MARTIN KANE KUPER
ATTORNEYS AT LAW

JAMES D. MARTIN[1234]
JOHN J. KANE[123]
ERIC KUPER[3]
JOHN W. HARDING[1]

JOHN F. GILLICK
DANA E. McDADE*
TODD DRAYTON*

*of Counsel*
ROBERT T. QUACKENBOSS

*Counsel*
ROBERT J. ZULLO, JR.*°
PETRA VAVRA

Certified by the Supreme Court of NJ as a Civil Trial Attorney[1]
Certified by the National Board of Trial Advocacy as a Civil Trial Lawyer[2]
Certified by the American Board of Trial Advocates as a Civil Trial Lawyer[3]
Fellow of the American College of Trial Lawyers[4]

NJ & PA Bar*
NJ & FLA Bar*
LLM Taxation°

September 9, 2009

**VIA LAWYER'S SERVICE**

Joseph H. Orlando, Esq.
Clerk, Appellate Division
Superior Court of New Jersey
25 West Market Street
Trenton, NJ 08625-0006

**RE: Jacqueline Betancourt v. Trinitas Hospital**
**Docket Number A-003849-08 T2**

Dear Mr. Orlando:

Enclosed for filing, please find an original and five copies of the brief of Thaddeus M. Pope, who was granted leave to appear as *Amicus Curae* in the above-referenced matter in an Order dated September 4, 2009 (attached hereto for your immediate reference), along with accompanying Certification of Service.

I ask that you kindly file same and return a stamped copy, marked "Filed," to my attention in the enclosed, postage paid envelope.

In addition, I understand that Mr. Pope's motion to appear in this matter, *Pro Hac Vice*, has been conditionally denied until such time as he provides a Certificate of Good Standing. Please be advised that same has been requested from the California Bar and will be provided as soon as it is received.

If you have any questions with regard to the foregoing, please do not hesitate to contact me. Your courtesy and cooperation is appreciated.

Respectfully submitted,

TODD DRAYTON

Enclosures
cc: All parties


180 Tices Lane, Building B, Suite 200 • East Brunswick, NJ 08816 • 732.214.1800 • 732.214.0307-fax
www.MartinKaneKuper.com

A -3849-08T2

ORDER ON MOTION

JACQUELINE BETANCOURT
VS
TRINITAS HOSPITAL

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A -003849-08T2
MOTION NO. M -007109-08
BEFORE PART: W
JUDGE(S): PAYNE
WAUGH

MOTION FILED: AUGUST 12, 2009 BY: JACQUELIN E BETANCOURT
ANSWER(S) FILED:

FILED
APPELLATE DIVISION
SEP 04 2009
CLERK

SUBMITTED TO COURT: AUGUST 31, 2009

O R D E R

THIS MATTER HAVING BEEN DULY PRESENTED TO THE COURT, IT IS ON THIS
1st DAY OF September, 2009, HEREBY ORDERED AS FOLLOWS:

| | GRANTED | DENIED | OTHER |
|---|---|---|---|
| MOTION BY RESPONDENT | | | |
| - TO APPEAR PRO HAC VICE (1) | (X) | ( ) | ( ) |
| - TO APPEAR AS AMICUS CURIAE (2) | ( ) | (X) | ( ) |

SUPPLEMENTAL:

(1) Denied unless certificate of good standing is provided
(2) Granted

RECEIVED
APPELLATE DIVISION
SEP 04 2009
SUPERIOR COURT
OF NEW JERSEY

UNN C-12-09

FOR THE COURT:

JUDLK

I hereby certify that the foregoing is a true copy of the original on file in my office.
CLERK OF THE APPELLATE DIVISION

EDITH K. PAYNE J.A.D.

## CERTIFICATION OF SERVICE

I hereby certify that the original and five (5) copies of the Brief of *Amicus Curae*, Law Professor, Thaddeus Mason Pope have on this date been forwarded to the Clerk of the Appellate Division for filing. I further certify that I have forwarded two (2) copies of same, also via Lawyers Service, to the below parties to this matter:

**Gary Riveles, Esq.**
Dughi & Hewit, PC
340 North Avenue
Cranford, NJ 07016

**Honorable John Malone, J.S.C.**
Union County Superior Court
Chancery Division
2 Broad Street
Elizabeth, NJ 07207

**Larry Loigman, Esq.**
110 Highway 35
Middleton, NJ 07748

**Steven I. Kern, Esq.**
Kern, Augustine, Conroy & Schoppmann, P.C.
1120 Route 22 East
Bridgewater, NJ 08807

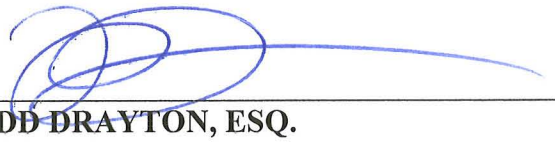
**John Jackson, Esq.**
Kalison, McBride, Jackson & Murphy
25 Independence Boulevard
Warren, NJ 07059

**Anne Studholme, Esq.**
23 Madison Street
Princeton, NJ 08542

**Rebecca M. Urbach, Esq.**
Assistant General Counsel
Greater New York Hospital Association
555 West 57th Street, 15th Floor
New York, NY 10019

I hereby certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made me are willfully false, I am subject to punishment.

**Martin, Kane & Kuper**
Attorneys for Plaintiff/Respondent



**TODD DRAYTON, ESQ.**

Dated: September 9, 2009

| | |
|---|---|
| **JACQUELINE BETANCOURT,**<br>**On behalf of**<br>**RUBEN BETANCOURT,**<br><br>**Plaintiff/Respondent,**<br><br>**vs.**<br><br>**TRINITAS HOSPITAL,**<br><br>**Defendant/Appellant.** | SUPERIOR COURT OF NEW JERSEY<br>APPELLATE DIVISION<br>DOCKET NO: A-003849-08T2<br><br>CIVIL ACTION<br><br>On Appeal from a Final Decision of<br>the Superior Court of<br>New Jersey, Chancery Division<br>Docket No. UNN-C-12-09<br><br>Sat Below: Hon. John F. Malone, J.S.C. |

---

**BRIEF OF *AMICUS CURIAE*,**
**LAW PROFESSOR THADDEUS MASON POPE**

---


WIDENER UNIVERSITY SCHOOL OF LAW
4601 Concord Pike
Wilmington, Delaware 19803
(302) 477-2230 Telephone
(901) 202-7549 Facsimile
*Attorney for Amicus Curiae, Professor Pope*

On the Brief: Professor Thaddeus M. Pope
and Of Counsel *Pro hac vice application pending*

MARTIN KANE & KUPER
180 Tices Lane, Building B, Suite 200
East Brunswick, New Jersey 08816
(732) 214-1800 Telephone
(732) 545-4780 Facsimile
*Attorney for Plaintiff/Respondent*

Of Counsel: Todd Drayton, Esq.

