F16 – Euthanasia – Conroy case

For 1978

	Block 513–Lot 4–1	Block 513–Lot 4–2	Block 514–Lot 13–1
Land	$58,400	$1,528,300	$ 755,100
Improvements	–0–	3,219,200	1,604,600
Total	$58,400	$4,747,500	$2,359,700

Such judgment was entered and this appeal by the City followed.

The projected valuations submitted by plaintiff's expert in the Tax Court were tendered on the cost, market data and income approaches. His cost approach yielded a valuation of $5,252,000; his market data approach, a valuation of $5,095,000; and his income approach, a valuation of $4,900.00. In his April 28, 1980 "Appraisal Update" to plaintiff, Rinaldi concluded in part:

> With regard to the three approaches to value (Cost, Income and Market) not any one of them can be relied on solely, due to the age, condition, size and configuration of the subject. It is, therefore, necessary to do all three approaches. The most reliable and the most relevant, however, is the Market Approach, strongly supported by the Income Approach and then the Cost Approach.

The City's expert utilized the cost and income approaches, his cost approach yielding a valuation of $10,785,800 and his income approach a valuation of $10,709,700.

In light of the record before us, it is apparent that the determinations of the Tax Court, made in disregard of the special purpose nature of the subject industrial complex and well settled principles of appraisal applicable thereto, cannot stand. We therefore reverse the judgment under review and remand the matter to the Tax Court for a new plenary hearing and determinations. The issues to be addressed by the proofs and the court's determinations shall be: (1) the true value of the property for each of the tax years 1977 and 1978; and (2) plaintiff's claim of entitlement to discrimination relief for the tax year 1978. The court's determinations are to be made in accord with well settled applicable appraisal techniques, *see The Appraisal of Real Estate, supra; The Anaconda Co. v. Perth Amboy, supra*, and are to be grounded on detailed findings of

fact and expression of the reasoning which, applied to the facts so found, led to such determinations.

Reversed and remanded for proceedings consistent herewith. We do not retain jurisdiction.

IN THE MATTER OF CLAIRE C. CONROY.

Superior Court of New Jersey
Appellate Division

Argued May 11, 1983—Decided July 8, 1983.

SYNOPSIS

Guardian of 84-year-old nursing home patient who was suffering from severe organic brain syndrome and a variety of other serious ailments sought removal of nasogastric tube from patient, who was totally dependent upon tube for nutriment and fluids. The Superior Court, Chancery Division, Essex County, Stanton, J.S.C., 188 N.J.Super. 523, held that nasogastric tube could be removed from patient. Guardian ad litem of patient appealed. The Superior Court, Appellate Division, Michels, P.J.A.D., held that since patient was not in a chronic vegetative state, but was simply very confused, bodily invasion patient suffered as a result of her treatment was small and death by dehydration and starvation would be painful, state's interest in preserving life outweighed patient's privacy interest, and thus removal of nasogastric tube, upon which patient was totally dependent for nutriment and fluids, would be improper.

Reversed.

1. Appeal and Error ⇐781(1)

Even though death of 84-year-old nursing home patient who was suffering from severe organic brain syndrome and various other serious ailments rendered moot the issues underlying appeal from order that nasogastric tube upon which patient was totally dependent for nutriment and foods could be removed, importance of issues presented by appeal required the resolution notwithstanding their mootness.

2. Appeal and Error ⇐781(1)

Although New Jersey's courts are not bound by case or controversy requirement that Constitution imposes on federal courts, state courts ordinarily will refuse to review questions that have become academic prior to judicial scrutiny out of reluctance to render a legal decision in abstract and a desire to conserve judicial resources. U.S.C.A. Const.Art. 3, § 2.

3. Appeal and Error ⇐781(1)

Courts will decide a moot case that presents issues of great public importance which is based upon a controversy capable of repetition, yet evading review because of short duration of any single plaintiff's interest.

4. Constitutional Law ⇐82(7)

Since 84-year-old nursing home patient who was suffering from severe organic brain syndrome and a variety of serious ailments was not in a chronic vegetative state, but was simply very confused, bodily invasion patient suffered as result of her treatment was small, and death by dehydration and starvation would be painful, state's interest in preserving life outweighed patient's privacy interest, and thus withdrawal of nasogastric tube upon which patient was totally dependent for nutriment and fluids would be improper.

5. Mental Health ⇐31

Right to terminate life-sustaining treatment based on a guardian's substituted judgment should be limited to incurable

and terminally ill who are brain dead, irreversibly comatose or vegetative, and who would gain no medical benefit from continued treatment.

