Instituting Dignity: The Duty to Die

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I. Patients' Rights
   A. Right to dignity and privacy
      1. Patients have a right to courtesy, respect, dignity, and timely, responsive attention to their needs. A patient who has decision-making capacity may accept or refuse any recommended medical intervention.[1]
      2. Every person has a right to dignity and privacy. An adult has the fundamental right to control his/her health care decisions, including the right to have life-sustaining treatment withheld or withdrawn. Cal. Prob. Code § 4650
   B. Health decisions are made by patients or their representatives
      1. The patient has the right to participate in the development and implementation of his or her plan of care. The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. 42 CFR § 482.13
      2. Consumers have the right and responsibility to fully participate in all decisions related to their health care. Consumers who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, family members, or other conservators.[2]

II. Advance Health Care Directives
   A. Allows people to select a health care agent and provide instruction for health care decisions in the event they are incapacitated.
   B. Covered providers are required to maintain written policies and procedures with respect to providing adults with written information regarding their rights under state law to make decisions concerning medical care, including formulating advance directives…and not conditioning the provision of care, or otherwise discriminating against an individual, based on whether or not there is an advance directive.[3]
   C. Health care provider must comply with health care instructions of patient or patient's surrogate. Cal. Prob. Code § 4733
   D. Health care instructions may include:
      1. Designation of health care agent

[1] Patient Rights, American Medical Association. Available at https://code-medical-ethics.ama-assn.org/ethics-opinions/patient-rights
[2] https://www.opm.gov/healthcare-insurance/healthcare/reference-materials/bill-of-rights/
[3]https://crsreports.congress.gov/product/pdf/IF/IF10237/6#:~:text=Patient%20Self%2DDetermination%20Act&text=The%20PSDA%20also%20mandated%20that,of%20care%2C%20or%20plan%20enrollment.

2. Designation of primary physician
3. Whether they want mechanical ventilation
4. Whether they want artificial nutrition and hydration
5. Disposition of body after death, including organ donation

E. State laws vary concerning the appropriate documents to cover these situations. All fifty states permit you to express your wishes as to medical treatment in terminal illness or injury situations, and to appoint someone to communicate for you in the event you cannot communicate for yourself.[4]

III. Rights of Conscience

A. Physicians can refuse to comply with patient's health care instructions. Providers
   1. Are not required to provide care that conflicts with an advance directive.
   2. Are not required to implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive and State law allows any health care provider or any agent of such provider to conscientiously object. 42 CFR § 489.102

B. The written policies of the provider or organization respecting the implementation of such rights, including a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience. At a minimum, a provider's statement of limitation should:
   1. Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians;
   2. Identify the state legal authority permitting such objection; and
   3. Describe the range of medical conditions or procedures affected by the conscience objection. 42 CFR § 489.102

C. A health care provider may decline to comply with an individual health care instruction or health care decision for reasons of conscience. Cal. Prob. Code § 4734

D. A health care provider or health care institution that declines to comply with an individual care instruction or health care decision must
   1. Promptly inform the patient or patient's health care agent.
   2. Make reasonable efforts to assist in the transfer of the patient to another health care provider who is willing to comply.
   3. Continue to provide care until a transfer is accomplished. Cal. Prob. Code § 4736

[4] Living Wills, Health Care Proxies, & Advance Health Care Directives, American Bar Association. Available at https://www.americanbar.org/groups/real_property_trust_estate/resources/estate-planning/living-wills-health-care-proxies-advance-directives/#:~:text=All%20fifty%20states%20permit%20you,you%20cannot%20communicate%20for%20yourself.