## TABLE OF CONTENTS

## TABLE OF AUTHORITIES

### CASES

**STATUTES**



**ADMINISTRATIVE REGULATIONS**



**OTHER PUBLICATIONS AND AUTHORITIES**

## INTEREST OF THE AMICUS CURIAE

This Brief is submitted on behalf of law professor Thaddeus Mason Pope, J.D., Ph.D. Thaddeus Pope is a law professor and a member of the Health Law Institute at the Widener University School of Law in Wilmington, Delaware.

In his professorial capacity, Professor Pope has extensive experience and expertise in key issues before this Court: medical futility and end-of-life disputes. His input on these issues has previously been solicited from the President's Council on Bioethics, as well as from the New Jersey Department of Health ,and the New Jersey Office of the Ombudsperson for the Institutionalized Elderly. He is also an active participant with the New Jersey Long Term Care Regional Ethics Committee system.

Professor Pope has published six lengthy law review articles and more than ten peer-reviewed bioethics and medical journal articles analyzing the issue of medical futility. These articles are cited in leading treatises on end-of-life healthcare law, and are reprinted in law school casebooks on bioethics and the law. Notably, Defendant/Appellant's *Amici* devote nearly twenty-five lines of

their brief citing and discussing some of Professor Pope's articles. [NJHA Br. at 24, 25, 38, 47, 57, 58]

Professor Pope has made numerous presentations on medical futility for bar associations, public and private hospitals, and academic and professional conferences. And he has consulted with hospitals, often as the member of the ethics committee, about drafting institutional policies addressing how to resolve medical futility conflicts.

*Amicus* believes that his expertise will assist the Court in resolving the matter before it, by providing the legal context within which to analyze the facts and issues of this case. This is particularly appropriate in cases with "broad implications," Taxpayers Ass'n of Weymouth Twp., Inc. v. Weymouth Twp., 80 N.J. 6, 17 (1976), and in cases of "general public interest." Casey v. Male, 63 N.J. Super. 255, 259 (Co. Ct. 1960). This is just such a case.

## PRELIMINARY STATEMENT

Defendant/Appellant and its *Amici* audaciously ask this Court for a novel and revolutionary ruling that they candidly admit constitutes whole-cloth legislation from the bench. While this is generally inappropriate, it is especially unwarranted here, where: (1) the trial court record is thin and too narrowly focused to ground the broad new rule advocated by Defendant/Appellant; (2) no authority supports the Defendant/Appellant's position; and (3) significant authority directly contradicts and prohibits Defendant/Appellant's position.

**1. The Disputed Treatment Is Within the Standard of Care.** The limited facts of this matter do not support the result petitioned by Defendant/Appellant, most obviously because Defendant/Appellant has already failed, before the trial court, to establish that the disputed treatment in this matter was outside the standard of care. Substantial evidence supports the trial court's finding, and that determination cannot be re-litigated on appeal. Therefore, even if there were a principle that healthcare providers could unilaterally refuse requested life-sustaining treatment

outside the standard of care, any such rule would have no application or relevance to this case.

**2. Any Treatment Refusal Right Is Conditioned on Transferring the Patient.** Not only does the "unilateral refusal right" sought by Defendant/Appellant have no basis in the facts of this case, but it is also plainly forbidden by New Jersey law. Once a New Jersey healthcare provider enters into a treatment relationship with a patient (as Trinitas Hospital did with Ruben Betancourt), the healthcare provider's right to refuse treatment is carefully circumscribed and limited by bright lines.

Specifically, both New Jersey administrative regulations and appellate precedent expressly condition the right to refuse critically needed treatment upon actual transfer of the patient to a new substitute/replacement provider. Otherwise, these authorities recognize, the patient would be abandoned; and that would be abhorrent.

**3. The New Jersey Advance Directives Act Is Irrelevant.** Defendant/Appellant's *Amici* themselves recognize that the New Jersey

Advance Directives "does not control or directly apply to this appeal." Because Mr. Betancourt did not have an advance directive, the Act is simply not relevant to this case. Moreover, even if the Act had any application to this case, it only confirms the position of Plaintiff/Respondent, that the withholding and withdrawal of life-sustaining treatment is ultimately the choice of the patient.

**4. Jacqueline Betancourt Is the Appropriate Guardian.** The trial court's appointment of Jacqueline Betancourt as guardian for her father was appropriate. Jacqueline and her father were very close. She had a substantial basis to exercise substituted judgment. And Jacqueline's treatment decisions for her father were supported by her entire family. Any potential conflict, here, is hardly sufficient to dismiss the guardian.

**5. Statutory and Supreme Court Authority Forbid the Judicial Creation of a New Internal Dispute Resolution Mechanism Making the Hospital's Own Ethics Committee a Forum of Last Resort.**

Erroneously assuming that there is a right to unilaterally refuse life-sustaining treatment (before effecting transfer), Defendant/Appellant and

its *Amici* ask this Court to give them sole power to determine when they may legitimately exercise such a right. They want this Court to create an internal dispute resolution mechanism, by which hospital providers can, single-handedly, determine when requested treatment falls outside the standard of care and, with legal immunity, withdraw life-sustaining treatment over the objections of the patient and/or his family. In essence, Defendant/Appellant wants this Court to appoint the fox to guard the henhouse.

This is forbidden, inappropriate, and dangerous. ***First***, ethics committees in New Jersey were only intended as informal mediators, not as adjudicators. ***Second***, the record in this case contains no evidence on how such a mechanism could or should work. Indeed, the evidence suggests that Trinitas Hospital has a serious conflict of interest due to financial and liability concerns. The longer Mr. Betancourt stayed at Trinitas, the more it would cost the hospital. Especially in these circumstances, the Court ought not repose trust and decision making authority in hospitals. ***Third***, if such a dramatic step were to be taken, it would require extensive and detailed safeguards, and is a step for the Legislature to take.

## PROCEDURAL HISTORY

Jacqueline Betancourt commenced this matter in Union County Superior Court, Chancery Division, by a Verified Complaint on January 21, 2009. [Def/App Appx. at 1a to 5a][1] Because Trinitas Hospital had indicated its plan to unilaterally withdraw life-sustaining medical treatment from her father, Ruben Betancourt, Jacqueline sought an Order requiring the hospital to continue that treatment.

