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New Jersey Policy on Advance Directives and Options for the Future

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ISSUE BRIEF

As advancements in life-sustaining medical technology have lengthened the lifespan of the average American, the lives of many now extend into their later years, when age or illness can diminish their ability to make decisions for themselves. The use of an advance directive is one way to ensure that in such cases, the individual maintains some level of control over his or her care.

This brief will highlight the purpose and background of advance directives, including discussion of their history, the current New Jersey law governing them, and a comparison of New Jersey policy to that of other states. Finally, some current initiatives will be described in addition to some options as to how New Jersey lawmakers may be able to increase and improve advance care planning among New Jersey residents.

What is an Advance Directive?

An advance directive is an order issued by an individual that is intended to govern their own medical care should he or she become unable to participate in the decision-making process due to serious illness or incapacity. It is a general term that describes the use of living wills, durable powers of attorney for health care, or a combination of both. A living will is a document in which an individual states the kind of health care he or she wants or does not want under certain circumstances. A durable power of attorney for health care differs from a living will in that rather than provide explicit instructions, this legal document allows an individual to appoint someone else to make decisions about his or her medical care if he or she is unable to communicate their own wishes.

Why an Advance Directive?

Advance directives help ensure that an individual will maintain some control in his or her post-competence care, particularly in situations where a patient's condition is irreversible or death is imminent. Additionally, advance directives provide guidance to the ultimate decision-makers and help mitigate any anxiety, uncertainty or conflicts that might arise during the decision-making process. This is especially significant when that decision is whether or not to withdraw life-sustaining treatment.

Advance directives are also beneficial to physicians and health care providers, as they would have the authority to provide more palliative care rather than feel obligated to continue potentially painful and invasive treatment, in a medically futile situation.

A Brief History of Advance Directive Law

Advance directive law in the United States got its jumpstart in the 1960s, when living wills were conceived as a mechanism for dictating post-competency medical care, when people began to realize that innovation in medical technology, while leading to longer lives, took a great financial, physical, and emotional toll on those past the hope of recovery.[1]

Two legal rulings also paved the way for advance directive law. The New Jersey Supreme Court's 1976 ruling in the case of Karen Quinlan established an individual's right to refuse life-sustaining treatment and allowed for a proxy

to refuse life sustaining-treatment on the patient's behalf in the event that the patient loses the ability to communicate.[2] Following this ruling, states began enacting legislation permitting people to put their post-competency treatment preferences in writing. The United States Supreme Court reaffirmed the *Quinlan* decision in 1990 when, in the case of *Cruzan v Missouri*, it ruled that families could decide to forgo life-sustaining treatment as long as such a decision was based on an understanding of the patient's own wishes.[1]

The federal response to the Cruzan case was the *Patient Self-Determination Act* of 1991, which required hospitals to confirm at admission whether patients have an advance directive as well as confirm that patients are educated on their rights in this regard. Congress defined an advance directive as a written instruction, such as a living will or durable power of attorney for health care, recognized under state law relating to the provision of such care when the individual is incapacitated.[3] While this law encouraged the completion of advance directives, it allowed individual states to determine the details, administration, requirements, and restrictions of such documents. The result is significant variation in state policies relating to advance directives and the right to govern one's own medical care.

New Jersey Advance Directive Policy

New Jersey has been, and continues to be, one of the most progressive states in supporting a patient's autonomy, as well as the right of the surrogate to make decisions on the patient's behalf.[4] In 1991, Governor James Florio signed the *New Jersey Advance Directives for Health Care Act*, which protects an individual's right to dictate his/her medical treatment. This law has been deemed model legislation because it provides broad parameters for competent persons to shape post-competence medical intervention.[5]

Key Elements of the NJ Statute[6]

- The allowance for both a living will & a durable power of attorney for health care,
- The flexibility of the decision-makers to deviate from the terms of an advance directive when appropriate, provided that they "exercise reasonable judgement to effectuate the patient's wishes, giving full weight to the terms, intent and spirit of the instruction directive",
- A relatively low evidentiary threshold, with provisions allowing for withholding of treatment in a number of situations, including those in which the treatments are experimental or will only prolong the dying process,
- The authorization for any adult over 18 to execute an advance directive, which must be signed by two witnesses and a notary,
- The allowance for revocation of the advance directive at any time through oral or written notification.