IV. Futility of Care

A. There is no uniform definition for medical futility.
    1. The American Medical Association (AMA) guidelines describe medically futile treatments as those having "no reasonable chance of benefiting [the] patient" but fall short of defining what the word "reasonable" means in this context.[5]
    2. The American Thoracic Society says a treatment is medically futile when it is highly unlikely to result in meaningful survival.
    3. The Society for Critical Care Medicine and others say that physicians must be certain that an intervention will fail to accomplish its intended goal before concluding that the intervention would be medically futile.[6]

B. If the goal of aggressive treatment is to prevent bodily death, dialysis and intubation are not futile as they can achieve this goal. On the other hand, if the intention of aggressive treatment is to return [a patient] to independent living, or prevent her imminent death, dialysis and intubation serve no useful purpose and are futile.[7]

C. Modern medical technology has made possible the artificial prolongation of human life beyond natural limits. In the interest of protecting individual autonomy, this prolongation of the process of dying for a person for whom continued health care does not improve the prognosis for recovery may violate patient dignity and cause unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the person.[8]

D. Disability and patient rights advocates, among others, argue that medical futility decisions often lack objectivity and procedural safeguards, leaving room for the physician's recommendation to be impacted by biases about the quality of life of people with disabilities. It has been well-documented that healthcare providers significantly undervalue life with a disability, in part because most medical education does not include accurate information on the lived experiences of people with disabilities.[9]

E. The emergence of the futility debate has been credited to a number of factors, including the development of advanced life-saving medical technologies, changes

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[5] McCabe MS, Storm C. When doctors and patients disagree about medical futility. J Oncol Pract. 2008 Jul;4(4):207-9. doi: 10.1200/JOP.0848503. PMID: 20856774; PMCID: PMC2793955.

[6] Mary S. McCabe, RN and Courtney Storm, JD, MBE, *When Doctors and Patients Disagree About Medical Futility*, American Society of Clinical Oncology (2008). Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2793955/

[7] Deborah L. Kasman, MD, MA, *When Is Medical Treatment Futile? A Guide for Students, Residents, and Physicians*, Journal of General Internal Medicine (2008). Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1492577/pdf/jgi_40134.pdf

[8] Cal. Prob. Code §4650(b)

[9] *Medical Futility and Disability Bias*, National Council on Disability (2019). Available at https://www.ncd.gov/assets/uploads/reports/2019/ncd_medical_futility_report_508.pdf

in the US healthcare reimbursement system, evolving concepts of patient autonomy, and the rise of the right-to-die movement.[10]

F. All states have medical futility provisions.
    1. A health care provider or health care institution can decline to comply with patient's (or surrogate's) health care instructions that require medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution. Medically ineffective health care means treatment which would not offer the patient any significant benefit. Cal. Prob. Code § 4735

II. Assisted Suicide and Euthanasia

A. Assisted suicide, euthanasia, and mercy killing have been criminal offenses throughout the United States and, under current law, it would be unlawful to provide services in support of such illegal activities.
    1. Because of recent legal developments, it may become lawful in areas of the United States to furnish services in support of such activities. 42 U.S.C. § 14402

B. Nothing in this subsection shall be construed to apply to or to affect any limitation relating to
    1. the withholding or withdrawing of medical treatment or medical care;
    2. the withholding or withdrawing of nutrition or hydration;
    3. abortion

C. California's Health Care Decisions law does not condone, authorize, or approve mercy killing, assisted suicide, or euthanasia. The law distinguishes between withdrawing care to allow someone to die naturally vs. an affirmative or deliberate act or omission to end life. Cal. Prob. Code § 4653

III. Patients Without Advance Directives

A. Default surrogate statutes
    1. Default surrogate statutes provide patients with a healthcare decision-maker when no healthcare agent or guardian has been appointed.
    2. As of December 2022, 46 states have enacted default surrogate statutes. (Massachusetts, Minnesota, Missouri, and Rhode Island do not have default surrogate consent laws.)[11]
    3. An increasing number of state statutes authorize distant relatives or persons with a meaningful relationship to the patient as healthcare decision-makers

[10] Ibid.
[11] *Recent Updates to Default Surrogate Statutes*, American Bar Association (2023) Available at https://www.americanbar.org/groups/law_aging/publications/bifocal/vol44/bifocal-vol-44-issue3/recent-updates-to-default-surrogate-statutes/

when no one else is available. This allows distant relatives and friends to act as decision-makers without needing to seek guardianship.[12]

B. Some states, like California, do not have a statutory hierarchy. If the patient does not have an advance directive, a health care provider will look to the individual(s) most likely to know the patient's wishes.