After an initial hearing on January 22, 2009, on January 23, 2009, Judge John F. Malone signed an Order to Show Cause, ordering the hospital both to continue providing treatment and to resume dialysis treatment that had been discontinued. [Def/App Appx. at 9a to 10a]

The Verified Complaint was subsequently supported by the Affidavit of Carl S. Goldstein, M.D., a physician not affiliated with Trinitas Hospital. [Def/App Appx. at 6a to 8a] The hospital submitted certifications from several physicians affiliated with the hospital. [Def/App Appx. at 11a to 30a]

1. "Def/App Appx." refers to the materials in the Appendix to the Opening Brief of Defendant/Appellant Trinitas Hospital.

On February 10, 2009, the Court issued a further Order, restraining the hospital from "discontinuing or suspending any treatment" from Mr. Betancourt until an evidentiary hearing. [Def/App Appx. at 42a to 43a] .

On February 17 and 23, 2009, the Court heard testimony from fact witnesses and medical experts. On March 4, 2009, the Court rendered a written decision: (1) appointing Jacqueline Betancourt as guardian, and (2) requiring Trinitas Hospital to continue the life-sustaining treatment. [Def/App Appx. at 44a to 51a] On March 20, 2009, the Court issued a Final Order consistent with its written decision. [Def/App Appx. at 52a to 53a] While Mr. Betancourt died on May 29, 2008, the hospital has proceeded with this appeal, filing its opening merits brief on June 1, 2009.

## STATEMENT OF FACTS

In January 2008, Ruben Betancourt was admitted to Trinitas Hospital for surgery to remove a tumor in his thymus gland. [Def/App Appx. at 44a] In connection with this surgery, Mr. Betancourt was post-operatively placed on a ventilator. But while in the ICU, Mr. Betancourt's endo-tracheal (breathing) tube was dislodged, resulting in anoxic encephalopathy (the lack of oxygen to his brain) and severe brain damage. [Def/App Appx. at 44a] Mr. Betancourt was subsequently admitted to various healthcare facilities in New Jersey.

On July 3, 2008, Mr. Betancourt was readmitted to Trinitas Hospital with a diagnosis of renal failure. [Def/App Appx. at 45a] While Mr. Betancourt's prospects for recovery were slim, he was being sustained by a mechanical ventilator, dialysis, and a feeding tube. [Def/App Appx. at 45a] Defendant/Appellant's own experts admitted that these interventions were working effectively. [Feb. 17, 2009 Tr. at 25:11-5, 53:14-22, 116:8-9, 122:12-13; Feb. 23, 2009 Tr. at 72:1-4] And Defendant/Appellant's own experts agreed that the disputed intervention (dialysis) would continue working to sustain Mr. Betancourt for months or even years. [Feb. 17, 2009 Tr. at 54:22-

25, 66:1-4, 71:17-72:3; Feb. 23, 2009 Tr. at 97:8-11] Indeed, it did work effectively for over a year.

Mr. Betancourt's family, exercising substituted judgment, determined that he would want to be sustained on his then-current treatment. Accordingly, the family instructed healthcare providers to maintain that treatment. Nevertheless, hospital representatives informed Mr. Betancourt's family that his life support should be discontinued, even without his consent and even though that would result in his death. [Def/App Appx. at 45a]

Unable to convince the family that continued treatment was not the right choice for Mr. Betancourt, the hospital unsuccessfully tried to transfer him to another facility. [Def/App Br. at 21] When it then became apparent that providers might unilaterally withdraw Mr. Betancourt's life-sustaining treatment, Mr. Betancourt's daughter, Jacqueline Betancourt, initiated this action by Order to Show Cause and Verified Complaint, on January 21, 2009. [Def/App Appx. at 5a]

## LEGAL ARGUMENT

### POINT I

### THE TRIAL COURT HAS ALREADY DETERMINED THAT THE REQUESTED TREATMENT IS WITHIN THE STANDARD OF CARE, AND ITS WELL-SUPPORTED FACTUAL FINDING CANNOT BE RELITIGATED ON APPEAL.

Defendant/Appellant and its *Amici* devote a substantial portion of their briefs to contending that dialysis for Ruben Betancourt is outside the standard of care. [Def/App Br. at 14-22] But the trial court, after hearing from the medical fact and expert witnesses for both parties, determined that the treatment requested for Mr. Betancourt was ***within*** the standard of care. That factual determination cannot be re-litigated on appeal. State v. Locurto, 157 N.J. 463, 470-71 (1999); In re Jobes, 108 N.J. 394, 409 (1987); Rova Farms Resort, Inc. v. Investors Ins. Co., 65 N.J. 474, 484 (1974).[2]

---

2. ("'[W]e do not disturb the factual findings and legal conclusions of the trial judge unless we are convinced that they are so manifestly unsupported by or inconsistent with the competent, relevant and reasonably credible evidence as to offend the interests of justice.'") (quoting Fagliarone v. Twp. of N. Bergen, 78 N.J. Super. 154, 155 (App. Div. 1963)). Deference is particularly important where, as in the present case, "'the evidence is largely testimonial and involves questions of credibility.'" Cesare v. Cesare, 154 N.J. 394, 401-02 (1998) (quoting In re Return of Weapons to J.W.D., 149 N.J. 108, 117 (1997)).

## A. THE TRIAL COURT FOUND THAT THE REQUESTED TREATMENT WAS WITHIN THE STANDARD OF CARE.

Defendant/Appellant's *Amici* contend the trial court "entirely avoided the issue" because it framed the ultimate question in terms of whether the guardian had the right to make the decision to continue treatment. [NJHA Br. at 2-3] But the trial court clearly addressed the standard of care question as an element of the guardianship issue.

After receiving affidavits from hospital-affiliated experts at the initial hearing on January 22, 2009, the trial judge specifically asked Plaintiff/Respondent to present opposing medical expert evidence. [Jan. 22, 2009 Tr. at 9:6-8, 26:10-14] The trial court clearly understood that one factor in determining the appropriateness of the guardian appointment was whether the treatment being requested by the applicant guardian, Jacqueline Betancourt, was within the standard of care. [Jan. 23, 2009 Tr. at 23:19-24:4 ("[T]o answer the question ultimately as to what needs to be done, the Court needs to be able to determine if . . . treatment is inappropriate against the standard of care . . . .")]

