining respiration and heartbeat. At that point, it would be appropriate to discuss the patient's religious beliefs. At present, physicians do have a discussion with the family before declaring or pronouncing death regarding the possible donation of organs or the need for an autopsy. If the family volunteered that the person had recently embraced Orthodoxy, it may be advisable for the physician to suggest that the family consult with a Rabbi who was close to the patient before completing the determination of death. The Rabbi could explain Orthodox belief and give advice if requested.

The family, however, may not know or may fail to say anything about the patient's beliefs. In some cases, the physician may realize that the patient was Orthodox from his manner of dress or ***1257** dietary preferences prior to becoming comatose. [FN291] If the family wants to remove the mechanical devices, the question is whether the physician is required to inquire further. The regulation does not specifically require that hospitals should solicit religious or moral objections, [FN292] but a hospital could make that part of its policy. In this specific case, it may be wise to advise physicians to inquire whether the family knew that this might violate the individual's beliefs. If the family knew that the individual would adhere to a strictly Orthodox view and still favored discontinuation, it may then be appropriate to consult with a Rabbi close to the brain dead individual for advice concerning the propriety of the decision according to Jewish law and to act as a close friend. If the family objects, and the physician is uncertain, it would be advisable that this dispute be resolved through normal hospital procedures such as reference to an ethics committee or through the courts as a last resort. It would seem that the intent of the regulation is that the religious belief of the individual be ascertained, if not from the next of kin then by someone who is familiar with her religious beliefs. [FN293]

It may be good hospital policy to require that physicians ask ***1258** about the individual's religious beliefs or moral convictions as part of its notification procedures. That would surely be sufficient to meet the reasonable accommodation requirement of the regulation. If no objections are raised by the family, the physician could follow ordinary hospital procedures for decisions regarding those who are determined to be brain dead. It is doubtful that a physician or hospital could be held liable for violating the individual's religious beliefs where they had made efforts to ascertain them.

In Case #2, assume that the brain dead individual has abandoned Orthodox practice but the family strictly adheres to Orthodox Judaism. In that situation, the physician would again be required to consult with the family concerning the imminent brain death determination. The physician may find that the family wants the patient to die according to Orthodox Jewish belief even though the patient no longer follows Orthodox practices. In this situation, the physician is required to accommodate the individual's objections. Without prior discussion or ad-

vance written directive from the individual herself, [FN294] the best course of action would be to respect the family's wishes at least initially. [FN295] This would give the family a chance to come to terms with the family member's death. It also recognizes the reality that the family or other surrogate controls the decision. [FN296] If the physician does not follow the family's wishes, she and the hospital may face a lawsuit. [FN297] Again, it would be advisable to consult a Rabbi to give guidance to the family. Although the regulations require only accommodation of the individual's belief, in this situation, the physician should not complete the determination of death until the family is comfortable with the decision.

Finally, in Case #3, consider the accident victim who carries no identification. She is resuscitated and put on a respirator. She meets brain death criteria and is being considered for organ donation. The responsibility of the hospital in this situation is to make ‘reasonable efforts' to notify the next of kin that a determination of death is imminent. Initial attempts to find any relatives fail, ***1259** however, because the individual lacked identification. It is impossible to carry out reasonable accommodation requirements if there is no way to ascertain them. If there is any indication that the person's religious beliefs may prohibit the use of brain death criteria, [FN298] the best course is to wait for a certain period of time before completing the determination. For instance, it is possible to find out if the accident occurred when it was the Jewish Sabbath or a Jewish holiday when Orthodox Jews do not carry and would therefore not have identification. It would be wise to specify a particular waiting period of forty-eight or seventy-two hours before completing the brain death determination. [FN299] This would most probably be considered a reasonable effort.

These new regulations should not present administrative problems once hospitals institute written policies which outline procedures and explain the possible scenarios that could arise. The intent of the regulations is to educate and sensitize physicians and health care professionals to individuals' religious and moral beliefs regarding life and death. It means that the categorization of individuals as brain dead does not automatically lead to turning off the machines. This should have the salutary effect of tailoring medical decisions to the individual rather than assuming that all those close to death should be treated in the same manner.

The New Jersey statute, however, presents a clearer directive to physicians and hospitals concerning both the administrative and legal implications of respecting religious beliefs and moral objections. First, the New York regulations leave the development of a reasonable accommodation policy to hospital and does not adequately guide physicians as to their responsibilities. Second, the New York regulations are silent on the effect of reasonable accommodation on the legal time of death. This leaves open the crucial question of who pays for continuation of mechanical devices care after a brain death determination. In these respects, the New Jersey proposed statute presents a more explicit and complete formulation***1260** for respecting religious beliefs and moral convictions in deciding when to discontinue mechanical devices sustaining respiration and heartbeat.

CONCLUSION

The adoption of a brain death definition raises serious questions about how to honor individual preferences regarding treatment decisions at the end of life. In particular, as the discontinuation of mechanical devices sustaining respiration and heartbeat becomes an automatic response to a brain death determination, individual objections based on religious beliefs or moral convictions may be ignored in the decisionmaking process.

The right to choose life after brain death is grounded in respect for individual autonomy and choice in treatment decisions before death and in decisions regarding disposition of one's own body after death. Respecting an individual's choice to continue respiration and heartbeat after a brain death determination may cause some uncertainty and lack of uniformity. Those problems, however, are not insurmountable when weighed against the

greater value of respecting individual preferences.

Protection for individual preferences can be provided either through statutory formulations providing an exemption from a brain death definition or regulations requiring hospitals to reasonably accommodate the religious beliefs or moral convictions in a determination of death. The proposed New Jersey Declaration of Death Act, which provides a statutory exemption to a brain death definition, is the best model for protecting individuals' religious beliefs and moral convictions. Both the proposed statute and the existing regulations provide, however, that individual preferences will control the decision to continue use of mechanical devices sustaining respiration and heartbeat after a brain death determination.

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[FN1]. *Both Sides Now* (song written by Joni Mitchell-Gandalf Productions BMI, sung by Judy Collins on *Wildflowers* album, Elektra Records).

[FN2]. *Psalms* 23:4.

[FN3]. Abram, *The Need for Uniform Law on the Determination of Death*, 27 N.Y.L. SCH. L. REV. 1187, 1204 (1982).

[FN4]. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DEFINING DEATH 3 (1981) [hereinafter DEFINING DEATH].

[FN5]. *See id.* at 24.

[FN6]. The term ‘mechanical’ is used to describe the equipment maintaining respiration and heartbeat rather than the term ‘life-sustaining.’ The term ‘life-sustaining’ is somewhat ambiguous because it is unclear how to define life and death. *See infra* notes 33-63 and accompanying text.

[FN7]. *See infra* notes 24-97 and accompanying text.

[FN8]. *See infra* notes 64-88 and accompanying text.

[FN9]. *See* U.S. CONST. amend. XIV.

[FN10]. *See* U.S. CONST. amend. I.

[FN11]. *See infra* notes 98-175 and accompanying text.

[FN12]. *See infra* notes 176-206 and accompanying text.

[FN13]. In cases involving Jehovah's Witnesses' refusal of blood transfusions, courts have overridden the individual's preferences in the case of an emergency where a patient's life will most probably be saved. *See e.g., In re* Estate of Dorone, 517 Pa. 3, 534 A.2d 452 (1987); University of Cincinnati Hosp. v. Edmond, 30 Ohio Misc. 2d 1, 506 N.E.2d 299 (1986); *see also infra* notes 149-75 and accompanying text.

[FN14]. *See infra* notes 98-175 and accompanying text.

[FN15]. *See infra* notes 176-206 and accompanying text.

[FN16]. *See infra* notes 207-45 and accompanying text. The only state interest that could override an individual's choice would be the preservation of another's life in an emergency. *See infra* Notes 176-206, 281-86 and accompanying text.

[FN17]. *See infra* notes 25-97 and accompanying text.

[FN18]. *See infra* notes 98-206 and accompanying text.

[FN19]. *See infra* notes 99-148 and accompanying text.

[FN20]. *See infra* notes 149-75 and accompanying text.

[FN21]. *See infra* notes 176-206 and accompanying text.

[FN22]. *See infra* notes 207-17 and accompanying text.

[FN23]. *See infra* notes 218-45 and accompanying text.

[FN24]. *See infra* notes 246-99 and accompanying text.

[FN25]. The choice facing physicians today when a patient has stopped breathing is whether or not to attempt resuscitation. Resuscitation is a viable option if the patient has a good chance of returning to a normal state. If not, the physician may still place the patient on life support systems in order to preserve the patient's organs for transplantation. *See, e.g.*, Strachan v. John F. Kennedy Memorial Hosp., 109 N.J. 523, 538 A.2d 346 (1988) (young suicide victim resuscitated to preserve organs for transplantation). For terminally ill patients, physicians may determine that resuscitation is not appropriate in case of a cardiac or respiratory arrest. In that instance, a 'Do Not Resuscitate' (DNR) or 'No-Code' order may be written. That order specifies that cardiopulmonary resuscitation is not indicated upon a cardiac or respiratory arrest. Consultation with the patient is ordinarily required before such an order is written. If the patient is not competent, a surrogate decisionmaker may authorize a DNR order. In New York, legislation has been passed requiring that a surrogate consider a patient's religious and moral beliefs as part of the decision regarding DNR orders. *See* N.Y. PUB. HEALTH LAW § 2965(5)(a) (McKinney Supp. 1988) (effective Apr. 1, 1988); *see also* Mooney, *Deciding not to Resuscitate Hospital Patients: Medical and Legal Perspectives*, 1986 U. ILL. L. REV. 1025.

[FN26]. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 7100 (West 1970 & Supp. 1988). This provision reads:

> The right to control disposition of the remains of a deceased person, unless other directions have been given by the decedent, vests in, and the duty of interment and the liability for the reasonable costs of interment of such remains devolves upon the following in the order named:
>
> (a) The surviving spouse.
>
> (b) The surviving child or children of the decedent.

(c) The surviving parent or parents of the decedent.

(d) The person or persons respectively in the next degrees of kindred in the order named by the laws of California as entitled to succeed to the estate of the decedent.

(e) The public administrator when the deceased has sufficient assets.

Id.; see also Smith v. Vidovich, 242 Cal. App. 2d 206, 207, 51 Cal. Rptr. 196, 196 (Cal. Dist. Ct. App. 1966) (husband who did not survive wife had no 'right to control, beyond the time of his death, the disposition of his wife's remains upon her death at some future time'); Cohen v. Groman Mortuary, Inc., 231 Cal. App. 2d 1, 5, 41 Cal. Rptr. 481, 484 (Cal. Dist. Ct. App. 1965) ('[w]here there is a surviving spouse, other relatives have neither the right to control disposition of remains of deceased person nor duty of interment and liability therefore.'); Enos v. Snyder, 131 Cal. 68, 63 P. 170 (1900) (absent a statute, custody of the corpse and the right of burial belong to the next of kin, not to the executor or administrator).

[FN27]. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 7113 (West Supp. 1988). Section 7113 provides:

> [a] cemetery authority or licensed funeral director or a licensed hospital or its authorized personnel may permit or assist, and a physician may perform, an autopsy of any remains in its or his custody . . . upon the receipt of a written authorization, telegram, or a verbal authorization obtained by telephone and recorded on tape or other recording device, from a person representing himself to be any of the following: (a) the surviving spouse; (b) a surviving child or parent; (c) a surviving brother or sister; (d) any other kin or person who has acquired the right to control the disposition of the remains . . ..

Id.

[FN28]. More euphemistic terms were often substituted such as 'the dear departed' or 'the departed one.'

[FN29]. Through the right of survivorship, joint tenancy automatically transfers to other joint tenants upon the event of death. *See* R. CUNNINGHAM, W. STOEBUCK & D. WHITMAN, THE LAW OF PROPERTY 202-07 (1984).

[FN30]. "Devise,' when used as a noun, means a disposition of real or personal property by will, and, when used as a verb, means to dispose of real or personal property by will.' CAL. PROB. CODE § 32 (West Supp. 1988).

[FN31]. 'Any part of the estate of a decedent not effectively disposed of by will passes to the decedent's heirs . . ..' *Id.* § 6400 (West Supp. 1988).

[FN32]. The family or the estate could sue for wrongful death. For example, '[w]hen the death of a person is caused by the wrongful act or neglect of another, his or her heirs or personal representatives on their behalf may maintain an action for damages against the person causing the death . . ..' CAL. CIV. PROC. CODE § 377 (West Supp. 1988).

[FN33]. See Capron & Kass, *A Statutory Definition of the Standards for Determining Human Death: An Appraisal and a Proposal*, 121 U. PA. L. REV. 87, 87-88 (1972). The Kansas legislature was the first to adopt a statute recognizing brain-based criteria for the determination of death. *See* Act of Mar. 17, 1970, ch. 378, 1970 Kan. Sess. Laws 994 (codified at KAN. STAT. ANN. § 77-205 (1984)). Maryland followed in 1972, and in 1973, New Mexico and Virginia enacted statutes based on the Kansas model. *See* MD. HEALTH-GEN. CODE ANN. § 5-201 to -203 (1982); N.M. STAT. ANN. § 12-2-4 (1988); VA. CODE ANN. § 54.325.7 (Supp. 1987).

[FN34]. *See* DEFINING DEATH, *supra* note 4, at 18-20.

[FN35]. the mechanical breathing device would be called a respirator when it aids the process of respiration. Respiration involves the delivery of fresh air to the lungs where it is exposed to the blood (ventilation), the gas

exchange between the blood and the alveoli in the lungs, the circulation of the blood through the circulatory system and the internal respiration between the blood and tissues. The respiration process is affected by the mechanical device usually in patients who have cardiopulmonary disease, because the machine may alter cardiac output (blood flow) and may adversely affect oxygen delivery. The mechanical device would be called a ventilator when it only affects the process of ventilation. Patients who do not have cardiopulmonary disease but still require a machine to breath would be using a ventilator, because it has minimal effect on cardiac function and thus alters circulation marginally. *See* Brandstetter, *Is It a 'Respirator' or a 'Ventilator*'?, Respiratory Times, Jan. 1, 1987, at 1, col. 1.