6. Constitutional Law ⇐82(6, 7)

When nutrition will continue life of a patient who is not comatose, brain dead, or vegetative, and whose death is not irreversibly imminent, its discontinuance cannot be permitted on theory of patient's right to privacy or, indeed on any other basis.

Before Judges MICHELS, PRESSLER and TRAUTWEIN.

John J. DeLaney, Jr., guardian *ad litem* for Claire C. Conroy, appellant, argued the cause *pro se* (*Young, Rose & Millspaugh*, of counsel; *John J. DeLaney, Jr.*, on the brief).

William I. Strasser argued the cause for respondent *Thomas C. Whittemore*, guardian of Claire C. Conroy (*Donohue, Donohue, Costenbader & Strasser*, attorneys; *William I. Strasser*, of counsel and on the brief).

Joseph H. Rodriguez, Public Advocate, intervenor-appellant, argued the cause *pro se* (*Herbert D. Hinkle*, Deputy Public Advocate, and *Linda J. Robinson*, Assistant Deputy Public Advocate, on the brief).

Mary K. Brennan argued the cause for *amicus curiae* New Jersey Hospital Association (*Sterns, Herbert & Weinroth*, attorneys; *Frank J. Petrino* and *Mary K. Brennan*, of counsel; *Richard M. Hluchan*, on the brief).

The opinion of the Court was delivered by

MICHELS, P.J.A.D.

John J. DeLaney, Jr. (DeLaney), guardian *ad litem* of Claire C. Conroy (Conroy), appeals from a judgment of the Chancery Division entered following a plenary trial, which declared that Thomas C. Whittemore (Whittemore) as guardian of Claire C. Conroy had "the right to cause the removal of the nasogastric

tube presently inserted in Claire C. Conroy." *In re Conroy*, 188 *N.J.Super.* 523, 532 (Ch.Div.1983). Conroy at the time the order was entered was 84 years old and suffered from severe organic brain syndrome and a myriad of other physical problems. Unable to swallow sufficient amounts of food and water for her own sustenance, she was being nourished through a nasogastric feeding tube. The judgment under review was stayed by this court pending appeal; Conroy died of natural causes while the appeal was pending.

The facts relevant to this appeal are not in substantial dispute. From her teens until her retirement at age 62 or 63, Conroy was employed by a cosmetics company. She never married, but was devoted to her three sisters and her several cats. The last of her sisters died in 1975, leaving her nephew Whittemore as her only living relative. According to Whittemore, Conroy began to show signs of confusion some time before 1979. In 1979 he petitioned for and was granted guardianship of Conroy, whom he then placed in the Parklane Nursing Home (Parklane). According to Dr. Ahmed Kazemi, Conroy's physician at Parklane, Conroy was ambulatory upon her admission but was somewhat confused as the result of organic brain syndrome.[1] With the passage of time, this condition became progressively more severe and her ability to walk, reason and feed herself deteriorated. In 1982 she developed necrotic ulcers on her left foot as a complication of diabetes. At this time, she was unable to maintain a conversation because of her extreme confusion, but was aware of and could respond to commands.

On July 23, 1982, after observing that Conroy was not eating, Dr. Kazemi placed her on a nasogastric tube, which is a simple

[1]"Organic brain syndrome" is defined as "[a] syndrome resulting from diffuse or local impairment of brain tissue function, manifested by alteration of orientation, memory, comprehension, and judgment." *Dox, Melloni & Eisner, Illustrated Medical Dictionary* 347 (1979). It is not the same as senile dementia, which is "mental deterioration caused by atrophy of the brain due to aging." *Id.* at 122.

flexible plastic tube that is run through the patient's nose int the stomach and through which liquid nutrients are passe Except for a two-week period in October and November 198 during which time she was fed pureed food but with poo results, this tube remained in place until her death. Conroy wa unable to swallow sufficient quantities of food and water to liv without the help of the nasogastric tube.

Dr. Kazemi further testified at trial that Conroy was n brain dead,[2] not comatose, and not in a chronic vegetative state Dr. Bernard Davidoff, who testified for the guardian *ad lite* DeLaney, described Conroy's mental state as "severely demen ed." Severe contractions of her lower legs kept her in semi-fetal position. Although Conroy did not respond to verb stimuli, she followed movements with her eyes, used her han to scratch herself, and was able to move her head, neck, arr and hands voluntarily. Catherine Rittel, an administrator-nur

[2]The Harvard Medical School Ad Hoc Committee's criteria for "br death" were summarized as follows in *In re Quinlan*, 70 *N.J.* 10, 27 cert. d 429 *U.S.* 922, 97 *S.Ct.* 319, 50 *L.Ed.*2d 289 (1976):

> The Ad Hoc standards, carefully delineated, included absence of sponse to pain or other stimuli, pupilary reflexes, corneal, pharyngeal a other reflexes, blood pressure, spontaneous respiration, as well as "fl or isoelectric electroencephalograms and the like, with all tests repea "at least 24 hours later with no change."