Moreover, in its written decision, the trial court separately addressed "the appointment of a guardian" issue and the issue of whether the guardian "is authorized to make [the disputed] decisions respecting medical treatment." [Def/App Appx. at 51a]

## B. THE TRIAL COURT'S FINDING ON STANDARD OF CARE IS SUBSTANTIALLY SUPPORTED BY THE EVIDENCE.

There is substantial evidence supporting the trial court's determination that the guardian-requested treatment was within the standard of care. The only neutral and independent expert [Feb. 23, 2009 Tr. at 42:3-5], Dr. Goldstein, testified (as quoted by the trial court) that "dialysis treatments were appropriate for Mr. Betancourt." [Def/App Appx. at 46a] "His current plan of care . . . comports in every way with the prevailing standards of care." [Feb. 23, 2009 Tr. at 45:14-17; Def/App Appx. at 8a][3]

There was a substantial basis for the trial court to credit Dr. Goldtsien's testimony over Defendant/Appellant's experts. First, Defendant/Appellant's experts were less credible because they submitted cookie cutter affidavits,

3. See also Feb. 23, 2009 Tr. at 46:6-17, 47:3-6.

saying the same thing with the same language. [Def/App Appx. at 11a to 30a; Feb. 23, 2009 Tr. at 105:17-22]

Second, the dispute focused on the continuation of dialysis; yet only two nephrologists testified. Plaintiff/Respondent's expert, Dr. Goldstein, has been board certified and practicing nephrology for 25 years. [Feb. 23, 2009 Tr. at 42:3-12] Defendant/Appellant's expert has been practicing nephrology for only eight years and is ***not*** board-certified in nephrology. [Feb. 23, 2009 Tr. at 65:3-10, 72:24-73:6]

Third, and perhaps most importantly, all of Defendant/Appellant's experts suffered from a serious conflict of interest. They were all employed by or strongly affiliated with Trinitas Hospital. [Feb. 23, 2009 Tr. at 92:5-10][4] The hospital, in turn, has a serious conflict of interest in this case. As the cost of Mr. Betancourt's treatment was approaching nearly $2 million, the hospital realized that it would be able to recover only a portion from Medicare. [Jan. 22, 2009 Tr. at 10:23-11:2 ("[T]here may be other . . .

4. See also Feb. 17, 2009 Tr. at 7:9-11, 51:25-52:1, 62:8-16, 77:9-20, 112:25-113:3, 126:17-22; Feb. 23, 2009 Tr. at 72:14-16, 104:16-21.

economic motivation. There is a sizable medical bill that remains unpaid.")]

Apart from the prospect of non-reimbursable expenses, Defendant/Appellant itself notes that Mr. Betancourt's brain damage, resulting from post-surgical self-extubation, was likely the result of medical malpractice. [Def/App Br. at 23 ("Ms. Betancourt intends to file a lawsuit against Trinitas Hospital for the event which caused the anoxic injury.")][5] The hospital had a financial motivation to mitigate its damages by shortening Mr. Betancourt's life.6

Highlighting and accentuating the untrustworthiness of Defendant/Appellant's experts was the hospital's outrageous act of secrecy and duplicity in removing Mr. Betancourt's dialysis tube, directly in advance of the initial trial court hearing. [Jan. 22, 2009 Tr. at 5:16-7:3, 18:5-19:20; Feb. 23, 2009 Tr. at 108:9-12]

---

5. See also id. at 25; Feb. 17, 2009 Tr. at 10:24-11:3; Feb. 23, 2009 Tr. 35:23-25.

6. Hospital ethics committees are often materially motivated by financial and liability concerns. See Thaddeus Mason Pope, "Multi-Institutional Ethics Committees: The Procedurally Fair Internal Dispute Resolution Mechanism," 31 Campbell L. Rev. 257, 275-85 (2009). It is inappropriate for a hospital's own ethics committee to decide on removing treatment under such circumstances. In re Torres, 357 N.W.2d 332 (Minn. 1984).

Furthermore, the evidence on standard of review was not all that sharply divided. Some of Defendant/Appellant's ***own experts*** testified that while they might not recommend dialysis for a patient like Mr. Betancourt, they would respect a patient or family request for dialysis because "it's a personal decision." [Feb. 17, 2009 Tr. at 118:12-19] This was largely Dr. Goldstein's reasoning. [Feb. 23, 2009 Tr. at 58:15-59:1 ("I may have held an opinion that dialysis was futile and a family member represented their interest to continue and I respected that opinion, that request.")][7]

## C. DEFENDANT/APPELLANT AND ITS *AMICI* CONCEDE THAT THEY CANNOT ESTABLISH THE DISPUTED TREATMENT IS OUTSIDE THE STANDARD OF CARE.

Defendant/Appellant concedes that there is "considerable debate within the medical community" over how to define medical futility. [Def/App Br. at 17; see also Jan. 23, 2009 Tr. at 16:23-17:1 ("[B]ecause it's such a value, based on values, and its really impossible to find a definition.")] Its *Amici* similarly concede that "there has been ***no agreement*** on how to define

7. See also id. at 55:2-7, 56:21-24, 59:21-60:2; Timothy E. Quill et al., "Discussing Treatment Preferences with Patients Who Want 'Everything,'" 151 Annals of Internal Med. 345, 348 (2009) ("Some patients and families may value life extension . . . the clinician should honor the patient's philosophy . . . .").

medical futility." [NJHA Br. at 21 (emphasis added)] "There is ***disagreement*** about how high a degree of expected functioning is required before the treatment will be considered not futile." [NJHA Br. at 21 (emphasis added)]

Indeed, consensus has been reached in only two situations: brain death and physiological futility. If the patient is dead under state law or if the proposed treatment has zero chance of producing its intended effect on the patient, then the treatment need not be provided. Thaddeus Mason Pope, "Medical Futility Statutes: No Safe Harbor to Unilaterally Refuse Life-Sustaining Treatment," 75 Tenn. L. Rev. 1, 26-31 (2007).

Neither of those situations applies here. Mr. Betancourt was alive and the dialysis treatments worked. This is not even the sort of last-ditch situation in which a patient asks for third-line chemotherapy with a vanishingly small chance of prolonging life. The disputed intervention, here, was successfully prolonging, and was expected to continue prolonging, Mr. Betancourt's life. Cf. Causey v. St. Francis Medical Center, 719 So. 2d 1072, 1074 (La. App. 1998) ("[I]f a physician can keep the patient alive, such care is not medically

or physiologically 'futile.'"). Dialysis was ***effective***. The dispute in this case concerns not medicine, but ethics: whether Mr. Betancourt's quality of life was such that effective treatment was ***worthwhile***.

Defendant/Appellant's *Amici* cite the same article by Professor Pope for the abstract proposition that "health professionals have a right to discontinue care when its continuation is contrary to accepted professional standards." [NJHA Br. at 25] But they fail to note the fundamental thesis of the article (as suggested by its title): that this is an "empty right" because there actually are no "accepted" professional standards regarding life-sustaining medical treatment.