[FN36]. *See* DEFINING DEATH, *supra* note 4, at 21.

[FN37]. The technical ability to measure bodily functions led to the development of the 'Harvard criteria' for determining 'irreversible coma.' *See id.* at 24 n.8. The term 'irreversible coma' includes brain death and other non-brain-dead states. *See id.* The 'persistent vegetative state' would fall in the second category which is marked by evidence of 'irreversible lack of cognition, often in the presence of vegetative function.' Korein, *The Problem of Brain Death: Development and History*, 315 ANNALS OF THE N.Y. ACAD. OF SCI. 19, 21 (1978); *see also* infra notes 104-48 and accompanying text.

[FN38]. 'Brain death' refers to cessation of the whole brain, which includes the cerebrum, cerebellum, and brain stem. It does not refer to the 'persistent vegetative state' where the brain stem continues to function and the patient is able to breathe on her own. *See* DEFINING DEATH, *supra* note 4, at 18-19. Neural impulses generated in the medulla, a part of the brain stem, stimulate the diaphragm and other muscles which cause the lungs to fill with air. Destruction of this respiratory center in the brain stem stops respiration, which deprives the heart of oxygen, causing it to cease functioning. Thus, loss of respiration and heartbeat is the consequence of the loss of all brain function. *See id.* at 15. That state, permanent loss of all brain function, is called 'brain death.' *See id.* at 18.

[FN39]. Since the first heart transplant surgery in 1968 by Dr. Christian Barnard, transplant surgery has increased dramatically. For instance, from 1981 to 1987, the number of heart transplants increased from 62 to 1512. In the same period, kidney transplants increased from 4,900 to 8,967; liver transplants from 26 to 1,200. In 1987, 35,000 cornea transplants were performed. *See* NEWSWEEK, Sept. 12, 1988, at 61, 63.

[FN40]. *See* DEFINING DEATH, *supra* note 4, at 23.

[FN41]. *Id.*

[FN42]. Other reasons for the legislation include 'the need to render appropriate care to patients and to replace artificial support with more fitting and respectful behavior when a patient has become a dead body.' *Id.* at 24.

[FN43]. *See id.* app. D at 136-39; *cf.* Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (Cal. Ct. App. 1983) (two physicians charged with murder for removing intravenous tubes from a patient in a persistent vegetative state).

[FN44]. *See* Capron & Kass, *supra* note 33, at 98-100; *see also* DEFINING DEATH, *supra* note 4, app. D at 139-42.

[FN45]. *See* Capron & Kass, *supra* note 33, at 101; *see, e.g.*, UNIF. BRAIN DEATH ACT § 1, 12 U.L.A. 17 (Supp. 1988).

[FN46]. *See* Bernat, Culver & Gert, *Defining Death in Theory and Practice*, HASTINGS CENTER REP., Feb. 1982, at 5. For other views, see Veatch. *The Definition of Death: Ethical, Philosophical, and Policy Confusion*, 315 ANNALS OF THE N.Y. ACAD. OF SCI. 307 (1978); DEFINING DEATH, *supra* note 4, at 31-43. *See generally* R. WEIR, ETHICAL ISSUES IN DEATH AND DYING 53-111 (2d ed. 1986).

[FN47]. *See e.g.*, Bernat, Culver & Gert, *supra* note 46, at 8.

> An individual who has sustained irreversible cessation of all functions of the entire brain, including the brain stem, is dead
>
> (a) *In the absence of artificial means of cardiopulmonary support*, death (the irreversible cessation of all brain functions) may be determined by the prolonged absence of spontaneous circulatory and respiratory functions.
>
> (b) *In the presence of artificial means of cardiopulmonary support*, death (the irreversible cessation of all brain functions) must be determined by tests of brain function.

Id. (emphasis added); *see also* Capron & Kass, *supra* note 33, at 105-06; LAW REFORM COMMISSION OF CANADA, CRITERIA FOR THE DETERMINATION OF DEATH 25 (1981).

[FN48]. *See* DEFINING DEATH, *supra* note 4, at 3-4.

[FN49]. In reality, the brain death definition does not supplant the traditional criteria. It is used for those whose respiration and heartbeat are sustained by mechanical devices.

[FN50]. *See id.* app. C. Promulgators of medical legislation included: AMA, *see* Approved at Dec. 7, 1979 Interim Meeting of the American Medical Association, ABA, *see* 100 A.B.A. ANN.REP. 231-32 (1978) (Feb. 1975 Mid-year Meeting); Capron-Kass, *see* Capron, *Legal Definition of Death*, 315 ANNALS OF THE N.Y. ACAD. OF SCI. 349, 356 (1978); Hawaii, *see* HAWAII REV. STAT. § 327c-1 (Supp. 1980); Iowa, *see* IOWA CODE ANN. § 702.8 (West 1980); Kansas, *see* KAN. STAT. ANN. § 77-202 (Supp. 1979); Louisiana, *see* LA. REV. STAT. ANN. § 9:111 (West Supp. 1981); Tennessee, *see* TENN. CODE ANN. § 53-459 (Supp. 1980); West Virginia, *see* W. VA. CODE § 16-19-1 (Supp. 1980).

[FN51]. *See* DEFINING DEATH, *supra* note 4, app. C (California, *see* CAL. HEALTH & SAFETY CODE §§ 7180-7182 (West Supp. 1989); Connecticut, *see* CONN. GEN. STAT. ANN. § 19-139i (West Supp. 1981); Georgia, *see* GA. CODE ANN. § 88-1715.1 (Supp. 1980)).

[FN52]. *See id.* (Uniform Brain Death Act, *see* UNIF. BRAIN DEATH ACT, 12 U.L.A. 17 (Supp. 1988); Alabama, *see* ALA. CODE §§ 22-31-1 to 22-31-4 (Supp. 1979); Alaska, *see* ALASKA STAT. § 09.65.120 (Supp. 1980); Florida, *see* FLA. STAT. § 382.085 (1980); Maryland, *see* MD. ANN. CODE art. 43, § 54F (1980); Michigan, *see* MICH. STAT. ANN. § 14.15 (Callaghan Supp. 1981); Montana, *see* MONT. CODE ANN. § 50-22-101 (1978) (all legal purposes); Nevada, *see* NEV. REV. STATE. § 451.007 (1979); New Mexico, *see* N.M. STAT. ANN. § 12-2-4 (1978) (medical, legal, statutory purposes); Texas, *see* TEX. REV. CIV. STAT. ANN. art. 4447t (Vernon Supp. 1980); Virginia, *see* VA. CODE ANN. § 54-325-7 (Supp. 1981)).

[FN53]. The Uniform Brain Death Act stated that '*[f]or legal and medical purposes*, an individual who has sustained irreversible cessation of all functioning of the brain, including the brain stem, is dead. A determination under this section must be made in accordance with reasonable medical standard.' UNIF. BRAIN DEATH ACT § 1, 12 U.L.A. 17 (Supp. 1988) (emphasis added). Note that this formulation does not make any reference to the traditional standards of cessation of respiration or heartbeat. This formulation was adopted by Alabama and West Virginia. *See* ALA. CODE §§ 22-31-1 to 22-31-4 (Supp. 1979); W. VA. CODE § 16-19-1 (Supp. 1980). Other states adopted similar language: Alaska, *see* ALASKA STAT. § 09.65.120 (Supp. 1980); Florida, *see*

FLA. STAT. § 382.085 (1980); Maryland, *see* MD. ANN. CODE art. 43, § 54F (1980); Michigan, *see* MICH. STAT. ANN. § 14.15 (Callaghan Supp. 1981); Montana, *see* MONT. CODE ANN. § 50-22-101 (1978) (all legal purposes); Nevada, *see* NEV. REV. STAT. § 451.007 (1979); New Mexico, *see* N.M. STAT. ANN. § 12-2-4 (1978) (medical, legal, statutory purposes); Texas, *see* TEX. REV. CIV. STAT. ANN. art. 4447t (Vernon Supp. 1980); Virginia, *see* VA. CODE ANN. § 54-325-7 (Supp. 1981).

[FN54]. *See* DEFINING DEATH, *supra* note 4, at 119. The Commissioners also added traditional criteria as an alternative: '[a]n individual *who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or* (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead.' UNIF. DETERMINATION OF DEATH ACT § 1, 12 U.L.A. 310, 312 (Supp. 1989) (emphasis added).

[FN55]. *See* UNIF. DETERMINATION OF DEATH ACT § 1, 12 U.L.A. 310, 312 (Supp. 1989).

[FN56]. *Id.*

[FN57]. *See* DEFINING DEATH, *supra* note 4, at 76-78.

[FN58]. The Uniform Determination of Death Act has been adopted by Arkansas, *see* ARK. CODE ANN. § 20-17-101 (1987); California, *see* CAL. HEALTH & SAFETY CODE §§ 7180-7183 (Supp. 1988); *see* Colorado, COLO. REV. STAT. § 12-36-136 (1985); Delaware, *see* DEL. CODE ANN. tit. 24, § 1760 (1987); District of Columbia, *see* D.C. CODE ANN. § 6-2401 (Supp. 1988); Georgia, *see* GA. CODE ANN. § 88-1716 (1986); Idaho, *see* IDAHO CODE § 54-1819 (1988); Indiana, *see* IND. CODE ANN. § 1-1-4-3 (Burns 1988); Kansas, *see* KAN. STAT. ANN. § 77-205 (1984); Maine, *see* ME. REV. STAT. ANN. tit. 22, §§ 2811-2813 (Supp. 1987); Maryland, *see* MD. HEALTH-GEN. CODE ANN. § 5-201 to 5-202 (1982 & Supp. 1988); Mississippi, *see* MISS. CODE ANN. §§ 41-36-1, 41-36-3 (1981); MISSOURI, *see* MO. ANN. STAT. § 194.005 (Vernon 1983); Montana, *see* MONT. CODE ANN. § 50-22-101 (1985); Nevada, *see* NEV. REV. STAT. ANN. § 451.007 (Michie 1986); New Hampshire, *see* N.H. REV. STAT. ANN. § 141-D:1 to 141-D:2 (Supp. 1988); Ohio, *see* OHIO REV. CODE ANN. § 2108.30 (Anderson Supp. 1987); Oklahoma, *see* OKLA. STAT. ANN. tit. 63, § 1-301(g) (West 1984 & Supp. 1989); Oregon, *see* OR. REV. STAT. § 432.300 (Supp. 1987); Pennsylvania, *see* PA. STAT. ANN. tit. 35, §§ 10201-10203 (Purdon Supp. 1988); Rhode Island, *see* R.I. GEN. LAWS § 23-4-16 (1985); South Carolina, *see* S.C. CODE ANN. §§ 44-43-450, 44-43-460 (Law. Co-op. 1985); Vermont, *see* VT. STAT. ANN. tit. 18, § 5218 (1987); Wyoming, *see* WYO. STAT. § 35-19-101 (1988). The Hastings Center has also endorsed this formulation. *See* GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING 86 (1987) [hereinafter HASTINGS GUIDELINES]. Other groups, including the American Bar Association, the American Medical Association, the American Academy of Neurology, the American Electroencephalographic Society, and the National Conference of Commissioners on Uniform State Laws have endorsed the Act's death criteria. *See* Smith, *Legal Recognition of Neocortical Death*, 71 CORNELL L. REV. 850, 855 (1986).

[FN59]. *See* ALA. CODE § 22-31-1 (1984); ALASKA STAT. § 09.65.120 (1988); ARK. CODE ANN. § 20-17-101 (1987); CAL. HEALTH & SAFETY CODE §§ 7180-7183 (West Supp. 1988); COLO. REV. STAT. § 12-36-136 (1985); CONN. GEN. STAT. ANN. § 19a-278(b), (c) (West 1986); DEL. CODE ANN. tit. 24, § 1760 (1987); D.C. CODE ANN. § 6-2401 (Supp. 1988); FLA. STAT. ANN. § 382.085 (West 1986); GA. CODE ANN. § 88-1716 (1986); HAW. REV. STAT. § 327C-1 (1985); IDAHO CODE § 54-1819 (1988); ILL. ANN. STAT. ch. 110 1/2 ¶302 (Smith-Hurd 1978); IND. CODE ANN. § 1-1-4-3 (Burns 1988); IOWA CODE ANN. § 702.8 (West 1979); KAN. STAT. ANN. § 77-205 (1984); LA. REV. STAT. ANN. § 9:111 (West Supp. 1988); ME. REV. STAT. ANN. tit. 22, §§ 2811-2813 (Supp. 1987); MD. HEALTH-GEN. CODE ANN. § 5-201 to -202 (1982 & Supp. 1988); MICH. COMP. LAWS ANN. § 333.1021 (West 1980); MISS. CODE ANN. §

41-36-3 (1981); MO. ANN. STAT. § 194.005 (Vernon 1983); MONT. CODE ANN. § 50-22-101 (1985); NEV. REV. STAT. ANN. § 451.007 (Michie 1986); N.H. REV. STAT. ANN. § 141-D:1 to 141-D:2 (Supp. 1988); N.M. STAT. ANN. § 12-2-4 (1988); N.Y. COMP. CODES R. & REGS. tit. 10(c), § 400.16 (1987) (New York adopted a brain death definition through regulation); N.C. GEN. STAT. § 90-323 (1978); OHIO REV. CODE ANN. § 2108.30 (Anderson Supp. 1987); OKLA. STAT. ANN. tit. 63, § 1-301(g) (West 1984 & Supp. 1989); OR. REV. STAT. § 432.300 (Supp. 1987); PA. STAT. ANN. tit. 35, §§ 10201-10203 (Purdon Supp. 1988); R.I. GEN. LAWS § 23-4-16 (1985); S.C. CODE ANN. §§ 44-43-450, 44-43-460 (Law. Co-op. 1985); TENN. CODE ANN. § 68-3-501 (1987); TEX. REV. CIV. STAT. ANN. art. 4447t (Vernon Supp. 1989); VT. STAT. ANN. tit. 18, § 5218 (1987); VA. CODE ANN. § 54-325.7 (1982 & Supp. 1987); W. VA. CODE § 16-10-1 to 16-10-3 (1985); WIS. STAT. ANN. § 146.71 (WEST SUPP. 1987); WYO. STAT. § 35-19-101 (1988).