[3]Dr. Fred Plum, an expert witness at the *Quinlan* trial, explained difference between vegetative and sapient brain function:

> We have an internal vegetative regulation which controls body tempe ture which controls breathing, which controls to a considerable deg blood pressure, which controls to some degree heart rate, which cont chewing, swallowing and which controls sleeping and waking. We h a more highly developed brain which is uniquely human which cont our relation to the outside world, our capacity to talk, to see, to feel sing, to think. [70 *N.J.* at 24.]

According to Cranford, "Ethical Viewpoint of a Neurologist," 45 *Conn.M* 722 (1981),

> Patients in a persistent vegetative state have relatively intact brainst functioning (vegetative functions such as breathing) but no cerel cortical function at all, such as awareness of self or others or any deg of cognition.

at Parklane, testified that Conroy smiled when she was massaged or her hair was combed and moaned when she was fed.

Neither physician could determine whether Conroy could feel pain. They speculated that although her gangrene and ulcers did not seem to be a source of pain, the leg contractions probably were. According to the physicians' testimony, if the nasogastric tube were to have been removed, Conroy would have died of dehydration and starvation in about a week. Dr. Kazemi described this as a painful death. Moreover, the trial judge recognized that "the removal of the tube will lead to suffering and death," and ordered the guardian and health care personnel "to take reasonable steps to minimize [Conroy's] discomfort ... during her passage from life." 188 *N.J.Super.* at 532.

The physicians agreed there was no chance of an improvement in Conroy's mental condition. Dr. Davidoff observed, however, that none of Conroy's medical conditions was fatal and therefore that it could not be predicted when or from what cause Conroy would die.

I.

THE ISSUE OF MOOTNESS

[1] We first address the guardian *ad litem*'s contention (withdrawn at oral argument) that this appeal should be dismissed because it has become moot. It is true, of course, that Conroy's death has rendered the issues that underlie this appeal moot. There no longer is a threat that the State will compel the continued treatment of Conroy against the exercise of her right to privacy or that the nasogastric tube will be removed contrary either to her best interests or to the State's interest in the preservation of life. Therefore, the conflict between the parties has become merely hypothetical. Nevertheless, we conclude that the importance of the issues presented by this appeal requires their resolution notwithstanding their mootness.

[2] Although New Jersey's courts are not bound by the "case or controversy" requirement that *U.S. Const.*, Art. III, § 2 imposes on federal courts, *see Salorio v. Glaser*, 82 *N.J.* 482, 490–491 appeal dismissed and *cert.* den. 449 *U.S.* 804, 101 *S.Ct.* 49, 66 *L.Ed.*2d 7 (1980); *Crescent Pk. Tenants Ass'n v. Realty Eq. Corp. of N.Y.*, 58 *N.J.* 98, 107–108 (1971), our courts ordinarily will refuse to review questions that have become academic prior to judicial scrutiny out of reluctance to render a legal decision in the abstract and a desire to conserve judicial resources. *See, e.g., Oxfeld v. New Jersey State Board of Education*, 68 *N.J.* 301, 303–304 (1975); *Sente v. Clifton*, 66 *N.J.* 204, 205 (1974); *Handabaka v. Division of Consumer Affairs*, 167 *N.J.Super.* 12, 14 (App.Div.1979).