The absence of a standard of care concerning end-of-life treatment has been carefully documented in the widely-respected Dartmouth Atlas. Dartmouth Institute for Health Policy and Clinical Practice, Tracking the Care of Patients with Severe Chronic Illness: The Dartmouth Atlas of Health Care 2008, available at http:www.dartmouthatlas.org. In fact, this report identified New Jersey as providing the most aggressive end-of-life treatment

in the United States. While some providers may think it inappropriate,[8] many New Jersey physicians and hospitals regularly provide just the type of treatment that Defendant/Appellant argues is outside the standard of care.[9]

Defendant/Appellant's *Amici* point out the ongoing federal legislative and regulatory emphasis on comparative effectiveness and efforts to reduce healthcare spending at the end of life. [GNYHA Br. at 19-20] But this only serves to highlight the fact that, right now, aggressive end-of-life treatment is regularly provided (especially in New Jersey) to chronically critically ill patients. It is the standard of care.

Desperate to demonstrate that Mr. Betancourt's guardian-requested treatment was outside the standard of care, Defendant/Appellant's *Amici*

---

8. A Dartmouth Atlas hospital performance report for New Jersey indicates that Trinitas provides less aggressive end-of-life treatment than many other New Jersey hospitals. Dartmouth Institute for Health Policy and Clinical Practice, Performance Report for Chronically Ill Beneficiaries in Traditional Medicare: All Hospitals in HRRs Containing New Jersey Hospitals, http://dartmouthatlas.org/data/download/perf_reports/NJ_HOSP_perfrpt.pdf

9. Certif. Lawrence Downs in Support of Medical Society of New Jersey to Appear as *Amicus Curiae* ¶ 7 (June 17, 2009). See also James Ahearn, "Tracing Health Cost Crisis to Overcare," Bergen Cty. Record, June 17, 2009, at A11; C.A. Campbell, "A Troubling Abundance of Care," Newark Star-Ledger, Dec. 2, 2007, at 1.

argue that the hospital's inability to transfer Mr. Betancourt "provides a strong indication that the requested treatment is indeed outside accepted medical practice." [NJHA Br. at 38] They cite Professor Pope for this proposition. But they again take the point completely out of context.

While Professor Pope suggests that inability to transfer ***might*** be relevant standard of care evidence, he also writes, on the same page: "the inability to transfer may show nothing about the consensus over medical inappropriateness. First, many facilities do not make a diligent effort to locate potential transferee providers. Second, many providers refuse transfer for purely economic and risk management reasons." Pope, 71 Tenn. L. Rev. at 61.

Finally, Defendant/Appellant's *Amici* argue that a guideline of the Renal Physician's Association establishes that dialysis for Mr. Betancourt is outside the standard of care. [NJHA Br. at 16-17] But the only witness to testify about that guideline emphatically and explicitly denied that it either set or reflected a standard of care. "It's not a standard of care and it's not a

mandate. It's just a guideline." [Feb. 23, 2009 Tr. at 60:3-10; see also id. at 51:14-21, 63:8-15][10]

## D. DEFENDANT/APPELLANT AND ITS *AMICI* HAVE FAILED TO SATISFY EVEN THEIR VERY OWN GUIDELINES FOR REFUSING LIFE-SUSTAINING TREATMENT.

Defendant/Appellant's *Amici* note that the Medical Society of New Jersey has developed "a set of guidelines and processes for dealing with medically futile therapy." [NJHA Br. at 19a] But, remarkably, applying those guidelines to this case dictates that treatment should have been continued. The Guidelines state: "individuals may differ in their judgments about whether a particular treatment is futile . . . physicians ***should not substitute*** their own values for those of the patient. [NJHA Br. at 19a (emphasis added)]

10. See also Samir S. Patel & Jean L. Holley, "Withholding and Withdrawing Dialysis in the Intensive Care Unit: Benefits Derived from Consulting the Renal Physicians Association/American Society of Nephrology Clinical Practice Guideline, Shared Decision-Making in the Appropriate Initiation of and Withdrawal from Dialysis," 3 Clinical J. Am. Soc'y Nephrology 587 (2008).

## POINT II

## A NEW JERSEY HEALTHCARE PROVIDER CANNOT LEGALLY STOP LIFE-SUSTAINING MEDICAL TREATMENT UNTIL THE PATIENT IS ACTUALLY TRANSFERRED TO A NEW PROVIDER.

Defendant/Appellant and its *Amici* argue that a healthcare provider is "not required to administer any course of treatment which the physician regards as medically inappropriate." [NJHA Br. at 36] Indeed, they reiterate this general, abstract principle repeatedly in their briefs. [Def/App Br. passim; NJHA Br. passim] But they completely fail to address the germane and pertinent issue: exactly how any such principle is implemented or operationalized.

Because Trinitas Hospital and its physicians were in a treatment relationship with Mr. Betancourt, and because Mr. Betancourt had an immediate and critical need for treatment,[11] that treatment relationship could be terminated ***only once*** a new provider assumed responsibility for Mr. Betancourt's

11. Mr. Betancourt obviously still needed the treatment that Trinitas was providing. Without it, he would die almost immediately. Therefore, discussion of cases in which hospitals could remove patients "no longer in need" are totally inapposite. [NJHA Br. at 48-49]

treatment. Cf. Bryan v. Rectors & Visitors of UVA, 95 F.3d 349, 352 (4th Cir. 1996) (concluding that unilaterally refusing life-sustaining treatment would constitute the "tort of abandonment").

None of the authority cited by Defendant/Appellant and its *Amici* supports the proposition that healthcare providers ever had the right to simply unilaterally withdraw life-sustaining treatment from Mr. Betancourt. *Amici* cite a regulation of the New Jersey State Board of Medical Examiners that permits a physician to terminate a treatment relationship after giving 30-days notice. [NJHA Br. 37-38] But this regulation actually totally undermines Defendant/Appellant's position.

In a portion of the BME regulation not cited or quoted by *Amici,* the regulation clearly states that "a licensee ***shall not terminate*** a licensee-patient relationship . . . where the licensee knows, or reasonably should know, that no other licensee is currently able to provide the type of care or services that the licensee is providing to the patient." N.J.A.C. 12:35-6.22(d)(2) (emphasis added).

This regulation does indeed provide that a physician may refuse to provide treatment. But to legally ***exercise*** that refusal right, the physician must first find a substitute provider. Here, because the hospital was unable to transfer Mr. Betancourt to another facility, it was obligated to continue treating him. [Feb. 17, 2009 Tr. at 50:3-9] The right to refuse/terminate is a conditional right, and Defendant/Appellant had not satisfied the necessary conditions.

In Warthen v. Toms River Community Memorial Hospital, this Court held that there was no public policy supporting a healthcare provider's right to refuse dialysis of a terminally ill patient, because "all patients have the fundamental right to expect that medical treatment will not be terminated against their will." 199 N.J. Super. 18 (App. Div. 1985).