[FN60]. *See* State v. Fierro, 124 Ariz. 182, 185-86, 603 P.2d 74, 77-78 (1979) (homicide); Commonwealth v. Golston, 373 Mass. 249, 253-55, 366 N.E.2d 744, 747-49 (1977), *cert. denied*, 434 U.S. 1039 (1978) (homicide); State v. Meints, 212 Neb. 410, 419-20, 322 N.W.2d 809, 814 (1982) (homicide); Strachan v. John F. Kennedy Memorial Hosp., 109 N.J. 523, 533, 538 A.2d 346, 351 (1988) (generally); *In re* Bowman, 94 WASH. 2d 407, 617 P.2d 731, 738 (1980) (generally).

[FN61]. *See* UNIF. DETERMINATION OF DEATH ACT § 1, 12 U.L.A. 312 (Supp. 1989).

[FN62]. *Id.* Rather than prescribe particular procedures that physicians must follow, the commissioners left this to the discretion of the medical profession. This recognized that medical tests could change with advances in 'biomedical knowledge, diagnostic tests, and equipment.' *Id.* prefatory note.

[FN63]. *See id.*

[FN64]. The Act also did not address liability of those making the decisions, time of death, or the subject of organ transplantation. *See id.*

[FN65]. *See* UNIF. ANATOMICAL GIFT ACT, 8A U.L.A. 2 prefatory note (1983 & Supp. 1988).

[FN66]. 109 N.J. 523, 538 A.2d 346 (1988), *rev'g*, Strachan v. John F. Kennedy Memorial Hosp., 209 N.J. Super. 300, 507 A.2d 718 (N.J. Super. Ct. App. Div. 1986); *see also* Annas, *Brain Death and Organ Donation: You Can Have One Without the Other*, HASTINGS CENTER REP., June-July 1988, at 28.

[FN67]. *See Strachan*, 109 N.J. at 530-31, 538 A.2d at 349-50.

[FN68]. *See id.* at 526, 538 A.D.2d at 347.

[FN69]. *Strachan*, 209 N.J. Super. at 304, 507 A.2d at 720. It seems that at that point Jeffrey could have possibly been declared dead. Considering the hospital's active involvement in organ transplants, he was probably continued on the respirator in order to harvest his organs.

[FN70]. It is also possible that the physicians were hoping the Strachans would change their minds concerning organ donation. For instance, when the Strachans first informed the physicians that they wanted to turn off the respirator, they were advised 'to think it over some more.' *Id.* 305, 507 A.2d at 720.

[FN71]. *Strachan*, 109 N.J. at 527, 538 A.2d at 348. The hospital counsel suggested several options: 1) proceed as if this was an organ transplantation, 2) obtain a court order, or 3) convene a prognosis committee to assist the physicians. *See id.*

[FN72]. *See id.* at 527, 538 A.2d at 348.

[FN73]. *See id.* at 528-29, 538 A.2d at 348-49. The Strachans claimed that violation of those duties resulted in emotional distress. The jury awarded each plaintiff $70,000. *See id.* at 529, 538 A.2d at 349. Because the New Jersey Supreme Court upheld their claims only on the failure of the hospital to release the dead body, they remanded for a retrial on the damages. *See id.* at 538-39, 538 A.2d at 354.

[FN74]. *Id.* at 530, 538 A.2d at 349 (emphasis in original). The court indicated that if these procedures are considered indispensable, they should be designed and imposed by the medical community not the court. *See id.*

[FN75]. *See id.*

[FN76]. *See id.*

[FN77]. The court remanded for a new trial only on the amount of damages. *See id.* at 538-39, 538 A.2d at 353-54.

[FN78]. 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

[FN79]. *See Strachan*, 109 N.J. at 533, 538 A.2d at 351. The court approved the UDDA definition as the 'appropriate legal definition of death.' *See id.* As to the hospital's lack of procedures, the court commented:

> [t]hat some of the developments in refining that definition and implementing it elsewhere came to pass after the critical events of the case before us is of small moment, given this Court's 1976 reference in *Quinlan*, with obvious approval, to 'brain death' as satisfying the criterion for 'death' and as 'representing . . . prevailing and accepted medical standards.'

Id.

[FN80]. *See id.* at 532, 538 A.2d at 350.

[FN81]. Time of death is time of determination, not time of pronouncement. *See id.* at 531-32, 538 A.2d at 350.

[FN82]. *See id.* at 538-39, 538 A.2d at 353-54. The court discussed whether damages for emotional distress were appropriate on the theory of negligent infliction of emotional distress. *See id.* at 533-38, 538 A.2d at 351-53. The court ultimately concluded, however, that this should be decided under the theory of negligent handling of a corpse. *See id.* at 538, 538 A.2d at 353; *see also* Goldberg, *Emotional Distress Damages and Breach of Contract: A New Approach*, 20 U.C. DAVIS L. REV. 57, 68-73 (1986).

[FN83]. LOS ANGELES COUNTY MEDICAL ASSOCIATION & LOS ANGELES COUNTY BAR ASSOCIATION, PRINCIPLES AND GUIDELINES CONCERNING THE FOREGOING OF LIFE-SUSTAINING TREATMENT FOR ADULT PATIENTS 7 app. II (1986) (emphasis in original) [hereinafter LACMA GUIDELINES].

[FN84]. *See id.*

[FN85]. *Id.* at 8.

[FN86]. *See id.*

[FN87]. *See id.*

[FN88]. *See, e.g.*, Bouvia v. Superior Court, 179 Cal. App. 2d 1127, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986) (twenty-eight-year-old quadriplegic patient requested removal of nasogastric tube); *In re* Farrell, 108 N.J. 335, 529 A.2d 404 (1987) (thirty-seven-year-old terminally ill patient requested withdrawal of respirator). Most states have enacted 'living will' statutes which allow individuals to indicate their preferences concerning the use of mechanical devices at the end of their lives. *See Farrell*, 108 N.J. at 342-43, 529 A.2d at 407 n.2.

Twenty-one states have recently enacted or revised their 'living will' statutes, specifically mentioning nutrition and hydration: Alaska, *see* Act Relating to the Rights of the Terminally Ill, ALASKA STAT. § 18.12.010(c) (1987); Arizona, *see* Medical Treatment Decision Act, ARIZ. REV. STAT. ANN. § 36-3201(4) (1985); Arkansas, *see* Rights of the Terminally Ill or Permanently Unconscious Act, ARK. CODE ANN. § 20-17-206(b) (1987); Colorado, *see* Medical Treatment Decision Act, COLO. REV. STAT. § 15-18-103(7) (Supp. 1986); Connecticut, *see* CONN. GEN. STAT. ANN. § 19a-570(1) (West Supp. 1988); Florida, *see* Life-Prolonging Procedure Act, FLA. STAT. ANN. § 765.03(3)(b) (West 1986); Georgia, *see* Living Wills Act, GA. CODE ANN. § 31-32-2(5)(A) (Supp. 1986); Idaho, *see* Natural Death Act, IDAHO CODE § 39-4503(3) (Supp. 1987); Indiana, *see* Living Wills and Life-Prolonging Procedures Act, IND. CODE ANN. §§ 16-8-11-4(2), 11-12(b)(c) (Burns Supp. 1987); Maine, *see* Uniform Rights of the Terminally Ill Act, ME. REV. STAT. ANN. tit. 22, § 2921(4) (Supp. 1985); Maryland, *see* Life-Sustaining Procedures Act, MD. HEALTH-GEN. CODE ANN. § 5-602 (Supp. 1987); Missouri, *see* Uniform Rights of the Terminally Ill Act, MO. ANN. STAT. 459-010(3) (Vernon Supp. 1988); Montana, *see* Living Will Act, MONT. CODE ANN. § 50-9-202 (1985 & Supp. 1988); New Hampshire, *see* Living Wills Act, N.H. REV. STAT. ANN. § 137-H:2(II) (Supp. 1987); Oklahoma, *see* Natural Death Act, OKLA. STAT. ANN. tit. 63, §§ 3102(4), 3106 (West Supp. 1988); South Carolina, *see* Death with Dignity Act, S.C. CODE ANN. § 44-77-20(b) (Law. Co-op. Supp. 1987); Tennessee, *see* Right to Natural Death Act, TENN. CODE ANN. § 32-11-103(5) (Supp. 1987); Utah, *see* Personal Choice and Living Will Act, UTAH CODE ANN. § 75-2-1103(6)(b) (Supp. 1987); West Virginia, *see* Natural Death Act, W. VA. CODE § 16-30-3 (1985); Wisconsin, *see* Natural Death Act, WIS. STAT. ANN. § 154.01.(5)(b) (West Supp. 1987); Wyoming, *see* Living Will Act, WYO. STAT. § 35-22-101(a)(iii) (Supp. 1987).

Seventeen states presently exclude nutrition and hydration from their definitions of life-sustaining procedures that can be controlled by advance written directive by competent individuals: Arizona, *see* Arizona Medical Treatment Decision Act, ARIZ. REV. STAT. ANN. § 36-3201(4) (1985); Colorado, *see* COLO. REV. STAT. § 15-18-103(7) (Supp. 1986); Connecticut, *see* CONN. GEN. STAT. ANN. § 19a-570(1) (West Supp. 1988); Florida, *see* FLA. STAT. ANN. § 765.03(3)(b) (West 1986); Georgia, *see* GA. CODE ANN. § 31-32-2(5)(A) (Supp. 1986); Idaho, *see* IDAHO CODE § 39-4503(3) (Supp. 1987); Indiana, *see* Indiana Living Wills and Life-Prolonging Procedures Act, IND. CODE ANN. §§ 16-8-11-4(2), 11-12(b)(c) (Burns Supp.1987); Maine, *see* ME.REV.STAT.ANN. tit. 22, § 2921(4) (Supp.1985); Maryland, *see* MD. HEALTH GEN. CODE ANN. § 5-602 (Supp.1987); Missouri, *see* Uniform Rights of the Terminally Ill Act, MO. ANN. STAT. 459-010(3) (Vernon Supp. 1988); New Hampshire, *see* N.H. REV. STAT. ANN. § 137-H:2(II) (Supp. 1987); Oklahoma, *see* Oklahoma Natural Death Act, OKLA. STAT. ANN. tit. 63, §§ 3102(4), 3106 (West Supp. 1988); Tennessee, *see* Tennessee Right to Natural Death Act, TENN. CODE ANN. § 32-11-103(5) (Supp. 1987); Utah, *see* UTAH CODE ANN. § 75-2-1103(6)(b) (Supp. 1987); West Virginia, *see* West Virginia Natural Death Act, W. VA. CODE § 16-30-3 (1985); Wisconsin, *see* Wisconsin Natural Death Act, WIS. STAT. ANN. § 154.01.(5)(b) (West Supp. 1987); Wyoming, *see* Wyoming Living Will Act, WYO. STAT. § 35-22-101(a)(iii) (Supp. 1987). For example, "[l]ife-sustaining procedure' does not include the administration of medication, food or fluids . . . deemed necessary to provide comfort or care.' ARIZ. REV. STAT. ANN. § 36-3201(4) (1985). Arkansas legislation provides '[t]his subchapter does not affect the responsibility of the attending physician or other health care provider to provide treatment, *including nutrition and hydration*, for a patient's comfort, care, or alleviation of pain.' Rights of the Terminally Ill or Permanently Unconscious Act, ARK. CODE ANN. § 20-17-206(b) (1987) (emphasis added). Similarly, South Carolina's definition of life-sustaining procedures provides that it does not

'affect the responsibility of the attending physician to provide treatment, *nutrition, and hydration,* for comfort care or alleviation of pain.' Death With Dignity Act, S.C. CODE ANN. § 44-77-20(b) (Law. Co-op. Supp. 1987) (emphasis added). Alaska and Montana do not exclude nutrition and hydration from life-sustaining procedures. In Alaska, the form declaration states: 'I [ ] do [ ] do not desire that *nutrition or hydration (food and water*) be provided by gastric tube or intravenously if necessary.' Act Relating to the Rights of the Terminally Ill, ALASKA STAT. § 18.12.010(c) (1987) (emphasis added). Montana legislation provides: '[t]his chapter does not prohibit the application of any medical procedure or intervention, including the provision of *nutrition and hydration*, considered necessary to provide comfort care or to alleviate pain.' Living Will Act, MONT. CODE ANN. § 50-9-202 (1985 & Supp. 1988) (emphasis added). A sample advance directive, or living will declaration, would direct that life-sustaining procedures 'be withheld or withdrawn, and that [the individual] be permitted to die naturally with only the provision of appropriate nutrition and hydration and the administration of medication and the performance of any medical procedure necessary to provide me with comfort care or to alleviate pain.' Living Wills and Life-Prolonging Procedures Act, IND. CODE ANN. § 16-8-11-12 (Burns Supp. 1987).

The scope of these living will provisions is not entirely clear. One view narrowly interprets the exclusion of nutrition and hydration to apply only to a competent individual's right to forego life-sustaining procedures by advance written directive if in a terminal condition. *See* Johnson, *The Death Prolonging Procedures Act and Refusal of Treatment in Missouri*, 30 ST. LOUIS U.L.J. 805, 831-32 (1986); *see also* Herlan, *Maine's Living Will Act and the Termination of Life-Sustaining Medical Procedures*, 39 ME. L. REV. 83, 102-03 (1983). Under this reasoning, it has no legal significance in other situations, such as withdrawing or withholding nutrition and hydration from those in a permanent vegetative state. *See* Corbett v. D'Allessandro, 487 So. 2d 368, 370-71 (Fla. Dist. Ct. App. 1986). *But see* Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988).