C. Unrepresented or unbefriended patients
   1. Between 2010 and 2030, the number of unrepresented patients is expected to rise dramatically due to the aging Baby Boomer generation, the expanding population of elderly with dementia, and the growing number of seniors who live on their own.[13]
   2. Many states allow an attending physician to initiate medical intervention on incapacitated patient if no one with legal authority to make decisions for the patient is available. See CA Health and Safety Code § 1418.8
   3. One study found that physicians reported considering withholding or withdrawing life support from 37% of unrepresented patients in an intensive care unit in which 16% of patients admitted were unrepresented.[14]

IV. Hospital Ethics Committees

A. The Joint Commission on the Accreditation of Healthcare Organizations requires healthcare organizations "have a mechanism in place to develop and implement a process that allows staff, [patients], and families to address ethical issues or issues prone to conflict."

B. The requirements for ethics committees were driven by increasing patient situations that involved a lack of clarity between patient and family wishes, expectations for treatment, the provider's prognosis, and/or the patient's treatment plan.[15]

C. In re Quinlan, 355 A.2d 647 (N.J. 1976), was the first case to adopt the notion that a health care facility could establish an ethics committee to act as an alternative to the more traditional probate court process for determining a patient's interests concerning end of life care.[16]

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[12] Ibid.

[13] *Who Makes Decisions for Incapacitated Patients Who Have No Surrogate or Advance Directive*?, American Bar Association (2019). Available at https://journalofethics.ama-assn.org/article/who-makes-decisions-incapacitated-patients-who-have-no-surrogate-or-advance-directive/2019-07

[14] AMA J Ethics. 2019;21(7):E587-593. doi: 10.1001/amajethics.2019.587.

[15] *The Ethical Conundrum of Healthcare Ethics Committees*, Case Management Institute (2023) Available at https://casemanagementinstitute.com/the-ethical-conundrum-of-healthcare-ethics-committees/

[16] Health Care Facility Ethics Committees: New Issues in the Age of Transparency, American Bar Association (2007). Available at https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/human_rights_vol34_2007/fall2007/hr_fall07_caulfi/

V. Challenging Health Care Decisions

A. Situations where a health care decision may be challenged:
   1. Where there is a question as to whether health care decisions are in the best interest of or against the wishes of a patient
   2. The petitioner seeks to determine whether health care decisions are consistent with a patient's advance health care directive or, if there is no directive, whether the decisions are in the patient's best interest.
   3. Where there is a question as to whether health care decisions are in the best interest of or against the wishes of a patient
   4. The petitioner seeks to determine whether health care decisions are consistent with a patient's advance health care directive or, if there is no directive, whether the decisions are in the patient's best interest.

B. Many states allow an "interested person" who has exhibited concern for and is familiar with the patient to challenge a health care decision.

C. In California, virtually anyone can file a petition to challenge the health care decisions of a health care agent or surrogate, spouses, family members, and friends, as well as any other interested person. Cal. Prob. Code § 4765 et. seq.

D. When a health care decision is challenged, courts will typically appoint a guardian ad litem for the patient.

VI. Ethical Considerations

A. Ordinary care
   1. Beneficial
   2. Can prolong life without becoming excessively precarious or burdensome
   3. Definition of ordinary care may change with advancements in technology (e.g., dialysis)

B. Extraordinary care
   1. Excessive pain
   2. Great cost or means
   3. Grave effort
   4. Severe dread or repugnance
   5. "No one is held to accept a cure which one abhors no less than the disease itself or death." Leonard Lessius

C. Examples of worldviews in medical decision-making
   1. Utilitarianism: Judging actions by which will have the best consequences for the greatest number of people. (e.g., Peter Singer) – may not be in the best interest of an individual patient.
   2. Deontology: The correct course of action is dependent on what your duties and obligations are. It means that the morality of an action is based on whether you followed the rules, rather than what the consequence of following them was.