[3] Nevertheless, our courts will decide a moot case that presents issues of great public importance or is based upon a controversy capable of repetition, yet evading review because of the short duration of any single plaintiff's interest. *See e.g., Guttenberg Sav. & Loan Ass'n v. Rivera*, 85 *N.J.* 617, 622–623 (1981); *Dunellen Educ. Bd. v. Dunellen Educ. Ass'n*, 64 *N.J.* 17, 22 (1973); *John F. Kennedy Mem. Hosp. v. Heston*, 58 *N.J.* 576, 579 (1971); *State v. Union Cty. Park Comm'n*, 48 *N.J.* 246, 248–249 (1966); *East Brunswick Tp. Educ. Bd. v. E. Brunswick Tp. Council*, 48 *N.J.* 94, 109 (1966); *State v. Perricone*, 37 *N.J.* 463, 469, *cert.* den. 371 *U.S.* 890, 83 *S.Ct.* 189, 9 *L.Ed.*2d 124 (1962); *Playcrafters Student Members v. Teaneck Tp. Educ. Bd.*, 177 *N.J.Super.* 66, 73–74 (App.Div.), aff'd o.b. 88 *N.J.* 74 (1981); *Humane Society of the U.S. v. Guido*, 173 *N.J.Super.* 223, 225 (App.Div.1980). *See generally Busik v. Levine*, 63 *N.J.* 351, 363–364, appeal dismissed 414 *U.S.* 1106, 94 *S.Ct.* 831, 38 *L.Ed.*2d 733 (1973).

The issues presented by this appeal are of such great public importance that their resolution is clearly warranted. This appeal offers an opportunity to provide guidance to family members, guardians, physicians and hospitals, the need for which extends far beyond the facts of this case. Moreover, this

is the type of case that is capable of repetition, yet which evades review because the patients involved often die during the course of litigation. *Cf. Roe v. Wade*, 410 *U.S.* 113, 125, 93 *S.Ct.* 705, 712–13, 35 *L.Ed.*2d 147 (1973). For these reasons, courts have consistently agreed to decide the rights of terminally ill patients to refuse life-sustaining treatment even after the patients have died or recovered. *See John F. Kennedy Mem. Hosp. v. Heston*, *supra*, 58 *N.J.* at 579; *State v. Perricone*, *supra*, 37 *N.J.* at 469; *Matter of Spring*, 380 *Mass.* 629, 405 *N.E.*2d 115 (1980); *Superintendent of Belchertown v. Saikewicz*, 373 *Mass.* 728, 370 *N.E.*2d 417 (1977); *Matter of Storar*, 52 *N.Y.*2d 363, 438 *N.Y.S.*2d 266, 268–69, 420 *N.E.*2d 64, 66–67 (Ct.App.), *cert.* den. 454 *U.S.* 858, 102 *S.Ct.* 309, 70 *L.Ed.*2d 153 (1981).

II.

CONROY'S RIGHT TO PRIVACY

[4] We turn, then, to the merits of this appeal.[4] The basic issue before us is whether the judgment here entered represents a legally permissible application of the principles of *In re Quinlan*, 70 *N.J.* 10, *cert.* den. 429 *U.S.* 922, 97 *S.Ct.* 319, 50 *L.Ed.* 2d 289 (1976). The decision in *Quinlan* was based upon the patient's right of privacy which was deemed, under the circumstances there, to outweigh the State's interest in the preservation of life. The question then is whether under the circumstances here there was also a right of privacy which outweighed that paramount state interest and which therefore could justify the withdrawal of life-sustaining nourishment from this patient.

[4]We observe that there is no contention that Whittemore is acting other than with the utmost sincerity and good faith, or that he is mistaken in concluding that Conroy would have asked to terminate treatment if she were able. We also find no merit in the guardian *ad litem*'s contention that compliance with the trial judge's order will expose the guardian and the physician to criminal liability. The *Quinlan* court said specifically that one whose action is necessary to effectuate a patient's exercise of her right to privacy "is protected from criminal prosecution." 70 *N.J.* at 52.

If the State's interest in the preservation of life outweighs the patient's right of privacy, such withdrawal would be an act of euthanasia, constituting homicide. It is only if the right of privacy could be reasonably deemed to prevail that withdrawal would be legally permissible under the *Quinlan* doctrine. We reverse the judgment here entered because in our view we regard it as the authorization of euthanasia.

The right to privacy is recognized under the United States Constitution as a "penumbra" derived from several more specific constitutional guarantees. *See Griswold v. Connecticut*, 381 *U.S.* 479, 484, 85 *S.Ct.* 1678, 1681, 14 *L.Ed.*2d 510 (1965). This right is also protected by *N.J. Const.* (1947), Art. I, par. 1. *In re Grady*, 85 *N.J.* 235, 249 (1981); *State v. Saunders*, 75 *N.J.* 200, 210–217 (1977). The right to privacy is not absolute, however; it must yield to important state interests in areas protected by that right. *Roe v. Wade*, *supra*, 410 *U.S.* at 155, 93 *S.Ct.* at 727–28. In *In re Quinlan*, *supra*, the Supreme Court of New Jersey applied the right to privacy balance to a comatose patient's petition to discontinue extraordinary life-sustaining treatment.