[FN89]. For instance, continuing mechanical respiration and heartbeat would be considered appropriate in two situations: 1) when efforts are being made to facilitate organ transplantation, and 2) to save the life of a fetus when the brain dead individual is pregnant. *See* HASTINGS GUIDELINES, *supra* note 58, at 89.

[FN90]. Although there is some disagreement whether brain death is an acceptable standard according to Jewish law (called 'halakha' in Hebrew), some scholars conclude that 'it is a serious violation of Jewish law were a 'brain-dead' patient disconnected from his or her respirator while the patient's other vital signs were still functioning.' Memorandum from David Zweibel to the New York, Task Force on Life and the Law, at 2 (April 28, 1986) (discussing determination of death). One prominent Orthodox Jewish organization, Agudath Israel of America, founded in 1922, represents the Orthodox Jewish community throughout the United States and its policies are determined by Orthodox rabbinic authorities. *See id*. at 1. It has sought enactment of 'specific provision[s] exempting patients whose religious definition of death does not coincide with government's.' *Id.* at 2.

[FN91]. Bleich, *Establishing Criteria of Death*, in JEWISH BIOETHICS 277, 290 (1979). '[I]t is only *irreversible* cessation of respiratory and cardiac activity accompanied by total absence of movement which constitute the halakhic [legal] criteria of death.' *Id.* (emphasis in original). 'From the point of view of the Halakhic definition of death, a person who is in the socalled 'brain death' state but whose heart and breathing are still functioning is certainly not dead.' Soloveichik, *The Halakhic Definition of Death*, in JEWISH BIOETHICS 296, 302 (1977); *see also* Bleich, *Neurological Criteria of Death and Time of Death Statutes*, in JEWISH BIOETHICS 303-16 (1979).

[FN92]. *See* DEFINING DEATH, *supra* note 4, at 41; *cf.* Begay v. State, 104 N.M. 483, 723 P.2d 252 (1985) (plaintiffs alleged performance of an autopsy on relative violated Navajo religious beliefs).

[FN93]. *See* Haberman, *Japan Ruling on Death may Bring Transplants*, N.Y. Times, Jan. 14, 1988, at 17, col. 5. 'To many Japanese, death occurs only when the heart-not the brain-ceases to function . . ..' *Id.* Another com-

mentator has noted:

> [s]ome claim that organ transplantation is incompatible with traditional Japanese ideas concerning the body, particularly Buddhist ideas about reincarnation. In this view, transplanting vital organs like the heart is taboo because a person whose body is cremated without all organs intact will not be able to survive in the afterlife. Though the majority of Japanese would not express such a view, the fact that some people who register at eye banks in Japan only volunteer to donate only one cornea may lend some credence to this suggestion.

Feldman, *Medical Ethics the Japanese Way*, HASTINGS CENTER REP., Oct. 1985, at 21, 24.

[FN94]. *See* DEFINING DEATH, *supra* note 4, at 41. Defining death as a persistent vegetative state or the permanent loss of higher brain functions is controversial. In 1981, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research considered adopting a higher brain standard but ultimately rejected it: '[o]n a matter so fundamental to a society's sense of itself-touching so deeply held personal and religious beliefs-and so final for the individuals involved, one would desire much greater consensus than now exists before taking the major step of radically revising the concept of death.' *Id.* The implications of the statement are that once consensus is reached, it would be acceptable to consider as legally dead those in a persistent vegetative state or with permanent loss of higher brain functions. Other reasons given for rejecting a higher brain standard were the possibility of considering senile or the severely retarded as dead under a higher brain standard and the uncertainty of ascertaining physiologically higher brain death. *See id*. Legislative action has been advocated in this regard, but not implemented in any state. *See* Smith, *supra* note 58, at 875-76.

[FN95]. *See In re* Drabick, 200 Cal. App.2d 185, 245 Cal. Rptr. 840 (Cal. Ct. App. 1988); *In re* Gardner, 534 A.2d 947 (Me. 1987); Brophy v. New England Sinai Hosp., 398 Mass. 417, 497 N.E.2d 626 (1986); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987); Delio v. Westchester County Med. Center, 129 A.D.2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987); *In re* Grant, 109 Wash. 2d 545, 747 P.2d 445 (1987). The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research in 1983 concluded that 'unlimited vigorous treatment of permanently unconscious patients may properly be discouraged . . ..' PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 190 (1983) [hereinafter FOREGOING LIFE-SUSTAINING TREATMENT]. More recently, the Hastings Center 'reject[ed] the contention that medical procedures for supplying nutrition and hydration should automatically be used whenever oral intake is chemically inadequate.' HASTINGS GUIDELINES, *supra* note 58, at 60. Couched in this cautious language is the concept that when individuals have permanently lost higher brain function, medical treatment becomes optional rather than mandatory.

[FN96]. She may fear that discontinuation of treatment which is now permitted for those who are brain dead or in a persistent vegetative state will become customary practice and then mandatory. She could also fear that this will lead to considering those with severe brain damage as dead under a higher brain death standard. *See, e.g.*, DEFINING DEATH, *supra* note 4, at 41. This fear is not without basis. In several cases involving patients with severe brain damage but not in a persistent vegetative state, courts have been called upon to decide whether nutrition and hydration could be withdrawn. No court has yet allowed actual withdrawal in that situation. *See, e.g.*, *In re* Visbeck, 210 N.J. Super. 527, 510 A.2d 125 (N.J. Sup. Ct. App. Div. 1986) (implantation of feeding tube ordered); *In re* Clark, 210 N.J. Super. 548, 510 A.2d 136 (N.J. Super. Ct. Ch. Div. 1986) (enterostomy to insert feeding tube ordered); Workmen's Circle Home v. Fink, 135 Misc. 2d 270, 514 N.Y.S.2d 893 (Sup. Ct., Bronx Co. 1987) (request to remove feeding tube and halt antibiotic therapy denied); *In re* O'Brien, 135 Misc. 2d 1076, 517 N.Y.S.2d 346 (Sup. Ct., N.Y. CO. 1986) (request to remove feeding tube denied). In *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985), the court may have permitted removal of the feeding tube, but the patient died dur-

ing the appeals process. *See id.* at 374, 486 A.2d at 1242-44. In *In re* O'Connor, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988), the court did not permit removal of a feeding tube because there was no 'clear and convincing evidence . . . sufficient to persuade the trier of fact that the patient held a firm and settled commitment to the termination of life support under the circumstances like those presented.' *Id.* at 531, 531 N.E.2d at 613, 534 N.Y.S.2d at 892.

[FN97]. UNIF. ANATOMICAL GIFT ACT, 8A U.L.A. 16 (1983); *see also* UNIF. ANATOMICAL GIFT ACT, 8A U.L.A. 2 (Supp. 1988) (proposed draft). The California Uniform Anatomical Gift Act provides a waiting period of twenty-four hours before authorization of an organ donation when no family members can be found. *See* CAL. HEALTH & SAFETY CODE § 7151.6 (West 1970 & Supp. 1988). In one reported case, the heart of an unidentified individual was transplanted after a 24-hour search for his next-of-kin was unsuccessful. *See Doctor Receives Heart of an Unidentified Donor*, L.A. Times, Apr. 22, 1988, pt. II, at 1, col. 1; *see also* Shapiro, *Life After Death: Organ Transplantation Forces a Choice Between Conflicting Interests*, L.A. Daily J., June 2, 1988, at 4, col. 3.

[FN98]. *See infra* notes 207-45 and accompanying text.

[FN99]. '[D]ecisions about the treatments that best promote a patient's health and wellbeing must be based on the particular patient's values and goals; no uniform objective determination can be adequate-whether defined by society or by health professionals.' FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 95, at 43. *See generally* PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS (1982). For a lively debate on the roles of the medical profession, the law and the family, see Baron, *Medical Paternalism and the Rule of Law: A Reply to Dr. Relman*, 4 AM. J.L. & MED. 337 (1978); Buchanan, *Medical Paternalism or Legal Imperialism: Not the Only Alternatives for Handling* Saikewicz-*type Cases*, 5 AM. J.L. & MED. 97 (1979); Relman, *The* Saikewicz *Decision: A Medical Viewpoint*, 4 AM. J.L. & MED. 233 (1978).

[FN100]. Most states have enacted 'living will' statutes that specify how individuals may control medical decisions at the end of life. *See In re* Farrell, 108 N.J. 335, 342-43 n.2, 529 A.2d 404, 407 n.2 (1987) (list of living will statutes). An individual may also use a durable power of attorney to control medical decisions. *See, e.g., In re* Peter, 108 N.J. 365, 370-71, 529 A.2d 419, 422 (1987) (patient had authorized a surrogate to 'make all decisions with respect to her health'). Although all states have durable power of attorney laws, at least seven have enacted laws that specifically include health care decisions. *See* Leflar, *Liberty and Death: Advance Health Care Directives and the Law of Arkansas*, 39 ARK. L. REV. 375, 428 (1986).

[FN101]. *See infra* notes 105-25 and accompanying text.

[FN102]. This right may be derived from the federal constitution (*see, e.g.*, Roe v. Wade, 410 U.S. 113 (1973)), or some state constitutions. *See, e.g.*, People v. Privitera, 23 Cal. 3d 697, 709-710, 591 P.2d 919, 926, 153 Cal. Rptr. 431, 438 (1977) (right of privacy under state constitution does not include a right of access to drugs of unproven efficacy such as laetrile); *see also infra* notes 125-48 and accompanying text.

[FN103]. The United States Constitution's first amendment guarantee of free exercise of religion is not absolute in the area of health or medical decisions. *See, e.g.*, McCartney v. Autin, 57 Misc. 2d 525, 293 N.Y.S.2d 188 (Sup. Ct., Broome Co. 1968) (compulsory vaccination); State *ex rel.* Swann v. Pack, 527 S.W.2d 99 (Tenn. 1975), *cert. denied*, 424 U.S. 954 (1976) (forbidding snake handling). Concerning the refusal of blood transfusions based on religious beliefs, see *infra* notes 149-75 and accompanying text. Some state constitutions also provide additional protection for religious beliefs. *See* Note, *Whose Beliefs are Entitled to Protection: Resolving*

the Conflicts Between the California and Federal Standards, 27 SANTA CLARA L. REV. 377 (1987).

[FN104]. *See, e.g.*, *Farrell*, 108 N.J. at 335, 529 A.2d at 404 (competent patient requesting withdrawal of respirator); *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987) (incompetent patient through durable power of attorney authorized removal of nutrition and hydration devices); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987) (where no prior indication by patient, family authorized to remove nutrition and hydration devices from patient in persistent vegetative state).

[FN105]. 129 A.D.2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987).

[FN106]. *Delio*, 129 A.D.2d at 2, 516 N.Y.S.2d at 679.

[FN107]. *Id.* at 3, 516 N.Y.S.2d at 679; *see also Peter*, 108 N.J. at 379, 529 A.2d at 426 (durable power of attorney and nine reliable hearsay witnesses considered sufficiently clear and convincing).

[FN108]. *See Delio*, 129 A.D.2d at 10-11, 516 N.Y.S.2d at 684.

[FN109]. *Id.; see also supra* note 38. *See generally* F. PLUM & J. POSNER, DIAGNOSIS OF STUPOR AND COMA 224-39 (2d ed. 1972).

[FN110]. *Delio*, 129 A.D.2d at 4, 516 N.Y.S.2d at 680.

[FN111]. *Id.* at 4-5, 516 N.Y.S.2d at 680.

[FN112]. *See id.* at 5, 516 N.Y.S.2d at 680.

[FN113]. *See id.* at 6-7, 516 N.Y.S.2d at 681. Daniel had insisted that his wife and mother promise that they would 'take every possible step to prevent the preservation of his life by artificial means.' *Id.* Daniel also discussed his convictions with his brother-in-law and sister-in-law as well as the attending surgeon. *See id.* at 9, 516 N.Y.S.2d at 683.

[FN114]. *Id.* at 7, 516 N.Y.S.2d at 682.

[FN115]. *See supra* note 94 (discussing controversy concerning using a neocortical definition of death).

[FN116]. *Delio*, 129 A.D.2d at 7, 516 N.Y.S.2d at 682.

[FN117]. *See id.* at 13, 516 N.Y.S.2d at 685. The court considered resting its decision on the right of privacy as well, but declined to do so because New York's highest court, the Court of Appeals, had found the common law right sufficient to embrace the right to refuse medical treatment. *See id.* at 14, 516 N.Y.S.2d at 686 (citing *In re* Storar, 52 N.Y.2d 363, 376-77, 420 N.E.2d 64, 70, 438 N.Y.S.2d 266, 272-73 (1981)).

[FN118]. 211 N.Y. 125, 105 N.E. 92 (1974) (removal of a tumor without consent considered a battery).

[FN119]. *Schloendorff*, 211 N.Y. at 129-30, 105 N.E. at 93.

[FN120]. *See Delio*, 129 A.D.2d at 15, 516 N.Y.S.2d at 686; *see also* Rasmussen by Mitchell v. Fleming, 154 Ariz. 207, 741 P.2d 674 (Ariz. Ct. App. 1987); *In re* Drabick, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (Cal. Ct. App. 1988); Severns v. Wilmington Medical Center, Inc., 421 A.2d 1334 (Del. 1980); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re*, Gardner, 534 A.2d 947 (Me.

1987); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987); *In re* Guardianship of Grant, 109 Wash. 2d 545, 747 P.2d 445 (1988).

[FN121]. *See Delio*, 129 A.D.2d at 19, 516 N.Y.S.2d at 689; *see also supra* note 95 (court decisions in six states have allowed removal of nutrition and hydration devices).

[FN122]. *See Delio*, 129 A.D.2d at 24, 516 N.Y.S.2d at 692. In all cases involving removal of nutrition and hydration devices, no state interest outweighed the patient's right to have them removed. *See supra* note 95.