Every single one of Defendant/Appellant's and its *Amici's* cases confirms this "transfer before terminate" rule. For example, both Defendant/Appellant and its *Amici* cite Couch v. Visiting Home Care Service of Ocean Cty., 329 N.J. Super. 47 (App. Div. 2000). [Def/App Br. at 21; NJHA Br. at 38, 46] But Couch applies the "transfer before

terminate" to a provider with substantially stronger grounds to terminate than Trinitas ever had.

In Couch, a quadriplegic and multiple sclerosis patient with other medical conditions requiring inpatient treatment "refused hospital admission in any way, shape, or form" because he wanted to stay at home. Id. at 50. After the Chancery Division of the Superior Court ordered the organizations that had been providing home nursing care to the patient to continue to do so. Id. at 48. The Appellate Division reversed this order, but only because the medical services that the patient required were both (1) beyond the capabilities and (2) outside the licenses of the defendant providers. Neither of these reasons obtains in the instant case. Trinitas Hospital was both licensed and fully capable of providing dialysis and other life-sustaining medical treatment to Ruben Betancourt.

More importantly, the Couch court permitted the defendant providers to "refuse to participate and withdraw from the case" ***only upon*** "providing reasonable assurances that ***basic treatment and care will continue.***" Id. at 53 (emphasis added). The Court clearly cautioned that when healthcare

providers "cannot properly and ethically continue their care, ***provisions must be made*** to furnish [patient] with appropriate alternative [care]." Id. at 54 (emphasis added). Trinitas Hospital has provided no assurances nor made any provisions to continue Mr. Betancourt's treatment and care.

Defendant/Appellant's *Amici* also cites Matthies v. Mastromonaco, 310 N.J. Super. 572 (App. Div. 1998). [NJHA Br. at 36, 38, 46] While not essential to the holding, as in Couch, the Appellate Division addressed a physician's concern that he might "be required to perform surgery or administer any other course of treatment that he or she believes to be contraindicated." Id. at 598. The Court concluded there was no "reasonable basis for the apprehension" because "the physician is free to refuse to participate and to withdraw from the case." Id. But the Court was clear that such refusal/withdrawal is permitted ***only when*** the physician "provides reasonable assurances that basic treatment and care will continue." Id.

Defendant/Appellant's *Amici* also rely on an American Medical Association Report that recommends when, in a medical futility dispute, transfer is not possible, "the intervention need not be offered." [GNYHA Br. at 10-11;

NJHA Br. at 25, 62-63] What they fail to quote from the report is a key line modifying and limiting this advice: "the legal ramifications of this course of action are uncertain." Council on Ethical and Judicial Affairs, American Medical Association, "Medical Futility in End-of-Life Care: Report of the Council on Ethical and Judicial Affairs," 281 JAMA 937, 941 (1999).

In short, the AMA itself recognized that its recommendations were likely inconsistent with provider's prevailing legal obligations. Pope, 75 Tenn. L. Rev. at 70-75 (arguing that the Guidelines have been ineffective in the face of legal uncertainty). Indeed, even Defendant/Appellant's *Amici* themselves recognize this point in discussing Jobes. [NJHA Br. at 45-46]

Admittedly, some states provide an explicit exception to the "transfer before terminate" rule. See, e.g., Cal. Prob. Code § 4736(c) ("A health care provider or health care institution that declines to comply . . . shall . . . provide continuing care to the patient until a transfer can be accomplished ***or until it appears that a transfer cannot be accomplished***) (emphasis added). But New Jersey does not provide this exception.

New Jersey courts and responsible state agencies have addressed the situation in which a healthcare provider does not want to provide medical treatment requested by the patient.[12] In balancing the professional integrity and independence of the provider against the medical need of the patient, the clear and consistent rule is that providers may withdraw immediately-needed treatment ***only when*** they line-up a replacement provider.[13] If they cannot find a replacement provider, then they cannot withdraw.

---

12. Not only is this the rule in New Jersey but also generally across the United States. See generally C.T. Drechsler, Annotation, "Liability of Physician Who Abandons Case," 57 A.L.R.2d 432 (1958 & Supp.); Mark A. Hall & Carl E. Schneider, "When Patients Say No (To Save Money): An Essay on the Tectonics of Health Law," 41 Conn. L. Rev. 743, 770 & n.133 (2009) (explaining that a healthcare provider may terminate a treatment relationship "only at a non-critical point in the treatment when the patient can find alternative care"); Payton v. Weaver, 182 Cal. Rptr. 225 (Cal. App. 1982).

13. Providers may also withdraw when they have patient consent. Since many patients would consent to stop life-sustaining treatment in Mr. Betancourt's situation, the state encourages the completion of advance directives. State of New Jersey Commission of Legal and Ethical Problems in the Delivery of Health Care, Advance Directives for Health Care Planning Ahead for Important Health Care Decisions (1991), available at http://www.state.nj.us/health/healthfacilities/documents/ltc/advance_directives.pdf. Because many patients now lack advance directives (giving providers consent to stop), they receive life-sustaining treatment much like Mr. Betancourt.

## POINT III

## THE NEW JERSEY ADVANCE DIRECTIVES FOR HEALTHCARE ACT HAS NO RELEVANCE TO THIS CASE AND, EVEN IF IT DID, THE ACT'S UNDERLYING PRINCIPLES SUPPORT PLAINTIFF/ RESPONDENT.

### A. THE NEW JERSEY ADVANCE DIRECTIVES FOR HEALTHCARE ACT HAS NO RELEVANCE TO THIS CASE.

Defendant/Appellant's *Amici* spend nine pages arguing that the New Jersey Advance Directives for Healthcare Act supports the unilateral refusal of treatment in this case. [NJHA Br. at 23-31] Yet, they themselves recognize that this "Act does not control or directly apply to this appeal." [NJHA Br. at 27; see also NJHA Br. at 30-31] Mr. Betancourt did not have an advance directive. [NJHA Br. at 30; Feb. 17, 2009 Tr. at 32:2-4; Feb 23, 2009 Tr. at 23:18-20] The Advance Directives for Healthcare Act is simply not relevant to this case.

### B. THE NEW JERSEY ADVANCE DIRECTIVES FOR HEALTHCARE ACT CONFIRMS THAT THE WITHHOLDING AND WITHDRAWAL OF LIFE-SUSTAINING TREATMENT IS THE CHOICE OF THE PATIENT.

Even if the Advance Directives For Healthcare Act had any application to this case, it only confirms the position of Plaintiff/Respondent: that the withholding

and withdrawal of life-sustaining treatment is ultimately the choice of the patient.