When the *Quinlan* case was decided, its subject—Karen Ann Quinlan—was a 22-year-old woman in an irreversible coma, a symptom of severe brain damage caused by prolonged anoxia. Karen was in a "chronic vegetative state," in which she retained neurological control over her blood pressure, heart rate, chewing, swallowing, sleeping and waking, but lost all more sophisticated brain stem and higher neurological functions. Thus, although she reacted to light, sound and noxious stimuli on a primitive reflex level, she was not consciously aware of her surroundings: she had no cognitive function. No existing medical technique could have been expected to restore her to cognitive or sapient life.

One of the brain stem functions Karen Quinlan was believed to have lost was the ability to breathe unassisted. Therefore she was connected to a respirator, described by the *Quin*

court as "a sophisticated machine which delivers a given volume of air at a certain rate and periodically provides a 'sigh' volume, a relatively large measured volume of air designed to purge the lungs of excretions." 70 *N.J.* at 25. Karen was fed by nasogastric tube.

Karen's father, Joseph Quinlan, sought an adjudication that his daughter was incompetent and a declaration that he be her guardian with the power to authorize discontinuance of "all extraordinary medical procedures now allegedly sustaining Karen's vital processes and hence her life."[5] The Supreme Court reversed the Chancery Division's judgment and granted the father's request. The *Quinlan* court saw the right to privacy as requiring a balancing of the State's interest in preserving life and the patient's interest in freedom from the burden of continued treatment. The Court reasoned:

> The claimed interests of the State in this case are essentially the preservation and sanctity of human life and defense of the right of the physician to administer medical treatment according to his best judgment. In this case the doctors say that removing Karen from the respirator will conflict with their professional judgment. The plaintiff answers that Karen's present treatment serves only a maintenance function; that the respirator cannot cure or improve her condition but at best can only prolong her inevitable slow deterioration and death; and that the interests of the patient, as seen by her surrogate, the guardian, must be evaluated by the court as predominant, even in the face of an opinion *contra* by the present attending physicians. Plaintiff's distinction is significant. The nature of Karen's care and the realistic chances of her recovery are quite unlike those of the patients discussed in many of the cases where treatments were ordered. In many of those cases the medical procedure required (usually a transfusion) constituted a minimal bodily invasion and the chances of recovery and return to functioning life were very good. 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. Ultimately there comes a point at which the individual's rights overcome the State interest. It is for that reason that we believe Karen's choice, if she were competent to make it, would be vindicated by the law. Her prognosis is extremely poor,—she will never resume cognitive life. And the bodily invasion is very great,—she requires 24 hour intensive nursing care, antibiotics, the assistance of a respirator, a catheter and feeding tube. [70 *N.J.* at 40–41.]

[5]It is significant that at no time during or after the *Quinlan* litigation has Joseph Quinlan requested that Karen's nasogastric tube be removed. When asked if he desired that this tube be removed, he reportedly said in amazement, "Oh no. That is her nourishment." Ramsey, "Prolonged Dying: Not Medically Indicated," 6 *Hastings Ctr. Rep.* 14 (1976).

A similar legal analysis has been employed by other jurisdictions in this type of case. *See In re Severns*, 425 *A.*2d 156, 158–159 (Del.Ch.1980); *Satz v. Perlmutter*, 362 *So.*2d 160, 162–163 (Fla.App.1978), aff'd o.b. 379 *So.*2d 359 (Fla.Sup.Ct.1980); *Matter of Spring, supra*, 380 *Mass* at 639–42, 405 *N.E.*2d at 122–123; *Superintendent of Belchertown v. Saikewicz, supra*, 373 *Mass.* at 740–45, 370 *N.E.*2d at 425–427; *Leach v. Akron Gen. Med. Ctr.*, 68 *Ohio Misc.* 1, 426 *N.E.*2d 809, 814–815 (Ct. Common Pleas 1980); *Matter of Welfare of Colyer*, 99 *Wash.*2d 114, 660 *P.*2d 738, 741–744 (1983). The New York Court of Appeals, though it based its decision on nonconstitutional grounds, has adopted a similar balance of interests standard in resolving this type of case. *Matter of Storar*, 52 *N.Y.*2d 363, 438 *N.Y.S.*2d 266, 275–276, 420 *N.E.*2d 64, 73–74, *cert.* den. 454 *U.S.* 858, 102 *S.Ct.* 309, 70 *L.Ed.*2d 153 (1981).