[FN123]. *See Delio*, 129 A.D.2d at 23, 516 N.Y.S.2d at 691. These interests were first articulated in cases involving the free exercise of religion by Jehovah's Witnesses in refusing the administration of blood transfusions that violated their religious beliefs. *See infra* notes 149-75 and accompanying text.

[FN124]. *See, e.g., In re* Drabick, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (1988); *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987); *In re* Gardner, 534 A.2d 947 (Me. 1987); Brophy v. New England Sinai Hosp., 398 Mass. 417, 497 N.E.2d 626 (1986); *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983).

[FN125]. 70 N.J. 10, 40, 355 A.2d 647, 663, *cert. denied*, 429 U.S. 922 (1976).

[FN126]. *See In re* Farrell, 108 N.J. 335, 348, 529 A.2d 404, 410 (1987) (common law right and federal constitutional right). *Farrell* was part of a triumvirate of cases decided by the New Jersey Supreme Court in 1987. The others were *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987) and *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987). Other courts also base the right to refuse medical treatment on both the common law right and the constitutional right of privacy. *See* Foody v. Manchester Memorial Hosp., 40 Conn. Supp. 127, 482 A.2d 713 (Conn. Super. Ct. 1984) (federal and state constitutional rights); Brophy v. New England Sinai Hosp., 398 Mass. 417, 497 N.E.2d 626 (1986) (federal and state constitutional rights); *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983) (federal and state constitutional rights). In recent cases, courts have relied solely on the common law right. *See In re* Drabick, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (Cal. Ct. App. 1988); *In re* Gardner, 534 A.2d 947 (Me. 1987) (informed consent). Other courts have relied on the common law right combined with the federal and state constitutional rights of privacy. *See* Rasmussen by Mitchell v. Fleming, 154 Ariz. 200, 741 P.2d 667 (Ariz. Ct. App. 1986); *In re* Grant, 109 Wash. 2d 545, 747 P.2d 445 (1987). Courts in some cases relied solely on the constitutional right of privacy. *See* Gray v. Romeo, 697 F. Supp. 580 (D.R.I. 1988); Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986) (federal and state); Severns v. Wilmington Medical Center, 421 A.2d 1334 (Del. 1980); *In re* Barry, 445 So. 2d 365 (Fla. Dist. Ct. App. 1984) (federal and state-Florida amended its constitution); Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980); *In re* Spring, 380 Mass. 629, 405 N.E.2d 115 (1980); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976); Leach v. Akron General Medical Center, 68 Ohio Misc. 2d 1, 426 N.E.2d 809 (1980).

[FN127]. 108 N.J. 365, 529 A.2d 419 (1987).

[FN128]. *Peter*, 108 N.J. at 370-71, 529 A.2d at 422.

[FN129]. *See id.* at 380, 529 A.2d at 427.

[FN130]. *Id.*

[FN131]. *Id.*

[FN132]. *Id.* Similarly, religious beliefs need not be 'acceptable, logical, consistent or comprehensible.' Thomas v. Review Bd., 540 U.S. 707, 714 (1981); *see also* L. TRIBE, AMERICAN CONSTITUTIONAL LAW 1181-83 (2d ed. 1988).

[FN133]. *Peter*, 108 N.J. at 373, 529 A.2d at 423.

[FN134]. 108 N.J. 394, 529 A.2d 434 (1987).

[FN135]. *Jobes*, 108 N.J. at 412-13, 529 A.2d at 443.

[FN136]. *See id.* at 401, 529 A.2d at 437-38. There was some controversy about the extent of her brain damage. Based on the testimony of the medical experts, the Supreme Court up-held the trial court's determination that she was in an irreversible vegetative state. *See id.* at 408-09, 529 A.2d at 441.

[FN137]. *See id.* at 413, 529 A.2d at 443.

[FN138]. *See id.* at 400, 529 A.2d at 437. In *Jobes*, at the time of the court's decision, Nancy Ellen had been sustained for over seven years by artificial feeding devices. *See id.* In contrast, in *Quinlan*, Karen Ann had been on a respirator for almost a year at the time of the court's decision, and the family only requested that Karen Ann's respirator be removed. *See Quinlan*, 70 N.J. at 18, 355 A.2d at 651. Although there was conjecture by the court that Karen Ann would die soon after the removal from the respirator, she actually lived for about nine years with artificial feeding and hydration.

[FN139]. *Jobes*, 108 N.J. at 414, 529 A.2d at 444.

[FN140]. *See id.* at 399, 529 A.2d at 436.

[FN141]. *See id.* at 414, 529 A.2d at 444. This is called the 'substituted judgment' doctrine, where a surrogate decisionmaker tries to decide as the incompetent individual would have if competent. The court refused to apply the standards from *In re* Conroy, 98 N.J. 321, 364-66, 486 A.2d 1209, 1231-32 (1985), to an individual in a persistent vegetative state. *See Jobes*, 108 N.J. at 414, 529 A.2d at 444. The *Conroy* standards are applicable to the very narrow circumstances where the patient is 'an elderly, incompetent nursing-home resident with severe and permanent mental and physical impairment and a life expectancy of approximately one year or less.' *Conroy*, 98 N.J. at 363, 486 A.2d at 1231.

[FN142]. *Jobes*, 108 N.J. at 414, 529 A.2d at 444.

[FN143]. *Id.* at 415-20, 529 A.2d at 444-47.

[FN144]. *See id.* at 415, 529 A.2d at 445. The family's knowledge includes 'his or her philosophical, religious and moral views, life goals, values about the purpose of life and the way it should be lived, and attitudes toward sickness, medical procedures, suffering and death, [and] that individual's likely treatment/nontreatment preferences.' *Id.* The court also recognized the 'special bonds' with the patient in that the family who will 'provide for the patient's comfort, care, and best interest, and . . . [will] treat the patient as a person, rather than a symbol of a cause.' *Id.* The court includes spouses, parents, adult children, and siblings in the group enabled to make the substituted judgment. Without close kinship a health care professional should not defer to other relatives but should opt for appointment of a guardian. The court leaves this to the discretion of the health care professional, however, to determine if another relative such as a cousin, aunt, uncle, niece, or nephew could be treated as a close family member. The court acknowledges that some family members may decide to request removal of life-

sustaining devices for their own interests rather than the patient's interest. In that case, a guardian should be appointed. *See id.* at 420, 529 A.2d at 447. The motives of a family may not be sinister, such as inheritance of the estate, but instead reflect the emotional and financial drain on the family.

[FN145]. *See id.* at 419-20, 529 A.2d at 447.

[FN146]. *See id.* at 419-20, 426-28, 529 A.2d at 447-448, 451.

[FN147]. *See id.* at 426, 529 A.2d at 450. The court ordered the nursing home to implement its order rather than transferring her to another institution. *See id.* The nursing home asked the New Jersey Supreme Court to reconsider that part of the judgment. After counsel for the Jobes family indicated that they would transfer Nancy Ellen, however, the nursing home's motion was dismissed as moot. *See In re* Jobes, 108 N.J. 589, 531 A.2d 1360, *cert. denied*, 108 S. Ct. 6 (1987); *see also* Annas, *Transferring the Ethical Hot Potato*, HASTINGS CENTER REP., Feb. 1987, at 20.

[FN148]. *See infra* notes 246-99 and accompanying text.

[FN149]. Jehovah's Witnesses believe that blood transfusions violate the Biblical injunction against 'eating blood.' *See Genesis* 9:3-4; *Leviticus* 17:10-14; *Deuteronomy* 12:33. Believers in faith healing reject medical treatment and instead put their trust in God's healing powers. *See, e.g., In re* Boyd, 403 A.2d 744, 751 (D.C. 1979) (Christian Scientist rejecting medication for medical illness); *In re* Milton, 29 Ohio St. 3d 20, 21, 505 N.E.2d 255, 256 (1987) (believer in faith healing refused treatment for cancer of uterus); Commonwealth v. Barnhart, 345 Pa. Super. 10, 497 A.2d 616 (Pa. Super. Ct. 1985), *appeal denied*, 538 A.2d 874, *cert. denied*, 109 S. Ct. 55 (1988) (parents-lifelong members of Faith Tabernacle Church-convicted of involuntary manslaughter in connection with death of two-year-old child from cancer); *see also* Note, *Religious Beliefs and the Criminal Justice System: Some Problems of the Faith Healer*, 8 LOY. L.A.L. REV. 396 (1975).

[FN150]. *See, e.g., In re Osborne*, 294 A.2d 372, 374 (D.C. 1972) (right to refuse a blood transfusion upheld where patient has provided for material well-being of his children); *In re* Brooks' Estate, 32 Ill. 2d 361, 372-74, 205 N.E.2d 435, 441-43 (1965) (right to refuse blood transfusion upheld because no endangerment to public health, welfare, or morals); Saint Mary's Hosp. v. Ramsey, 465 So. 2d 666, 668-69 (Fla. Dist. Ct. App. 1985) (even in emergency no state interest outweighs patient's right to refuse blood transfusion); *In re* Brown, 478 So. 2d 1033, 1038-39 (Miss. 1985) (right to refuse blood transfusion upheld despite state interest in preserving life of a witness to a felony); *In re* Melideo, 88 Misc. 2d 974, 975, 390 N.Y.S.2d 523, 524 (Sup. Ct., Suffolk Co. 1976) (right to refuse blood transfusion upheld where patient is competent, not pregnant and has no children).

[FN151]. *See, e.g., Boyd*, 403 A.2d at 750 (incompetent); *Osborne*, 294 A.2d at 374 (competent); *Milton*, 29 Ohio St. 3d at 26, 505 N.E.2d at 260 (determining factor was competence of individual).

[FN152]. The religious belief cases were actually the origin of the state interests that were later adopted as the basis of the self-determination and privacy cases. As early as 1964, in Application of President & Directors of Georgetown College, Inc., 331 F.2d 1000, 1007-10 (D.C. Cir. 1964), the District of Columbia Circuit Court of Appeals delineated the state's interests in protection of minors, prevention of suicide, and preservation of life. In John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, 582-83, 279 A.2d 670, 673 (1971), the New Jersey Supreme Court identified the interests of conserving life, preventing suicide, and the integrity of the medical profession. *See id.; see also Osborne*, 294 A.2d at 374-75 (protection of life, protection of children). Although the free exercise argument was made but not accepted in *Quinlan*, the court balanced the state interests of preservation and sanctity of life as well as the integrity of the medical profession against the individual's right of privacy.

See Quinlan, 70 N.J. at 38-40, 355 A.2d at 662-63. Since then, the same state interests are balanced against all the rights in question.

[FN153]. *See, e.g., Quinlan*, 70 N.J. at 10, 355 A.2d at 647 (court decided on privacy not free exercise); *In re* Estate of Dorone, 349 Pa. Super. 59, 63, 502 A.2d 1271, 1273 (Pa. Super. Ct. 1985) (both self-determination and free exercise raised but court decided on basis of the latter); *see also* L. TRIBE, *supra* note 132, at 1179-83 (definition of religion). In some cases, the courts have required state action before applying the right involving private hospitals. *See, e.g.*, Staelens v. Yake, 432 F. Supp. 834, 837-38 (N.D. Ill. 1977) (private hospital receiving state funds did not act under color of state law in section 1983 action). *But see* Holmes v. Silver Cross Hosp., 340 F. Supp. 125, 132-34 (N.D. Ill. 1972) (private hospital did act under color of state law in section 1983 action because licensed and regulated by the state).

[FN154]. 500 So. 2d 679 (Fla. Dist. Ct. App. 1987).

[FN155]. *See Wons*, 500 So. 2d at 683.

[FN156]. *Id.* at 688 (relying on Satz v. Perlmutter, 379 So. 2d 359 (Fla. 1980); St. Mary's Hosp. v. Ramsey, 465 So. 2d 666 (Fla. Dist. Ct. App. 1985)).

[FN157]. *Id.*

[FN158]. *See, e.g.*, Application of President & Directors of Georgetown College, Inc., 331 F.2d 1000, 1008 (D.C. Cir. 1964) (protection of seven-month-old child); Raleigh-Fitkin Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537 (1964) (protection of unborn fetus after thirty-second week of pregnancy); Crouse Irving Memorial Hosp. v. Paddock, 127 Misc. 2d 101, 485 N.Y.S.2d 443 (Sup. Ct., Onondaga Co. 1985) (protection of child immediately after birth); Powell v. Columbian-Presbyterian Medical Center, 49 Misc. 2d 215, 267 N.Y.S.2d 450 (Sup. Ct., N.Y. Co. 1965) (protection of six children); *cf. In re* Appeal in Cochise County Juvenile Action, 133 Ariz. 165, 650 P.2d 467 (1981) (children considered 'dependent children' when mother believed miracles would safeguard her children); *In re* Eric B., 189 Cal. App. 3d 996, 325 Cal. Rptr. 22 (Cal. Ct. App. 1987) (child with cancer made ward of the state when Christian Scientist parents refused treatment); Muhlenberg Hosp. v. Patterson, 128 N.J. Super. 498, 320 A.2d 518 (N.J. Super. Ct. App. Div. 1974) (blood transfusion ordered for premature baby over Jehovah's Witness parent's objection); *Re re* Green, 448 Pa. 338, 292 A.2d 387 (1972) (child considered 'neglected child' because Jehovah's Witness parents objected to blood transfusions for surgery).

[FN159]. The courts seem less hesitant to override an individual's religious belief when indicated by a family member. *See, e.g.*, John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, 279 A.2d 670 (1971); University of Cincinnati Hosp. v. Edmond, 30 Ohio Misc. 2d 1, 506 N.E.2d 299 (1986); *In re* Estate of Dorone, 349 Pa. Super. 59, 502 A.2d 1271 (Pa. Super. Ct. 1985), *aff'd*, 517 Pa. 3, 534 A.2d 452 (1987). This is especially true when it involves minor children. *See supra* note 158.