In addition to the above, the New Jersey law includes provisions for how to proceed in the event that conflict arises between family members, or between the designated surrogate and medical staff. In the event of disagreement, the interested parties may seek to resolve the conflict through the policies set forth by the health care facility, such as an ethics committee and someone designated by the institution to intervene in such circumstances. If the situation remains unresolved, the issue may be taken up by the courts. If a health care institution refuses to withhold or withdraw treatment (for instance, on the grounds of religious objection or personal reasons), it has the right to do so. However, the facility must ensure that the patient is transferred to a place where his or her preferences will be honored.

What Makes New Jersey Advance Policy Unique?

While all fifty states have laws that facilitate the use of advance directives – although two, Massachusetts and Michigan, do not legally acknowledge living wills, all recognize health care proxies – the lack of guidance offered in the *Patient Self-Determination Act* has resulted in a variation among states' approaches towards advanced directives.

Examples of State Variations

- The evidentiary threshold: While New Jersey's threshold to cease intervention is relatively low, some states have much higher thresholds,
- The specific language or forms that must be used in preparing an advance directive,
- Whether or not a witness or notary must be present when drafting the document,
- The withdrawal of medical intervention in pregnant patients: Only New Jersey, Florida, Maryland and Wisconsin allow for the withdrawal of life support in such cases,
- The method, whether oral or in writing, in which modifications to the advance directive can be made,
- The response to situations in which there are no instructions or named health care proxy.

In an attempt to establish more uniformity across states, and ultimately increase the likelihood that an individual's wishes will be honored regardless of where treatment is received, a number of states have enacted the *Uniform Health Care Decisions Act*.[7] This act standardizes documentation as well as the responses to a number of the other situations mentioned above.

The Future of Advance Directive Policy in New Jersey

The still resonant case of *Terry Schiavo* [1] has created an ideal opportunity to refine state advance directive policies. New Jersey lawmakers and advocates have responded to this opportunity with a renewed effort to strengthen the current approach toward advance planning and end-of-life care.

New legislation has been introduced, though to date none has come to a vote. One bill, *S2519*, would require offices to provide marriage license applicants with a book on advance directives, while yet another, *S2520* (of which an identical bill existed in the NJ State Assembly, *A4217*), would require judges in divorce, and in termination of domestic partnership actions, to inquire whether the parties involved want to change or revoke a previously drafted advance directive. Both of these bills have, however, stalled as of this writing. In the meantime, lawmakers are considering other initiatives to create more awareness, usage, and implementation of advance directives.

Future recommendations are clearly intended to not only increase the number of New Jerseyans who complete advance directives, but to also encourage people to openly discuss their treatment options with their family and providers so that an advance directive can be more meaningful and effective in governing care, should its execution become necessary.

Policy Options

Historically, New Jersey has been a leader in advance care planning. And while an adequate statutory structure may be in place, the challenge for policymakers is to educate the public on their options. In order to increase and improve advance care planning in New Jersey, a collaborative effort between lawmakers,

advocates, physicians, and individuals, and state agencies will be necessary. This could include community outreach and public awareness campaigns designed to address an issue, end-of-life care, that most people are reluctant to discuss.

The state could also use a regulatory approach (e.g., physician payment reform, palliative care licensing requirement) to promote dialogue between patients and physicians. This would increase the likelihood that a patient will utilize an advance directive, as well as the likelihood that a patient's final wishes are honored should the enactment of an advance directive become necessary.

References

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Endnotes

[1] Terry Schiavo was in a persistent vegetative state while her husband and parents fought over whether or not to have her feeding tube removed. The conflict gained national attention and Congress tried to intervene in the matter after the courts ordered the tube removed. Eventually, the tube was removed and she died in the days following.

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