Application of the *Quinlan* right to privacy standard requries an examination of the relative interests of the State and the patient in the continuation or withdrawal of treatment.

A.

The Patient's Prognosis as Determining the State's Interest

The State's interest in preserving a patient's life is small with regard to the hopelessly ill or irreversibly comatose patient, but great with regard to the patient whose condition will substantially improve as the result of continued treatment. This distinction is borne our by the case law. In *John F. Kennedy Mem. Hosp. v. Heston, supra*, 58 *N.J.* at 581–585, our Supreme Court ordered blood transfusions for a young woman who required surgery to save her life, despite her mother's objections on religious grounds. The court emphasized the State's interest in preserving the life of a patient who, if treated, may enjoy long life and good health:

Appellant suggests there is a difference between passively submitting to death and actively seeking it. The distinction may be merely verbal, as it would be if an adult sought death by starvation instead of a drug. If the State may interrupt one mode of self-destruction, it may with equal authority interfere with the other. It is arguably different when an individual, overtaken by illness, decides to let it run a fatal course. But unless the medical option itself is laden with the risk of death or of serious infirmity, the State's interest in sustaining life in such circumstances is hardly distinguishable from its interest in the case of suicide. [58 *N.J.* at 581–582.]

See also Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson, 42 *N.J.* 421, 423, *cert.* den. 377 *U.S.* 985, 84 *S.Ct.* 1894, 12 *L.Ed.2d* 1032 (1964); *State v. Perricone*, *supra*, 37 *N.J.* at 475–477.

This distinction has been recognized by the Supreme Judicial Court of Massachusetts. In *Superintendent of Belchertown v. Saikewicz*, *supra*, that court granted an application to discontinue chemotherapy in the case of a 67-year-old man suffering from terminal and incurable leukemia. However, the opposite result was reached in *Commissioner of Correction v. Myers*, 379 *Mass.* 255, 399 *N.E.2d* 452 (1979). The patient in that case was a 24-year-old prisoner who suffered from a chronic kidney condition. Dialysis would have allowed him to lead a relatively normal and healthy life; without the dialysis, he would have died within ten to fifteen days. The court found that the balance of interests tipped toward the State. It observed:

> In contrast, the State's interest in the preservation of life is directly implicated here. Characterized as "the most significant of the asserted State interests," *id.* [373 *Mass.*] at [741], 370 *N.E.2d* at 425, this particular concern was outweighed in *Saikewicz* by the crucial fact that the patient's leukemia was incurable and would soon cause death regardless of any medical treatment. As we observed, "[t]here is a substantial distinction in the State's insistence that human life be saved where the affliction is curable, as opposed to the State interest where . . . the issue is not whether, but when, for how long, and at what cost to the individual that life may be briefly extended." *id.* at [742], 370 *N.E.2d* at 425–426.
>
> Myers' prognosis contrasts sharply with that of Saikewicz. Although Myers' kidney disease prior to the transplant could be technically classified as "incurable," it clearly was not life-threatening in the sense that his "life [would] soon, and inevitably, be extinguished" regardless of the treatment he received. *Id.* at [742], 370 *N.E.2d* at 425. On the contrary, continued dialysis and medication permitted Myers to live an otherwise normal and healthy life, and following the kidney transplant, daily medication presently provides the possibility of complete cure. Therefore, compelling Myers to take his medication, or, in the regrettable event that his body rejects the transplanted kidney, compelling him to submi dialysis does not involve a situation where "heavy physical and emoti burdens" would be imposed "to effect a brief and uncertain delay in the nat process of death." *Id.* at [744], 370 *N.E.2d* at 427. Consequently, the Sta interest in the preservation of life is "quite strong" in this instance. *Custody of a Minor*, [375] *Mass.* [733], [755] n. 12, 379 *N.E.2d* 1053 (1978). *N.E.2d* at 456.]

By contrast, courts have been far more ready to allow irreversibly comatose or incurably terminally ill person to ref treatment. *See, e.g., In re Severns*, *supra* (comatose chr vegetative patient); *Satz v. Perlmutter*, *supra* (patient suffer from incurable terminal amyotrophic lateral sclerosis); *Ma of Spring*, *supra* (comatose chronic vegetative patient); *Leac Akron Gen. Med. Ctr.*, *supra* (semi-comatose, vegetative pati suffering from terminal amyotrophic lateral sclerosis); *Ma of Welfare of Colyer*, *supra* (comatose chronic vegetative tient). *See also In re Quackenbush*, 156 *N.J.Super.* 282, 288– (Cty.Ct.1978).