[FN160]. Where the patient refuses a blood transfusion and then lives, the Maryland Court of Appeals has refused to resolve the issue of whether a hospital can obtain a court order to administer blood transfusions. The court has considered the cases moot. *See* Mercy Hosp. v. Jackson, 306 Md. 556, 564-65, 510 A.2d 562, 565-66 (1986) (blood transfusion refused in delivery of baby); Hamilton v. McAuliffe, 277 Md. 336, 341-42, 353 A.2d 634, 637-38 (1976) (blood transfusion refused in surgery associated with gun shot wound). Where the blood transfusions are given over the objections of patient, courts have not considered the question moot. *See, e.g., Heston*, 58 N.J. at 576, 279 A.2d at 670 (patient received blood transfusion and recovered); *Dorone*, 349 Pa. Super. at 62-63, 502 A.2d at 1273 (patient died despite administration of blood).

[FN161]. *Georgetown College*, 331 F.2d at 1009.

[FN162]. *See supra* note 158.

[FN163]. *See In re* Application of Jamaica Hosp., 128 Misc. 2d 1006, 1008, 491 N.Y.S.2d 898, 900 (Sup. Ct., Queens Co. 1985). According to the Hastings Guidelines, it is considered desirable to sustain a brain dead individual if there is a chance of saving an unborn fetus. *See* HASTINGS GUIDELINES, *supra* note 58, at 89.

[FN164]. 128 Misc. 2d 1006, 491 N.Y.S.2d 898 (Sup. Ct., Queens Co. 1985).

[FN165]. *See Jamaica Hosp.*, 128 Misc. 2d at 1007-08, 491 N.Y.S.2d at 899-900.

[FN166]. 349 Pa. Super. 59, 502 A.2d 1271 (Pa. Super. Ct. 1985), *aff'd*, 517 Pa. 3, 534 A.2d 452 (1987).

[FN167]. 30 Ohio Misc. 2d 1, 506 N.E.2d 299 (1986).

[FN168]. In *Dorone*, the individual carried a card identifying himself as a Jehovah's Witness, but apparently the card was left with his personal effects when he was transferred to a regional trauma center. *See Dorone*, 349 Pa. Super. at 69-70, 502 A.2d at 1277.

[FN169]. *See Edmond*, 30 Ohio Misc. 2d at 1, 506 N.E.2d at 299.

[FN170]. *See Dorone*, 349 Pa. Super. at 74-75, 502 A.2d at 1279; *see also Edmond*, 30 Ohio Misc. 2d at 4, 506 N.E.2d at 302.

[FN171]. *Dorone*, 349 Pa. Super. at 72, 502 A.2d at 1278 (quoting *In re* Osborne, 294 A.2d 372, 374 (D.C. 1972)).

[FN172]. *Edmond*, 30 Ohio Misc. 2d at 4, 506 N.E.2d at 302. The only case cited by the court was John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, 279 A.2d 670 (1971). There the court stated that '[t]he solution sides with life, the conservation of which, we think, a matter of state interest.' *Id.* at 583, 279 A.2d at 673.

[FN173]. Even prior to Roe v. Wade, 410 U.S. 113 (1973), where the United States Supreme Court recognized the individual's right to privacy in making medical decisions, medical intervention against a patient's religious beliefs was criticized. *See* Cantor, *A Patient's Decision to Decline Life-saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228 (1973). *But see* Note, *Compulsory Medical Treatment and the Free Exercise of Religion*, 42 IND. L.J. 386, 404 (1976) ('When a human life is endangered, society's interest is of such paramount importance that the lesser religious interest must give way and the balance must be struck in favor of life.'); Note, *Unauthorized Rendition of Lifesaving Medical Treatment*, 53 CALIF. L. REV. 860, 873 (1965) ('only emergency medical treatment, which a high degree of probably success, would be justified'). *See generally* Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 FORDHAM L. REV. 1 (1975).

[FN174]. *See* Cantor, *supra* note 173, at 244, 254.

[FN175]. Although there is some urgency in deciding to donate organs for transplantation or to use a respirator for another patient, in most situations, the use of the mechanical devices prolongs the time for decisionmaking.

[FN176]. *See supra* notes 66-88 and accompanying text.

[FN177]. *See supra* notes 99-175 and accompanying text.

[FN178]. CAL. HEALTH & SAFETY CODE § 7100 (West 1970 & Supp. 1988). These directions are subject to the coroner's power to carry out an autopsy. If the decedent has not given instructions, the right to control the disposition of the remains devolves to the next of kin, in the order of, surviving spouse, child or children, parent or parents, or next degree of kindred as specified in succession of estates. If there are no next of kin, control of disposition falls to the public administrator. *See id.*

[FN179]. *See id.*

[FN180]. *See id.*

[FN181]. *See* UNIF. ANATOMICAL GIFT ACT, 8A U.L.A. 19-20 (Supp. 1988).

[FN182]. UNIF. ANATOMICAL GIFT ACT, 8A U.L.A. 19-20 (1983); *see also* CAL. HEALTH & SAFETY CODE § 7151 (West 1970). In 1987, the National Conference of Commissioners on Uniform State Laws approved a revised version of the UAGA which more clearly indicates the range of choice available to the individual. 'An individual who is at least [18] years of age may (i) make an anatomical gift for any of the purposes stated in Section 6(a), (ii) limit an anatomical gift to one or more of those purposes, or (iii) refuse to make an anatomical gift.' UNIF. ANATOMICAL GIFT ACT, § 2, 8A U.L.A. 5 (Supp. 1988) (proposed draft).

[FN183]. *See* UNIF. ANATOMICAL ACT, § 4, 8A U.L.A. 43 (1983); UNIF. ANATOMICAL GIFT ACT, § 2, 8A U.L.A. 5 (Supp. 1988) (proposed draft). The gift may also be indicated on a driver's license. *See* CAL. HEALTH & SAFETY CODE § 7154(b) (West Supp. 1988).

[FN184]. *See* UNIF. ANATOMICAL GIFT ACT, § 2, 8A U.L.A. 34 (1983); CAL. HEALTH & SAFETY CODE § 7151.5 (West 1970 & Supp. 1988). The order of priority among the family is the spouse, an adult son or daughter, either parent, an adult brother or sister, or a guardian of the person of the decedent at the time of his death. In California, if none of the people listed are available after a diligent search, the decedent's body may be donated twenty-four hours after the search began. *See* CAL. HEALTH & SAFETY CODE § 7151.6 (West Supp. 1988).

[FN185]. *See* CAL. HEALTH & SAFETY CODE § 7113 (West 1970 & Supp. 1988). This authorization may be provided in the decedent's will or other written document or by the next of kin in writing or verbally. *See id.*

[FN186]. *See id.* § 7114.

[FN187]. *See supra* note 184.

[FN188]. 109 N.J. 523, 538 A.2d 346 (1988), *rev'g*, 209 N.J. Super. 300, 307 A.2d 718 (N.J. Super. Ct. App. Div. 1986).

[FN189]. *See supra* notes 66-88 and accompanying text.

[FN190]. *See* CAL. HEALTH & SAFETY CODE § 7151.7 (West Supp. 1988).

[FN191]. *See id.* According to Orthodox Jewish law, autopsy is forbidden because it violates the dignity of the deceased body. This prohibition against postmortem procedures is based on a portion from the Bible, *Deuteronomy* 21:23: '[h]is body shall not remain all night upon the tree, but thou shalt surely bury him the same day; for he that is hanged is a reproach unto God.' *Id.* The body as well as the soul should be accorded respect. Even

after death, it is forbidden to desecrate the human body which is created in the image of God. 1 J.D. BLEICH, CONTEMPORARY HALAKHIC PROBLEMS 125-26 (1977); M. LAMM, THE JEWISH WAY IN DEATH AND MOURNING 8-12 (1969); Snyder v. Holy Cross Hosp., 30 Md. App. 317, 322 n.4, 352 A.2d 334, 337 n.4 (Md. Ct. Spec. App. 1976).

[FN192]. *See* CAL. HEALTH & SAFETY CODE § 7113 (West Supp. 1988). The provision reads:

> [t]his section shall not authorize the obtaining of a verbal authorization by telephone and recorded on tape or other recording device for an autopsy of a deceased person if it is made known to the physician who is to perform the autopsy that the deceased was, at the time of his death, a member of a religion, church, or denomination which relies solely upon prayer for the healing of disease.

Id.; see also supra note 149.

[FN193]. Since 1983, four states have enacted such legislation. *See* N.Y. PUB. HEALTH LAW § 4210-c (McKinney 1985); N.J. STAT. ANN. § 52:17B-88.2 (West 1986); CAL. GOV'T CODE § 27491.43 (West 1985); OHIO REV. CODE ANN. § 313.13.1 (Anderson 1987).

[FN194]. The New York statute uses the language 'if there is *otherwise* reason to believe that a dissection or autopsy is contrary to the decedent's religious beliefs.' N.Y. PUB. HEALTH LAW § 4210-c (McKinney 1985) (emphasis added). The New Jersey statute uses the language 'if there is an *obvious* reason to believe that the autopsy or dissection is contrary to the religious beliefs of the deceased.' N.J. STAT. ANN. § 52:17B-88.2 (West 1986) (emphasis added). Such reasons could include an indication in the decedent's medical records or a physician's statement if she knew the decedent's beliefs. The California statute does not have a similar provision and limits the objections to a certificate of religious belief. *See* CAL. GOV'T CODE § 27491.43(a), (b) (West 1985). The Ohio statute has language similar to New York but defines a reason as 'if a document signed by the deceased and stating an objection to an autopsy is found on the deceased's person or in his effects.' OHIO REV. CODE ANN. § 313.13.1(B) (Anderson 1987). Such a certificate or document would state '[b]ased on my religious beliefs, I object to an autopsy and all post-mortem anatomical disections or other autopsy procedures being conducted in my body.' Goldberg, *Autopsy and Religious Belief*, 8 L.A. LAW. 31, 32 (1985). Realistically, however, it is doubtful that a coroner would look for such a document without an objection from the next of kin. The coroner may, however, require a 'Waiver of Autopsy' stating:

> [b]ecause of religious reasons, I strongly object to an autopsy on [name of person], and as legal next-of-kin I will accept that the cause and manner of death given by the Chief Medical Examiner-Coroner is based on assumption and not based on autopsy findings. I will also accept the consequences of objecting to the autopsy.

Department of Chief Medical Examiner-Coroner, Waiver of Autopsy, Los Angeles, California.

[FN195]. *See* CAL. GOV'T CODE § 27491.43(a)(1) (West 1985). In New York and New Jersey, where similar autopsy laws have been enacted, the coroner is prohibited from performing an autopsy or other procedure of there is a religious objection. There is no requirement, however, that the objection be in writing. In New York, an autopsy is barred if there is 'the objection of a surviving relative or friend' based on religious belief of the decedent or 'there is otherwise reason to believe that a dissection or autopsy is contrary to the decedent's religious beliefs.' N.Y. PUB. HEALTH LAW § 4210-c(1) (McKinney 1985). Similarly, in New Jersey, an autopsy is barred if there is 'the objection of a member of the deceased's immediate family or in the absence thereof, a friend of the deceased' based on the religious belief of the decedent or 'if there is an obvious reason to believe that a dissection or autopsy is contrary to the decedent's religious beliefs.' N.J. STAT. ANN. § 52:17B-88.2 (West 1986). The reasons to believe that it would be contrary to the decedent's beliefs would be, for instance, strict adherence to Jewish dietary laws and observance of the Sabbath and Jewish holidays by the deceased. *See*

also MD. HEALTH-GEN. CODE ANN. § 5-310(b)(2) (1982). In California, the objection to the autopsy must be in writing, in a document called a certificate of religious belief (CRB), which must be produced within forty-eight hours by the relative or friend voicing the objection. *See* CAL. GOV'T CODE § 27941.43(a)(2) (West 1985). Similarly, in Ohio, a coroner will perform an autopsy unless a relative or friend of the deceased person informs the coroner that an autopsy is contrary to the deceased person's religious beliefs or the coroner has reason to believe that an autopsy is contrary to the decedent's religious beliefs. *See* OHIO REV. CODE ANN. § 313.13.1(c)(1) (Anderson 1987).

[FN196]. *See* CAL. GOV'T CODE § 27491.43(c) (West 1985). This section provides that the coroner may 'at any time perform an autopsy or any other procedure if he or she has a reasonable suspicion that the death was caused by the criminal act of another or by a contagious disease constituting a public health hazard.' *Id.* New Jersey, New York, and Ohio also allow an autopsy if there is a criminal investigation or an immediate and substantial threat to the public health. *See* N.J. STAT. ANN. § 52:17B-88.1(a)(1), (2) (West 1986); N.Y. PUB. HEALTH LAW § 4210-c(a)(i), (ii) (McKinney 1985); OHIO REV. CODE ANN. § 313.13.1(c)(1) (Anderson 1987). New Jersey adds other 'compelling public necessities' i.e., the death of an inmate of a prison, jail, or penitentiary and the death of a child under twelve-years-old in certain circumstances. *See* N.J. STAT. ANN. § 52:17B-88.1(a)(3), (4) (West 1986). All three states have a waiting period before proceeding unless the delay would prejudice the accuracy of the autopsy. *See id.* § 52:17B-88.3 (West 1986); N.Y. PUB. HEALTH LAW § 4210-c(a) (McKinney 1985) (or if the objecting party is a suspect in the homicide); OHIO REV. CODE ANN. § 313.13.1(c)(1) (Anderson 1987).

[FN197]. *See* CAL. GOV'T CODE § 27491.43(a)(2) (West 1985); N.J. STAT. ANN. § 52:17B-88.1 (West 1986); N.Y. PUB. HEALTH LAW § 4210-c(2)(b) (McKinney 1985); OHIO REV. CODE ANN. § 313.13(c)(1) (Anderson 1987).

[FN198]. *See* CAL. GOV'T CODE § 27491(d)(1)-(5) (West 1985); N.Y. PUB. HEALTH LAW § 4210-c(4) (McKinney 1985); N.J. STAT. ANN. § 52:17B-88.3 (West 1986); OHIO REV. CODE ANN. § 313.13(c)(1) (Anderson 1987).