3. Non-malfeasance: "Do no harm." Consider the benefits of all procedures and weigh them against the potential risks and burdens on the patient.
4. Beneficence: Goes beyond "do no harm." Also acting for the benefit of patients and promoting their welfare.
5. Distributive justice: Expected benefit is insufficient to justify public resources being used.
6. Autonomy: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."[17]

VII. Denial of Care

A. Also called WWLST: Withholding or withdrawing of life-sustaining therapy
B. Withholding and withdrawal of life support is a process through which various medical interventions are either not given to patients or removed from them with the expectation that the patients will die from their underlying illnesses.[18]
C. Studies have demonstrated that most patients who die in intensive care units (ICUs) in the United States do so during the withholding and withdrawal of life support and the administration of palliative care.[19]
D. Many intensivists report an explicit intent to shorten life when they perform WWLST[20]
E. Blurring lines between withholding and withdrawing care
   A. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations.[21]
   B. Active killing, even when motivated by a desire to end bodily or psychic pain, makes caregivers the final masters and arbiters of life and death for the person entrusted to their care. It denies the patient's right to life.[22]
   C. Most bioethicists appear willing to define with- drawing a treatment as a form of "active" euthanasia (to perform an act that by itself causes the death of the patient), and withholding a treatment as a form of "passive" euthanasia (not to

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[17] Cardozo B. Basic right to consent to medical care − Schlendorff vs the Society of the New York Hospital, 211 NY 125 105 NE 92 1914 LEXUS 1028 (1914)

[18] John M. Luce and Ann Alpers, *Legal Aspects of Withholding and Withdrawing Life Support from Critically Ill Patients in the United States*, American Journal of Respiratory and Critical Care Medicine (2000). Available at https://www.atsjournals.org/doi/full/10.1164/ajrccm.162.6.1-00

[19] *Ibid.*

[20] Ewan C. Goligher, MD, E. Wesley Ely, MD, Daniel P. Sulmassy, MD, et al, *Physician-Assisted Suicide and Euthanasia in the Intensive Care Unit: A Dialogue on Core Ethical Issues*, Crit. Care Med. (February 2018). Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5245170/pdf/nihms768538.pdf

[21] AMA Code of Medical Ethics Opinion 5.8. Available at https://www.ama-assn.org/delivering-care/euthanasia

[22] *Taking Care: Ethical Caregiving in our Aging Society*, The President's Council on Bioethics (2005). Available at https://repository.library.georgetown.edu/bitstream/handle/10822/559378/taking_care.pdf?sequence=1&isAllowed=y

administer a lifesaving medical treatment, as a consequence of which the patient dies).[23]

D. Euthanasia has been employed to expedite death during WWLST in some jurisdictions (5). Furthermore, euthanasia has been considered to enhance number and quality of organs for donation (8), and intensivists may be involved in such discussions.[24]

VIII. What is Life-Sustaining Treatment?

A. Medical procedures that would only prolong the process of dying or sustain a condition of permanent unconsciousness. A patient who is receiving life-sustaining treatment will die soon, whether or not treatment is administered. Life-sustaining treatment may include a respirator, cardiopulmonary resuscitation (CPR), dialysis, surgery, and other medical procedures.[25]

B. Life sustaining procedures are medical procedures which utilize mechanical or other artificial means to sustain, restore, or supplant a vital function, which serve only or primarily to prolong the moment of death, and where, in the judgment of the attending and consulting physicians, as reflected in the patient's medical records, death is imminent if such procedures are not utilized.[26]

C. Mechanical Ventilation

1. Mechanical ventilation is a life support treatment. A mechanical ventilator is a machine that helps people breathe when they are not able to breathe enough on their own.[27]
2. The mechanical ventilator is also called a ventilator, respirator, or breathing machine.
3. The NAE affirms the Uniform Determination of Death Act (1980), which defines death as either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem. The withholding or withdrawal of extraordinary life-support systems to allow natural death at this time is not only morally appropriate, but compelling.[28]

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[23] Virginia Sanchini et al., *The withholding/withdrawing distinction in the end-of-life debate.* Multidisciplinary Respiratory Medicine (2014). Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3978132/pdf/2049-6958-9-13.pdf

[24] Ewan C. Goligher, MD, E. Wesley Ely, MD, Daniel P. Sulmassy, MD, et al, *Physician-Assisted Suicide and Euthanasia in the Intensive Care Unit: A Dialogue on Core Ethical Issues*, Crit. Care Med. (February, 2018). Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5245170/pdf/nihms768538.pdf

[25] NOLO's Plain English Law Dictionary, https://www.nolo.com/dictionary/life-sustaining-treatment-term.html