Defendant/Appellant's *Amici* note that the Advance Directives For Healthcare Act provides that it "shall not be construed to require a physician, nurse, or other healthcare professional to . . . continue healthcare in a manner contrary to law or accepted professional standards." [NJHA Br. at 27-28 (citing N.J.S.A. 26:2H-65)] But their attempt to extract "principles of law and public policy" from this provision are misguided.

By its express terms, this provision applies only where requested treatment contradicts "accepted professional standards." The trial court found that there would be no such contradiction. [See supra, Point I] And Defendant/Appellant has not established, and cannot establish, such contradiction in any case.

Moreover, the Act itself specifically anticipated that patients would legitimately make treatment decisions exactly like those made on Mr. Betancourt's behalf.

> Modern advances in science and medicine have made possible the prolongation of the lives of many seriously ill individuals, without always offering realistic prospects for improvement or cure. ***For some individuals the possibility of extended life is experienced as***

> ***meaningful and of benefit.*** For others, artificial prolongation of life may seem to provide nothing medically necessary or beneficial, serving only to extend suffering and prolong the dying process. This State recognizes the inherent dignity and value of human life and within this context recognizes the ***fundamental right of individuals to make health care decisions to have life-prolonging medical or surgical means or procedures provided,*** withheld, or withdrawn.

N.J.S.A. 26:2H-54(b) (emphasis added).

Defendant/Appellant's *Amici* also suggest that it would have been appropriate to unilaterally withdraw Mr. Betancourt's life-sustaining treatment because he satisfied one or more conditions specified in the Advance Directives for Healthcare Act. [NJHA Br. at 29-30 (citing N.J.S.A. 26:2H-67(a))] But this section not only fails to support Defendant/Appellant, it actually illustrates how the Act empowers patients over providers.

The Act clearly states that the specified conditions are ones in which "treatment may be withheld or withdrawn" ***only with patient consent,*** when "consistent with the terms of an advance directive." N.J.S.A. 26:2H-67(a). The legislation plainly places the decision whether to continue or forego treatment, under the specified conditions, in the hands of the patient himself.

## C. DEFENDANT/APPELLANT HAS FAILED TO SATISFY MANDATORY CONDITIONS FOR EXERCISING ANY TREATMENT REFUSAL RIGHT IN THE NEW JERSEY ADVANCE DIRECTIVES FOR HEALTHCARE ACT.

Even if Defendant/Appellant satisfied the prerequisites for triggering a treatment refusal right in the Advance Directives for Healthcare Act, that right is conditional on transferring care to a new healthcare provider. [See supra, Point II] This is especially true when the treatment at issue is life-sustaining. Jobes, 108 N.J. at 425 ("[I]t would be difficult, perhaps impossible, to find another facility . . . . Therefore, to allow the nursing home to discharge . . . would essentially frustrate Mrs. Jobes' right of self-determination.").

Moreover, the Act confirms the "transfer before refuse" requirement by expressly requiring that before a physician may "decline to participate" in requested treatment, "the physician ***shall act . . . to effect an appropriate, respectful, and timely transfer of care***, and to assure that the patient is not abandoned or treated disrespectfully." N.J.S.A. 26:2H-62(b) (emphasis added). In short, to any extent that the Act provides an exit/withdrawal option, Defendant/Appellant has failed to satisfy its prerequisite conditions.

**POINT IV**

**THERE IS SUBSTANTIAL EVIDENCE SUPPORTING THE TRIAL COURT'S DETERMINATION THAT JACQUELINE BETANCOURT WAS AN APPROPRIATE GUARDIAN.**

The trial court's appointment of Jacqueline Betancourt as guardian for her father was the appropriate. Family members are generally best qualified both because of their grasp of the patient's approach to life but also because of their special bonds with him. Jobes, 108 N.J. at 416.

Jacqueline and her father were very close. [Feb. 23, 2009 Tr. at 85:15-21] She had a substantial basis to exercise substituted judgment. [Feb. 23, 2009 Tr. at 24:16-22, 33:16-23, 76:21-77:4, 83:3-6] And Jacqueline's treatment decisions for her father were supported by her entire family. [Feb. 17, 2009 at 33:11-14][14]

Still, Defendant/Appellant suggests that Jacqueline was an inappropriate guardian because the potential medical malpractice action provided an incentive to continue treatment. [Def/App Br. at 25] But this argument is hardly

14. Jobes, 108 N.J. at 399. Even if the treatment decision had to be made on a best interest standard, the evidence establishes that Mr. Betancourt had no perception or awareness of any pain or suffering. [Feb. 17, 2009 Tr. at

sufficient, given the "manifest abuse of discretion" standard of review. Wolosoff v. CSI Liquidating Trust, 205 N.J. Super. 349, 360 (App. Div. 1985) The trial court already made the appointment aware of the malpractice issue.

In any case, potential conflict is hardly sufficient reason to dismiss the guardian. "[T]he issue is not the existence of a conflict of interest, but its pervasiveness and its effect. Only when a surrogate decision is motivated primarily by something other than by concern for what is best for the patient [should a new surrogate be sought]." Alan Meisel & Kathy L. Cerminara, The Right to Die: The Law of End-of-Life Decisionmaking 3.24[c] (3d ed. Aspen 2004 & Supp. 2008) (explaining that since surrogates are usually family members, they almost always "stand to lose or gain in some way from the patient's death.")[15]

36:33-37:6, 79:13-15, 83:5-7, 105:16-17; NJHA Br. at 9]

15. Indeed, if the mere appointment of guardian gave Jacqueline both the right to make treatment decisions and the right to bring the medical malpractice action, then any other appointed guardian would have precisely the same conflict.

## POINT V

## THE JUDICIAL CREATION OF A BINDING INTERNAL DISPUTE RESOLUTION MECHANISM WOULD VIOLATE LAW, PUBLIC POLICY, AND CONSTITUTIONAL DUE PROCESS.

Defendant/Appellant's *Amici* boldly ask this Court "legislate from the bench" [NJHA Br. at 58] and "to set forth . . . procedures to be followed by physicians and hospitals when similar situations arise in the future." [NJHA Br. at 3] They argue that hospitals can be trusted to resolve these sorts of treatment disputes on their own, without judicial intervention. But this radical proposal would violate law, public policy, and constitutional due process.