[FN199]. *See* CAL. GOV'T CODE § 27491.43(a)(2) (West 1985). 'Friend' is not defined in the California statute, but is in the New York and New Jersey statutes as a person who before the decedent's death had enough contact with the decedent to be familiar or knowledgeable with the decedent's activities, health and religious beliefs,' and presents an affidavit giving facts and circumstances of the friendship and that he will assume responsibility for disposition of the deceased's body. *See* N.J. STAT. ANN. § 52:17B-88.1 (West 1986); N.Y. PUB. HEALTH LAW § 4210-c(2)(b) (McKinney 1985). The Ohio statute is similar in its definition of friend, but also requires that the friend be authorized by a written instrument executed by the deceased person to make burial arrangements. *See* OHIO REV. CODE ANN. § 313.13.1(A)(1) (Anderson 1987).

[FN200]. The New York and Ohio statutes provide that an autopsy is a 'compelling public necessity' if it is necessary to the conduct of an investigation by law enforcement officials of a homicide, or any other criminal investigation, or is necessary to establish the cause of the deceased person's death for purposes of protecting against an immediate and substantial threat to the public health. *See* N.Y. PUB. HEALTH LAW § 4210-(C)(2)(i), (ii) (McKinney 1985); OHIO REV. CODE ANN. § 313.13.1(C)(1) (Anderson 1987). New Jersey expands New York's and Ohio's definition to include situations wherein death was that of an inmate of a prison or a child under the age of twelve years suspected of having been abused or neglected or suspected of being a threat to public health. *See* N.J. STAT. ANN. § 52.17B-88.1 (West 1986).

[FN201]. *See* CAL. GOV'T CODE § 27941.43 (West 1985).

[FN202]. *See* N.J. STAT. ANN. § 52.17B-88.1(a)(1), (2) (West 1986); N.Y. PUB. HEALTH LAW § 4210-c(2)(i), (ii) (McKinney 1985); OHIO REV. CODE ANN. § 313.13.1(c)(1) (Anderson 1987); *see also supra* note 200. New Jersey adds other 'compelling necessities' such as the death of an inmate in prison, jail or penitentiary and the death of a child under twelve years old in certain circumstances. N.J. STAT. ANN. § 52.17B-88.1(a)(3), (4) (West 1986).

[FN203]. *See* CAL. GOV'T CODE § 27941.43(d)(5) (West 1985); N.J. STAT. ANN. § 52.17B-88.5 (West 1986); N.Y. PUB. HEALTH LAW § 4210-c(5) (McKinney 1985); OHIO REV. CODE ANN. § 313.13.1(d)(2) (Anderson 1987).

[FN204]. The physician ordinarily acts as a private individual, while a coroner is an agent of the state. In some cases, courts may require that the physician's actions involve state action. *See, e.g.*, Staelens v. Yake, 432 F. Supp. 834, 838 (N.D. Ill. 1977) (physicians were not acting under color of state law in section 1983 action); Holmes v. Silver Cross Hosp., 340 F. Supp. 125, 134-36 (N.D. Ill. 1972) (physicians were acting under color of state law in section 1983 action).

[FN205]. Section 27491 of the California Government Code makes it the duty of the coroner to investigate deaths which are violent, sudden, unusual, unattended, or involve abortion, homicide, suicide, accidental poisoning, accident, drowning, fire, hanging, gunshot, stabbing, cutting, exposure, starvation, acute alcoholism, drug addiction, strangulation, aspiration, sudden infant death syndrome, criminal means, rape, crime against nature, death in prison, deaths due to contagious or occupational diseases, deaths to patients in mental hospitals, etc. *See* CAL. GOV'T CODE § 27491 (West 1978). The coroner has the authority to order an autopsy or other postmortem examination to carry out his duty. *See id.* § 27491.4 (West 1979).

[FN206]. *See id.*

[FN207]. For example, the court in Brophy v. New England Sinai Hosp., 398 Mass. 417, 433, 497 N.E.2d 626, 635 (1986), recognized that interest. The court stated that '[t]he concern for the preservation of the life of the patient normally involves an interest in the prolongation of life.' *Id.*

[FN208]. *See id.* '[W]e must recognize that the State's interest in life encompasses a broader interest than mere corporal existence . . ..' *Id.* The dissent in *Brophy* agreed that '[t]he interest in the preservation consists of at least two related concerns. First, the State has an interest in preserving the life of the particular patient. Second, the State has a closely related interest in preserving the sanctity of all human life.' *Id.* at 443, 497 N.E.2d at 640 (Lynch, J., dissenting).

[FN209]. Use of brain-death criteria solely in organ transplantation 'perpetuates the common misconception that a patient who is dead by neurological criteria is somehow less dead than a patient who is dead by cardiopulmonary criteria.' HASTINGS GUIDELINES, *supra* note 58, at 88. '[D]efinite problems would arise if there were a number of 'definitions' according to which some people could be said to be 'more dead' than others.' Capron & Kass, *supra* note 33, at 106.

[FN210]. The constitutional right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice.

Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 744, 370 N.E.2d 417, 426 (1977).

[FN211]. The economic interests of physicians and hospitals may also be in conflict. The physicians and hospit-

als face the prospect of litigation if they carry out the wishes of the patient and are later sued for malpractice or wrongful death. *See, e.g.*, Davis v. United States, 629 F. Supp. 1 (E.D. Ark.), *aff'd*, 802 F.2d 463 (8th Cir. 1986) (suit against Veterans Administration Hospital under Federal Tort Claims Act for medical malpractice when a Jehovah's Witness refused to receive blood transfusions needed for surgery); Randolph v. City of New York, 117 A.D.2d 44, 501 N.Y.S.2d 837 (1st Dep't 1986), *modified*, 69 N.Y.2d 844, 507 N.E.2d 298, 514 N.Y.S.2d 705 (1987) (suit against physicians, hospital and city for medical malpractice when a Jehovah's Witness died during surgery); Shorter v. Drury, 103 Wash. 2d 645, 695 P.2d 116 (1985) (suit against physician for wrongful death/medical malpractice when a Jehovah's Witness died during surgery). They may also face litigation if they do not carry out the wishes of the patients, such as the tort of wrongful prolongation of life. *See* Oddi, *The Tort of Interference with the Right to Die: The Wrongful Living Cause of Action*, 75 GEO. L.J. 625 (1986).

[FN212]. Currently, the ethical dilemma seems to have disappeared because the medical profession's major responsibility is to carry out the patient's right to determine her own treatment. *See In re* Farrell, 108 N.J. 335, 350-51, 529 A.2d 404, 411-12 (1987).

[FN213]. The courts of thirteen states have approved decisions to forego life-sustaining treatment. *See In re* Drabick, 200 Cal. App. 3d 185, 189 n.1, 245 Cal. Rptr. 840, 841 n.1 (Cal. Ct. App. 1988).

[FN214]. *See In re* Jobes, 108 N.J. 394, 426, 529 A.2d 434, 450 (1987) (court ordered nursing home to withdraw feeding tubes rather than transfer).

[FN215]. *See supra* notes 154-65 and accompanying text.

[FN216]. *See infra* notes 218-45 and accompanying text.

[FN217]. *See infra* notes 239-45 and accompanying text.

[FN218]. *See infra* notes 207-10 and accompanying text.

[FN219]. This is somewhat analogous to the emergency situations where an individual's religious beliefs are overridden to save their lives. *See supra* notes 149-75 and accompanying text.

[FN220]. This assumes that the organ transplantation is in accordance with the individual patient's choice. *See* HASTINGS GUIDELINES, *supra* note 58, at 89-90. It is also considered desirable to sustain a brain dead individual if there is a chance of saving an unborn fetus. *See id.*

[FN221]. There has been controversy, however, over the use of anencephalic newborns as organ donors. *See* Harrison, *The Anencephalic Newborn as Organ Donor*, HASTINGS CENTER REP. Apr. 1986, at 21.

[FN222]. *See* DEFINING DEATH, *supra* note 4, at 1, 7; NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, THE DETERMINATION OF DEATH 11 (Draft Report, Feb. 1986) [hereinafter NEW YORK DETERMINATION OF DEATH DRAFT REPORT]. *But see* NEW JERSEY COMMISSION, PROPOSAL FOR A NEW JERSEY DECLARATION OF DEATH ACT 5 (June 15, 1988) [hereinafter NEW JERSEY PROPOSED DECLARATION OF DEATH ACT].

[FN223]. *See* DEFINING DEATH, *supra* note 4, at 7-8.

[FN224]. *See id.* at 8; *see also* Smith, *supra* note 58, at 874.

[FN225]. *See* UNIF DETERMINATION OF DEATH ACT, 12 U.L.A. 310 (Supp. 1988); CAL. HEALTH &

SAFETY CODE §§ 7181, 7182 (West Supp. 1988) (requiring independent confirmation of another physician).

[FN226]. *See infra* notes 227-38 and accompanying text.

[FN227]. *See* Brennan & Delgado, *Death: Multiple Definitions or a Single Standard?*, 54 S. CAL. L. REV. 1323, 1326 (1981); *see also* Dworkin, *Death in Context*, 48 IND. L.J. 623, 628-32 (1973); Capron, *The Purpose of Death: A Reply to Professor Dworkin*, 48 IND. L.J. 640, 643-46 (1973).

[FN228]. *See supra* notes 99-148.

[FN229]. *See, e.g.*, Delio v. Westchester Co. Medical Center, 129 A.D.2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987) (court allowed the patient's own subjective definition of death to control the treatment decision, despite the fact that Daniel did not meet the current legal definition of death).

[FN230]. *See* NEW YORK DETERMINATION OF DEATH DRAFT REPORT, *supra* note 222, at 6.

[FN231]. *See* Brennan & Delgado, *supra* note 227.

[FN232]. She could succumb to infection or other organs could fail. Those with brain death usually cannot be sustained by mechanical devices longer than two to ten days. *See* F. PLUM & J. POSNER, *supra* note 109, at 225. Children can be sustained for a longer period. *See* DEFINING DEATH, *supra* note 4, at 17.

[FN233]. *See, e.g.*, Strachan v. John F. Kennedy Memorial Hosp., 109 N.J. 523, 538 A.2d 346 (1988). *But see infra* notes 294-99 and accompanying text.

[FN234]. If it was unclear that he wished to donate his organs, the decision could be made by the family or physician as provided in section 2 of the Uniform Anatomical Gift Act. *See* UNIF. ANATOMICAL GIFT ACT, § 2, 8A U.L.A. 34 (1983).

[FN235]. *See infra* notes 249-81 and accompanying text.

[FN236]. This could be handled statutorily as in the case of simultaneous death. *See, e.g.*, UNIF. SIMULTANEOUS DEATH ACT, 8A U.L.A. 557 (1983). The problem could also arise in the case of intestacy. For instance, a family could be seriously injured in a car accident and the parents, and a brother and a sister all put on respirators. The question could possibly arise concerning the time of death. If the parents and the sister did not believe in brain death but the brother did, he could be declared dead and his heirs would be deprived of any intestacy rights if the parents died later without a will. In that case, the sister's heirs would take the whole estate. A court could choose, however, to use a uniform standard for determining time of death in order to divide the estate equitably.

[FN237]. A court could use either the time of the formal brain death determination for both or the time of the actual declaration of death which would differ depending on the individual's religious beliefs. *Cf.* Brennan & Delgado, *supra* note 227, at 1330-44 (defining death in the context of double indemnity life insurance).

[FN238]. The legislature could enact a statute specifying that the time of death would be determined by the time stated in the death certificate. Therefore, it would not be necessary to inquire further about when brain death took place. *Cf.* UNIF. SIMULTANEOUS DEATH ACT, 8A U.L.A. 557 (1983); NEW JERSEY PROPOSED DECLARATION OF DEATH ACT, *supra* note 222; *see also infra* notes 269-72.

[FN239]. For example, federal funding for Medicare and Medicaid increased nearly 600 percent from 1970 to

1983. Medicaid payments increased from $1.9 million in 1972 to $9.8 million in 1981. *See* Patrick, *Honor Thy Father and Mother: Paying the Medical Bills of Elderly Parents*, 19 U. RICH. L. REV. 69, 70 (1984). *See generally* Evans, *Finding the Levers, Finding the Courage: Lessons from Cost Containment in North America*, 11 J. HEALTH POL., POL'Y & L. 585 (1986); Schramm, *A State-Based Approach to Hospital-Cost Containment*, 18 HARV. J. ON LEGIS. 603 (1981).

[FN240]. For example, in 1980, about eighteen percent of Medicare hospital stays involved intensive care or coronary care units. *See* Ruby, Banta & Burns, *Medicare Coverage, Medicare Costs and Medical Technology*, 10 J. HEALTH POL., POL'Y & L. 141, 142 n.7 (1985). In 1978, almost half of Medicare terminal care expenditures occurred in the last two months of life. *See* Fraser, *Medicare Reimbursement for Hospice Care: Ethical and Policy Implications of Cost-Containment Strategies*, 10 J. HEALTH POL., POL'Y & L. 565, 566 (1985).

[FN241]. *See* F. PLUM & J. POSNER, *supra* note 109, at 225.

[FN242]. *See infra* notes 269-72 and accompanying text.

[FN243]. One way states have coped with the increased cost of state-funded health care is to enact family responsibility statutes. *See* Patrick, *supra* note 239, at 69. Another way is to deem the noninstitutionalized spouse's income to be available to the institutionalized spouse. *See* Comment, *Interspousal Income Deeming to Determine Medicaid Eligibility and Governmental Assistance: The Statutory and Constitutional Infirmities*, 49 U. CIN. L. REV. 637 (1980). *But see, e.g.*, Reese v. Kizer, 194 Cal. App. 3d 885, 240 Cal. Rptr. 151 (Cal. Ct. App. 1987), *rev'd*, 46 Cal. 3d 996, 760 P.2d 495, 251 Cal. Rptr 299 (1988) (noninstitutionalized spouse's community property interest in all community property excluded from income of institutionalized spouse); Septuagenarian v. Septuagenarian, 126 Misc. 2d 699, 483 N.Y.S.2d 932 (Fam. Ct., Queens Co. 1984) (noninstitutionalized spouse required to receive support at customary standard of living).