[26] John F. Kennedy Mem'l Hosp. v. Bludworth, 432 So. 2d 611, 619 (Fla. 4th DCA 1983)

[27] *Mechanical Ventilation*, American Thoracic Society. Available at https://www.thoracic.org/patients/patient-resources/resources/mechanical-ventilation.pdf

[28] *Allowing Natural Death*, National Association of Evangelicals, January 2013 Resolution. Available at https://www.nae.org/allowing-natural-death/

4. If the person is not going to die from any disease, but instead, simply needs assistance with breathing because of some injury, it is less clear to me why assistance should not be given.[28]

D. Artificial Nutrition and Hydration (ANH)

1. While medically assisted nutrition and hydration are not morally obligatory in certain cases, these forms of basic care should in principle be provided to all patients who need them, including patients diagnosed as being in a "persistent vegetative state" (PVS), because even the most severely debilitated and helpless patient retains the full dignity of a human person and must receive ordinary and proportionate care.[25]
2. Artificial nutrition and hydration is a medical treatment that allows a person to receive nutrition (food) and hydration (fluids) when they are no longer able to take them by mouth. Artificial nutrition and hydration is given to a person who for some reason cannot eat or drink enough to sustain life or health.[29]
3. "I should like particularly to underline how the administration of water and food, even when provided by artificial means, always represents a natural means of preserving life, not a medical act. Its use, furthermore, should be considered, in principle, ordinary and proportionate, and as such morally obligatory, insofar as and until it is seen to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering."[24]
4. Should the provision of food and water be regarded as medical care? It seems, rather, to be the sort of care that all human beings owe each other… Deprive a person of food and water and she will die as surely as if we had administered a lethal drug, and it is hard to claim we did not aim at her death.[27]
5. Should the provision of food and water be regarded as medical care? It seems, rather, to be the sort of care that all human beings owe each other… Deprive a person of food and water and she will die as surely as if we had administered a lethal drug, and it is hard to claim we did not aim at her death.[27]

IX. Legal Issues

A. Informed Consent and Refusal

1. In the United States, the withholding and withdrawal of life support is legally justified primarily by the principles of informed consent and informed refusal, both of which have strong roots in the common law. The principles hold that treatment may not be initiated without the approval of patients or their

[29] *Artificial Nutrition (Food) and Hydration (Fluid) at the End of Life*, National Hospice and Palliative Care Organization. Available at http://www.caringinfo.org/files/public/brochures/artificialnutritionandhydration.pdf

surrogates excepting in emergency situations, and that patients or surrogates may refuse any or all therapies.[30]

B. Due Process

1. "To bereave a man of life, or by violence to confiscate his estate, without accusation or trial, would be so gross and notorious an act of despotism, as must at once convey the alarm of tyranny throughout the whole kingdom."[31]
2. The Due Process Clause does not require a State to accept the "substituted judgment" of close family members in the absence of substantial proof that their views reflect the patient's. This Court's decision upholding a State's favored treatment of traditional family relationships, Michael H. v. Gerald D., 491 U.S. 110, may not be turned into a constitutional requirement that a State must recognize the primacy of these relationships in a situation like this. Nor may a decision upholding a State's right to permit family decision-making, Parham v. J.R., 442 U.S. 584, be turned into a constitutional requirement that the State recognize such decision-making.[32]

X. Cases

A. Quinlan[33]

A. First so-called "right to die" case in the U.S.
B. 21 y/o Karen Ann Quinlan suffered anoxic brain injury after ingesting alcohol and Valium. She was placed on a respirator. Six months later, her parents sued the hospital to have her taken off of life support. They won their lawsuit, but Karen continued to breathe after being removed from the respirator and lived for 10 more years.
C. "The matter is of transcendent importance, involving questions related to the definition and existence of death"
D. "We think that the State's interest contra weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims."