### A. JUDICIAL LEGISLATION IS INAPPROPRIATE, ESPECIALLY HERE ON A VERY LIMITED RECORD.

*Amici* admit that the narrow facts and issues in this matter "***do not provide the necessary context*** to address . . . permutations of the decision to withdraw life-sustaining treatment." [NJHA Br. 10 (emphasis added)] Still, they suggest the Court need not resolve "conflicts about . . . what quality of life justifies the . . . foregoing of life-sustaining medical treatment." [NJHA Br. at 10]

This suggestion is implausible. The very essence of Defendant/Appellant's position is that it should be permitted to withdraw Mr. Betancourt's life support

Highlighting the inappropriateness of judicial legislation, here, is the fact that every jurisdiction in the world that has created a binding internal dispute resolution mechanism for end-of-life treatment disputes has done so legislatively.[18]

Texas is the only jurisdiction in the United States with a dispute resolution mechanism of the type that Defendant/Appellant's *Amici* urge this court to implement. Tex. Health & Safety Code § 166.046.[19] But the long, painstaking history and development of the Texas statute stands in sharp, stark contrast to the limited facts in this case, which developed in a narrow preliminary injunction hearing. See generally Robert L. Fine, "The Texas Advance Directives Act of 1999: Politics and Reality," 13 HEC Forum 59 (2001) (describing the many meetings, between 1997 and 1999, of a "multidisciplinary task force" that reviewed and recommended changes to the law regarding end-of-life decisions); Robert L. Fine, "A Model for End-of-Life Care?" Wash.

---

18. See, e.g., Tex. Health & Safety Code § 166.046; Ontario Health Care Consent Act, S.O., ch. 2 (1996) (Can.), available at http://www.canlii.org/on/laws/sta/1996c.2sch.a/20080821/whole.html.
19. Remarkably, *Amici*'s proposal is materially more aggressive than the Texas law, because it permits unilateral withdrawal ***even when*** the ethics committee "supports the position of the patient or the patient's healthcare

Times, Sept. 6, 2009 ("The law was developed by a broad coalition of concerned parties, including right-to-life advocates and representatives of Texas doctors, nurses, hospitals, nursing homes, hospice facilities and lawyers.").

## B. THE NEW JERSEY SUPREME COURT HAS GIVEN HOSPITAL ETHICS COMMITTEES THE AUTHORITY TO APPROVE STOPPING LIFE-SUSTAINING TREATMENT ONLY WHERE THERE IS CONSENSUS.

In recommending the use of ethics committees in end-of-life treatment decisions, the New Jersey Supreme Court clearly limited their role to that of a mediator only. Jobes, 108 N.J. at 451 ("'[W]hen ethics committees serve as reviewers, they do not supplant the principal decisionmaker . . . .'") (quoting President's Commission Report at 164). Ethics committees were intended as a one-way extra safeguard, for when a surrogate consented to withhold or withdraw life-sustaining treatment from a patient. Jobes, 108 N.J. at 422 & 427. They were devised to ensure that patient preferences were honored.

---

representative." [NJHA Br. at 62].

because its physicians, contrary to the unanimous opinion of Mr. Betancourt's family, unilaterally determined his quality of life to be such that his life is not worth living. Indeed, Defendant/Appellant makes this very point in its appellate brief. [Def/App Br. at 2 ("The questions presented here implicate multiple ethical, moral, and medical dilemmas."); id. at 19 ("disagree on the worth of pursuing life . . . subjective . . . incorporates value judgments")][16]

The limited facts and narrow procedural posture of this case make it an unsuitable vehicle for devising a radically new and controversial dispute resolution mechanism.[17] Indeed, it is precisely because courts generally have such limited fact-finding capabilities that "the judiciary does not pass laws." State v. Haliski, 140 N.J. 1, 26 (1995); Dixon v. Gassert, 26 N.J. 1, 18 (1958) ("It is not our function to legislate"). "[T]he Legislature is better equipped than we to develop and frame a comprehensive plan for resolving these problems." Jobes, 108 N.J. at 424 (quoting In re Conroy, 98 N.J. 321, 387-88 (1985)).

16. Defendant/Appellant also argued this point to the trial court. [Jan. 22, 2009 Tr. at 9:9 ("[W]e're addressing questions of quality of life . . . .")]
17. For example, there is no evidence on how a decision in this case would impact the "quality and availability of healthcare services." [GNYHA Br. at 3; NJHA Br. at 51] There is no evidence as to how long or how hard a provider should attempt transfer before being allowed to withdraw without transferring. [NJHA Br. at 63-64]

The ethics committee was never intended to be the forum of last resort in cases of dispute between providers and surrogates. "If a disagreement arises among the . . . guardians or doctors . . . judicial intervention will be required." Jobes, 108 N.J. at 427-28. Cf. N.J.S.A. 26:2H-69(b)(2) ("Nothing in this Act shall be construed to impair the right of a patient, healthcare representative . . . who consults with an institutional or regional reviewing body to seek review by a court of competent jurisdiction.").

To give the ethics committee the right to withdraw life-sustaining treatment is to abandon all settled standards for healthcare decision making. In Conroy, the Supreme Court warned that it would ***not*** be appropriate for "a court to designate a person with the authority to determine that someone else's life is not worth living simply because to that person, the patient's 'quality of life' or value to society seems negligible." 98 N.J. at 367. Yet, that is precisely what *Amici* ask this Court to allow ethics committees to do.

## C. HOSPITAL ETHICS COMMITTEES LACK THE NECESSARY NEUTRALITY, TRAINING, AND STANDARDS TO ADJUDICATE TREATMENT DISPUTES.

Not only does New Jersey (or hardly any state's law) not give adjudicatory power to ethics committees, but ethics committees are not prepared to

exercise such power in any case. Many lack the necessary independence, diversity, composition, training, and resources. Pope, 31 Campbell L. Rev. at 257. Ethics committees are overwhelmingly intramural bodies; that is, they are comprised of professionals employed directly or indirectly by the very same institution whose decision the ethics committee adjudicates. Consequently, many make decisions that suffer from risks of corruption, bias, carelessness, and arbitrariness. Id. They cannot, as now constituted, be designated as forums of last resort in cases of conflict.

This is somewhat illustrated by a case that both Defendant/Appellant and its *Amici* cite: Causey v. St. Francis Medical Center, 719 So. 2d 1072 (La. App. 1998). [Def/App Br. at 18-20; NJHA Br. at 32-33] The court refused to defer to the medical appropriateness judgments made by the patient's physicians or by the hospital's Morals and Ethics Board. Instead, the court determined that the standard of review had to be determined like any other medical malpractice case, and sent the case to a review panel. Causey, 719 So. 2d at 1076.

There may have been some basis for judicial deference to intramural professional medical judgment in the 1970s and 1980s. But today, after substantial experience with the corruption of medical judgment (from both pharmaceutical detail men and reimbursement incentives), there is less basis for such deference.

## CONCLUSION

For the foregoing reasons, *amicus curiae*, Professor Thaddeus M. Pope, requests the Court to affirm the judgment of the trial court.

Respectfully submitted,

Sept. 8, 2009

Thaddeus M. Pope, *pro hac vice* application pending

Todd Drayton, Esq.