[FN244]. *See infra* notes 269-72 and accompanying text.

[FN245]. In the case of abortions, the United States Supreme Court has held that the state is not obligated to pay for abortions even though this may deter the indigent's woman's choice to abort. *See* Harris v. McRae, 448 U.S. 297, 314 (1980); Maher v. Roe, 432 U.S. 464, 475-76 (1977); *see also* L. TRIBE, *supra* note 132, at 1345-47; Tribe, *The Abortion Funding Conundrum: Inalienable Rights, Affirmative Duties, and the Dilemma of Dependence*, 99 HARV. L. REV. 330, 334-36 (1985).

[FN246]. California, Assembly Bill 3311 introduced by Assembly Member Katz in 1986; New York, Senate Bill 6415 introduced by Senator Levy and Assemblyman Silver and passed by New York Legislature, but not signed into law by Governor Cuomo.

[FN247]. In New York, the bill was actually passed by the Legislature, but it was not signed by Governor Cuomo. In California, although bills were introduced, they were never passed.

[FN248]. *See infra* notes 281-99 and accompanying text.

[FN249]. The New York bill stated in part:

> Life-sustaining decisions. Notwithstanding any other provision of law, no decision or decisions with respect to an individual to commence or terminate life support systems, to refuse to resuscitate, to commence or terminate medical treatment, or regarding organ transplantation shall employ a definition of death that would be contrary to the religious beliefs or practices or moral convictions of such individual.

. . .

S. 6415, 1987-88 Reg. Sess. (1987). The California bill stated in part that '[a]n individual whose heartbeat and respiration are maintained by mechanical means is not dead if a determination of death would violate the religious beliefs or convictions of the individual . . ..' A.B. 3311, 1985-86 Reg. Sess. (1986).

[FN250]. *See infra* notes 281-99 and accompanying text.

[FN251]. *See* DEFINING DEATH, *supra* note 4, at 1, 7; NEW YORK DETERMINATION OF DEATH DRAFT REPORT, *supra* note 222, at 11; *see also supra* notes 222-38 and accompanying text.

[FN252]. NEW JERSEY PROPOSED DECLARATION OF DEATH ACT, *supra* note 222, at 5; *see also infra* notes 253-58 and accompanying text.

[FN253]. The proposed statute was endorsed in principle by a unanimous vote of the twenty-one Commissioners voting in December 1987. The final proposal was formally approved with twenty voting in favor and only two in opposition. *See* NEW JERSEY PROPOSED DECLARATION OF DEATH ACT, *supra* note 222, at 8.

[FN254]. The New Jersey Supreme Court has recognized the brain-death definition. *See* Strachan v. John F. Kennedy Memorial Hosp., 109 N.J. 523, 538 A.2d 346 (1988); *see also supra* notes 66-82.

[FN255]. *See supra* notes 52-60 and accompanying text.

[FN256]. NEW JERSEY PROPOSED DECLARATION OF DEATH ACT, *supra* note 222, at §§ 2, 3.

[FN257]. *Id.* § 3.

[FN258]. *Id.* § 5.

[FN259]. *Id.*

[FN260]. *Id.* § 6(A). 'A person close to the individual,' other than a family member, is described as a 'personal physician, religious leader, or friend.' *Id.*

[FN261]. *Id.* § 6(A). This section also includes 'another responsible person designated for this purpose.' *Id.*

[FN262]. *Id.*

[FN263]. *Id.* The persons to be contacted include 'a family member, personal physician, religious leader, or friend.' *Id.*

[FN264]. *See id.*

[FN265]. *Id.*

[FN266]. The proposed statute is ambiguous on this point. The language used is '[i]f a claim of exemption is reasonably advanced on the individual's behalf under this Act . . ..' *Id.* § 6(B). Section 5 provides that the physician shall not declare death using brain-death criteria if the declaration would violate the individual's beliefs or convictions. *Id.* § 5. Under section 6(B), however, the physician is required not only to 'refrain from discontinuing such individual dead' based on brain-death criteria, but also 'refrain from discontinuing . . . mechanical or other artificial means employed to maintain the individual's circulatory or respiratory functions.' *Id.* § 6(B). The

ambiguity arises because the additional prohibition against discontinuing mechanical devices seems to arise only if an exemption is claimed by the person contacted by the physician. If the physician found an advance directive in the chart, it is not clear that she would similarly have to refrain from discontinuing mechanical devices. Although the 'should have known' language of section 5 seems broad enough to cover the situation, it would probably be more clear if section 6(B) read '[i]f a *physician finds that a declaration of death on the basis of neurological criteria would violate the individual's personal religious beliefs or moral convictions or* a claim of exemption is reasonably advanced on the individual's behalf . . ..'

[FN267]. *See id.* § 6(B).

> If a claim of exemption is reasonably advanced on the individual's behalf under this Act, a physician or other health care provider charged with responsibility for the treatment and care of that individual shall 1) refrain from declaring such individual dead upon the basis of neurological criteria, and 2) refrain from discontinuing, solely upon the basis of the individual's neurological status, mechanical or other artificial means employed to maintain the individual's circulatory or respiratory functions.

Id.

[FN268]. *See id.* § 5.

> The death of an individual shall not be declared upon the basis of neurological criteria pursuant to Sections 3 and 4 of this Act when such a declaration would violate the personal religious beliefs or moral convictions of that individual, and when that fact has been communicated to, or should, pursuant to the provisions of Section 6, reasonably be known by, the licensed physician authorized to declare death.

Id. In such cases, death shall be declared, and the time of death fixed, solely upon the basis of traditional cardiorespiratory criteria pursuant to Section 2 of this Act. *Id.* Proposed statute section 2 states that '[a]n individual who has sustained irreversible cessation of all circulatory and respiratory functions, as determined in accordance with currently accepted medical standards, shall be declared dead.' *Id.* § 2.

[FN269]. *Id.* § 4(D).

[FN270]. *Id.* § 5.

[FN271]. *Id.* § 8.

[FN272]. *Id.*

[FN273]. *See supra* note 253. In late 1988, the proposed statute was introduced by Senator Ambrosio (S. 2659) and Assemblymen Kamin and Schwartz (A.B. 3399).

[FN274]. NEW JERSEY PROPOSED DECLARATION OF DEATH ACT, *supra* note 222, at § 6(A).

[FN275]. *Id.* § 6(A).

[FN276]. *Id.* § 6(B).

[FN277]. *Id.* § 6(A).

[FN278]. *Id.* § 5.

[FN279]. This addition would be placed at the beginning of section 6(B).

[FN280]. *Id.* § 6(A).

[FN281]. Determination of Brain Death, 10 N.Y. COMP. R. & REGS. tit. 10, § 400.16 (1987). This administrative regulation did not originally include a reasonable accommodation section. After the legislature passed a broader version of a reasonable accommodation statute which was not signed by Governor Cuomo, the Department of Health decided to add a reasonable accommodation clause to its regulation. The bill passed the New York legislature in June, 1987; the regulation was promulgated on October 16, 1987. *See supra* note 249. Other legislation requires that a surrogate decisionmaker consider a patient's religious and moral beliefs as part of the decision regarding cardiopulmonary resuscitation. N.Y. PUB. HEALTH LAW §§ 2965(5)(a), S.413-A to -A.678-A (McKinney Supp. 1989) (orders not to resuscitate). In California, a very broad bill was introduced in 1987 prescribing that '[e]very general acute care hospital licensed in the state shall reasonably accommodate the religious beliefs of patients.' A.B. 1390 (introduced by Assembly Member Richard Katz). This bill never made it out of Committee.

[FN282]. *See* 10 N.Y. COMP. R. & REGS. tit. 10, § 400.16(d) (1987).

[FN283]. *Id.* § 400.16(e)(3) (1987). The hospital is also required to include in the policy 1) a description of the test to be employed in making the determination, and 2) a procedure for the notification of the individual's next of kin or other person closest to the individual in accordance with subdivision (d). *See id.* § 400.16(e)(1), (2) (1987).

[FN284]. Although it was suggested that a hospital should be required to specifically ask the person notified if a brain death determination would violate the patient's religious beliefs, this was rejected by the Department of Health. *See* Assessment of Public Comment, Sec. 400.16. This provision is also weaker than the New Jersey proposed statute because a physician is not required to make any independent assessment of whether a brain death determination would violate an individual's religious beliefs or moral convictions. *See infra* notes 292-95 and accompanying text.

[FN285]. The term 'reasonable accommodation' originated in the employment context, when Congress amended the Equal Employment Opportunity Act in 1972. The term 'religion' includes all aspects of religious observance and practice, as well as belief, unless an employer demonstrates that he is unable to reasonably accommodate an employee's or prospective employee's religious observance or practice without undue hardship on the conduct of the employer's business. *See* Equal Employment Opportunity Act of 1972, Pub. L. No. 92-261, § 2(7), 86 Stat. 103, 103 (1982) (codified at 42 U.S.C. § 2000e(j)).

In Trans World Airlines, Inc. v. Hardison, 432 U.S. 63 (1977), the Supreme Court interpreted the reasonable accommodation requirement to mean '[a]ny cost in efficiency or wage expenditures that is more than deminimis constitutes undue hardship.' *Id.* at 84; *see also* Irons, *Religious Discrimination in Employment: Title VII and the Constitution*, 29 J. CHURCH & ST. 253-68 (1987); McConnell, *Accommodation of Religion*, 1985 SUP. CT. REV. 1; Zerangue, *Sabbath Observance and The Workplace: Religion Clause and Title VII's Reasonable Accommodation Rule*, 46 LA. L. REV. 1265 (1986); Note, *Heaven Can Wait: Judicial Interpretation of Title VII's Religious Accommodation Requirement Since* Trans World Airlines v. Hardison, 53 FORDHAM L. REV. 839 (1985); Comment, *The Supreme Court Narrows An Employer's Duty to Accommodate An Employee's Religious Practices Under Title VII*, 53 BROOKLYN L. REV. 245 (1987).

[FN286]. *See* Assessment of Public Comment, Sec. 400.16.

[FN287]. L. TRIBE, *supra* note 132, at 1181. The beliefs are 'adequately religious even if they are not 'acceptable, logical, consistent, or comprehensible'; even if the religious adherent's beliefs are, although sincerely held, not fully developed; and even if the other believers construe and apply the religious tenets differently from the claimant.' *Id.* (citing Thomas v. Review Bd., 450 U.S. 707, 714-15 (1981)).

[FN288]. Assessment of Public Comment, Sec. 400.16.

[FN289]. *See* Welsh v. United States, 398 U.S. 333, 344 (1970) (conscientious objection included 'deeply held moral, ethical or religious beliefs'); United States v. Seeger, 380 U.S. 163, 166 (1965) (conscientious objection includes a sincere belief 'parallel to that filled by the orthodox belief in God').

[FN290]. *See* Hobbie v. Unemployment Appeals Comm'n, 480 U.S. 136 (1987) (a claimant's recent conversion did not alter her eligibility to a free exercise exemption).

[FN291]. In the proposed New Jersey statute, the physician is required to check the available medical records before declaring death or discontinuing mechanical devices. NEW JERSEY PROPOSED DECLARATION OF DEATH ACT, *supra* note 222, § 6(A). Under New York regulations, it would be required only if the hospital determined that this was necessary.

[FN292]. The Department viewed the requirement of reasonable accommodation as 'permissive enough to allow hospitals to deal with unforeseen circumstances.' Assessment of Public Comment, 10 N.Y. COMP. R. & REGS., tit. 10, § 400.16 (1987). The legislation which was the impetus behind the reasonable accommodation clause in the regulation was much more specific concerning the responsibility of the decisionmaker:

> [i]t shall be the duty of any person empowered to make such decision or decisions to use reasonable efforts to determine, from such individual's family member or friend, that such action will not violate such individual's religious beliefs or practices or moral convictions.

S.B. 6415. Also, the legislation was intended to cover not only determinations of death by brain death criteria, but also 'decisions with respect to an individual to commence or terminate life support systems, to refuse to resuscitate, to commence or terminate medical treatment, or regarding organ transplantation . . ..' *Id.* Although this broad legislation was not signed by Governor Cuomo, a similar section has been added to legislation regarding orders not to resuscitate. Specifically Public Health Law section 2965(5)(a) provides that '[t]he surrogate shall make a decision regarding cardiopulmonary resuscitation on the basis of the adult patient's wishes including a consideration of the patient's religious and moral beliefs . . ..' N.Y. PUB. HEALTH LAW § 2965(5)(a) (McKinney Supp. 1989).

[FN293]. Senate Bill 6415 required that the 'friend' be 'any person who maintained such regular contact with such individual as to be familiar with his activities, health, religious beliefs or practices or moral convictions . . ..' *Id.*

[FN294]. This case scenario assumes that there is no advance directive in the form of a living will or durable power of attorney. *See supra* note 100.

[FN295]. There is little chance that the physician or hospital would be liable for wrongfully prolonging the patient's life. *See* Oddi, *supra* note 211, at 625.

[FN296]. *See supra* notes 134-48 and accompanying text.

[FN297]. *See supra* note 211.

[FN298]. For instance, it is possible to identify some Orthodox sects by their distinctive dress or appearance. Also, it may be easy to ascertain whether it is a Jewish holiday when Orthodox Jews would not carry identification.

[FN299]. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 7151.6 (West Supp. 1988); *see also supra* note 198.

The seventy-two-hour period is to account for the possibility that some Jewish holidays would span that period. Some holidays occur on Thursday and Friday and then Saturday would be the Jewish Sabbath. In those cases, an Orthodox family could not be reached by telephone as use of the telephone is prohibited on those days.
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