We conclude that Conroy's prognosis supports a significa greater state interest in continued treatment than in the c cited above. At the time of trial, Conroy was unable to m from a fetal position and had a severely limited ability respond to her surroundings. However, she was not in a chr vegetative state; she was simply very confused. Dr. Kaz testified that because Conroy was aware of some exte stimuli and responded to them, she was neither vegetative comatose. This testimony draws a very different picture f that drawn in the *Quinlan* case. It seems to describe a wo who, like an infant less than a year old, experienced responded to her surroundings but lacked the intellectual ca ty to understand most of them. By comparison, Karen Qui was unaware of her environment and had only the most re ive reactions to outside stimuli:

> The further medical consensus was that Karen in addition to being comat in a chronic and persistent "vegetative" state, having no awareness of any or anyone around her and existing at a primitive reflex level. Although she have some brain stem function (ineffective for respiration) and has reactions one normally associates with being alive, such as moving, reacti

light, sound and noxious stimuli, blinking her eyes, and the like, the quality of her feeling impulses is unknown. She grimaces, makes sterotyped cries and sounds and has chewing motions. Her blood pressure is normal. [70 *N.J.* at 25.]

The distinction between an "awake" but confused patient like Conroy and an "asleep," vegetative patient like Karen Quinlan is material and is determinative in this case. The *Quinlan* court held that the State's interest in preserving a patient's life depends on whether the patient ever will return to cognitive, sapient life. 70 *N.J.* at 41. Thus, it is plain that *Quinlan* applies only to noncognitive, vegetative patients.[6] The *Quinlan* court evidently was of the opinion that the State's interest in preserving life outweighs the patient's right to privacy when the patient retains the capacity to relate to the outside world. In the present case, Conroy was sapient, but lacked the intellectual capacity to understand what she observed. Under the principles of the *Quinlan* case, the State had a substantial and overriding interest in preserving her life.

[5] We are also troubled by the trial judge's framing of the issue as whether the patient will return "to some meaningful level of intellectual functioning." Put simply, to allow a physician or family member to discontinue life-sustaining treatment to a person solely because that person's lack of intellectual capacity precludes him from enjoying a meaningful quality of life would establish a dangerous precedent that logically could be extended far beyond the facts of the case now before us. In our view, the right to terminate life-sustaining treatment based on a guardian's substituted judgment should be limited to incurable and terminally ill patients who are brain dead, irreversibly comatose or vegetative and who would gain no medical benefit from continued treatment. *A fortiori*, there can be no justification for withholding nourishment, which is really not "treatment" at all (*see* § IIB below), from a patient who does not

[6]Respondents rely on footnote 10 to the *Quinlan* opinion to support a contrary view. *See* 70 *N.J.* at 54 n. 10. That footnote, however, refers to "Do Not Resuscitate" orders, not to the termination of life-sustaining treatment.

meet these criteria. Any further extension of the *Quinlan* rule would place into the hands of physicians, family members and judges the determination of whose quality of life is so slight that he should not be kept alive.[7]

B.

The Nature of Treatment as Defining the Patient's Interest

"[T]he individual's right to privacy grows as the degree of bodily invasion increases." *In re Quinlan, supra*, 70 *N.J.* at 41. In our view, "bodily invasion" means not only the degree of physical discomfort, incapacitation or debilitation a given treatment will cause a patient, but also the feelings of helplessness, dependence and loss of dignity the treatment will engender. Thus, the patient's interest in privacy is greater when his medical condition requires 24-hour care, dependence on machines to carry on bodily functions, or regular exposure and handling of his body. *See ibid.* The courts seem to have accepted this rule, in that they have been far more willing to allow patients to refuse complex, highly intrusive treatments like respirators (*In re Severns, supra; In re Quinlan, supra; Leach v. Akron Gen. Med. Ctr., supra; Matter of Colyer, supra*), hemodialysis (*In re Spring, supra*), chemotherapy (*Superintendent of Belchertown v. Saikewicz, supra*) or amputation (*In re Quackenbush, supra*) than to refuse a simple and routine treatment like a blood transfusion (*see John F. Kennedy Mem. Hosp. v. Heston, supra; State v. Perricone, supra*). As the court explained in *In re Quackenbush,*

[7]We note that the Report of the President's Commission for the Study of Ethical Problems in Medicine and Bio-medical and Behavioral Research, relied on heavily by respondents here, would restrict the discontinuance of life-sustaining treatment to "those in whom *all* possible components of consciousness are absent. This signifies an absence of all mental life, that is, of all thought, feeling, sensation, desire, emotion and awareness of self or environment.... [Such a patient] does not engage in purposive action, and manifests no other signs of mental activity." Therefore, the recommendations of the President's Commission do not apply to Claire Conroy.