B. Cruzan[34]

A. Nancy Cruzan sustained a severe brain injury in an auto accident and was placed on life support. Five years later, her parents sued her physicians to have her ventilator removed. The trial court ruled in the Cruzans' favor. The

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[30] Luce and Alpers, *Supra.*
[31] William Blackstone, Commentaries on the Laws of England. Available at https://lonang.com/library/reference/blackstone-commentaries-law-england/bla-101/
[32] *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990)
[33] *In re Quinlan*, 70 N.J. 10 (1976), 355 A.2d 647
[34] *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990)

Supreme Court of Missouri overturned the decision, ruling "that no one may refuse treatment for another person, absent an adequate living will" or the clear and convincing, inherently reliable evidence absent here. The State of Missouri and Nancy's GAL appealed to the US Supreme Court.

B. Held: The United States Constitution does not forbid Missouri to require that evidence of an incompetent's wishes as to the withdrawal of life-sustaining treatment be proved by clear and convincing evidence.

C. Nancy Cruzan's statements that she would not want to live like a "vegetable" did not amount to clear and convincing proof of her desire to have hydration and nutrition withdrawn.

C. Schiavo[35]

A. At 26, Terri Schiavo went into cardiac arrest and had to be resuscitated. She was placed on a ventilator, but was soon able to breathe on her own; however, she required a feeding tube. Eight years after her injury, her husband successfully petitioned to have her feeding tube removed. Terri died from starvation and dehydration after 13 days.

B. Florida Gov. Jeb Bush issued an executive order staying the court's order permitting the withdrawal of food and water, which was later held unconstitutional.

C. Terri's GAL reported that "evidence regarding her intentions consisted of admitted hearsay regarding conversations between Theresa and her spouse and spousal relatives. The context and nature of this hearsay were deemed sufficiently probative, competent and reliable to serve as a basis for admission, and was determined to be sufficiently clear and convincing." The GAL referred to the Supreme Court's holding in Cruzan which permitted states to require clear and convincing evidence of a person's wishes prior to removing life support.[36]

D. Wendland (California)[37]

A. Robert Wendland was in a car accident that left him conscious but severely physically and mentally disabled. His wife had conservatorship of him and sought permission to remove his feeding tube. His mother and sister objected.

B. In California, if a conservator seeks to remove life-sustaining treatment from a conservatee, the conservator must prove by clear and convincing evidence that the conservatee would want life-sustaining treatment removed or that to withhold treatment would be in the conservatee's best interests.

E. McMath (California)

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[35] *In re the Guardianship of Terri Schiavo* (2005)

[36] *A Report to Governor Jeb Bush and the 6th Judicial Circuit in the Matter of Theresa Marie Schiavo*, submitted by Jay Wolfson, DrPH, JD, Guardian Ad Litem for Theresa Marie Schiavo (December 2003). Available at https://euthanasia.procon.org/sourcefiles/GuardianAdLitemReportSchiavo.pdf

[37] *Wendland v. Wendland*, 28 P.3d 151 (Cal. 1991).

A. 13 y/o Jahi McMath underwent a tonsillectomy at Oakland Children's Hospital. She suffered complications that resulted in severe blood loss and cardiac arrest after which Jahi was declared brain dead. Jahi's mother obtained a temporary injunction keeping her daughter on life support until she could be transferred to a hospital and then to home health care in New Jersey.
B. New Jersey's brain death statute prohibits the declaration of brain death in cases where the patient or his/her parents believe that death cannot be determined solely by neurological criteria.[38]

XI. How Can You Protect Yourself and Your Loved Ones?
A. Advance Directive
B. Living Will
C. Durable Power of Attorney for Health Care
D. Health Care Agent
E. POLST

XII. Scripture References
A. Open your mouth for the mute, for the rights of all who are destitute. Proverbs 31:8
B. Our bodies are buried in brokenness, but they will be raised in glory. They are buried in weakness, but they will be raised in strength. 1 Corinthians 15:43
C. Listen to your father who begot you, and do not despise your mother when she is old (Proverbs 23:22)
D. You shall rise before the aged, and defer to the old; and you shall fear your God: I am the Lord (Leviticus 19:32).
E. Maintain the right of the afflicted and the destitute (Psalm 82:3)
F. Now we that are strong ought to bear the infirmities of the weak, and not to please ourselves. (Romans 15:1)
G. Deliver those who are drawn toward death, and hold back those stumbling to the slaughter. (Proverbs 24:11)

[38] New Jersey Statutes Title 26. Health and Vital Statistics 26 § 6A-5