The *Quinlan* decision distinguished *Heston*, noting that a blood transfusion is a minimal bodily invasion and that the woman had a potential for vibrant health and long life. That distinction is viable in this case. Mr. Quackenbush is confronted with a significant bodily invasion and does not have the long life and vibrant health potential.

The extent of the bodily invasion required to overcome the State's interest is not defined in *Quinlan*. Further, there is a suggestion of a need for a combination of significant bodily invasion and a dim prognosis before the individual's right of privacy overcomes the State's interest in preservation of life. Under the circumstances of this case, I hold that the extensive bodily invasion involved here—the amputation of both legs above the knee and possibly the amputation of both legs entirely—is sufficient to make the State's interest in the preservation of life give way to Robert Quackenbush's right of privacy to decide his own future regardless of the absence of a dim prognosis. [156 *N.J.Super.* at 288–289.]

In this light, the treatment given to Conroy differs significantly from that given Karen Quinlan. The bodily invasion necessary to treat Karen Quinlan was "very great." 70 *N.J.* at 41. It included 24-hour intensive nursing care, antibiotics and the assistance of a respirator, a catheter and a feeding tube. As a result, her personal dignity was taken from her and she was placed in a position of helplessness and dependence. In contrast, Conroy was in the less restrictive environment of a nursing home, was not subject to intensive nursing care, and had none of her bodily functions replaced by a machine. The nasogastric tube was no more than a simple device which was part of Conroy's routine nursing care. It was not really "medical treatment" at all. In truth, Conroy was little different from the many other ill, senile or mentally disabled persons who are bedridden and cared for in nursing homes. Consequently, the bodily invasion she suffered as the result of her treatment was small, and should not be held to outweigh the State's interest in preserving her life.

No reported case has considered whether an artificial means of feeding may be withdrawn from an irreversibly ill or comatose patient. However, similar considerations were before the New York Court of Appeals in *In re Storar, supra*, 438 *N.Y.S.*2d at 275–276, 420 *N.E.*2d at 73–74. The patient in that case was a 52-year-old profoundly retarded man who was diagnosed as

having terminal and incurable cancer of the bladder. Stor would die within six months. To maintain his health until the he required blood transfusions every eight to fifteen day Storar disliked the transfusions and was frightened by them ar the blood in his urine they caused. Without them, he would d within weeks. The trial judge denied the hospital's petition continue the transfusions over the patient's mother's objectior The Court of Appeals reversed, in language highly relevant the present appeal:

In the *Storar* case there is the additional complication of two threats to life. There was cancer of the bladder which was incurable and would in probability claim his life. There was also the related loss of blood which pos the risk of an earlier death, but which, at least at the time of the hearing, co be replaced by transfusions. Thus, as one of the experts noted, the transfusic were analogous to food—they would not cure the cancer, but they co eliminate the risk of death from another treatable cause. Of course, John Sto did not like them, as might be expected of one with an infant's mentality. E the evidence convincingly shows that the transfusions did not involve excess pain and that without them his mental and physical abilities would not maintained at the usual level. With the transfusions on the other hand, he w essentially the same as he was before except of course he had a fatal illn which would ultimately claim his life. Thus, on the record, we have conclud that the application for permission to continue the transfusions should have be granted. Although we understand and respect his mother's despair, as respect the beliefs of those who oppose transfusions on religious grounds, a co should not in the circumstances of this case allow an incompetent patient bleed to death because someone, even someone as close as a parent or sibli feels that this is best for one with an incurable disease. [438 *N.Y.S.*2d 275–276, 420 *N.E.*2d at 73–74.]

[6] The same reasoning applies to the withdrawal of fo and water from a patient. Nourishment does not itself cu disease. Neither is it an artificial life-sustaining device. Rath it is a basic necessity of life whose withdrawal causes death a whose provision permits life to continue until the patient dies his illness or injury. Whether nourishment may *ever* be wit drawn from a patient whose medical condition is unlikely improve is not the issue here. We hold only that when nutriti will continue the life of a patient who is not comatose, bra dead or vegetative, and whose death is not irreversibly imm

nent, its discontinuance cannot be permitted on the theory of the patient's right to privacy or, indeed, on any other basis.

III.

THE ETHICAL QUESTIONS

While we are satisfied that the proper balance between the preservation of life and the patient's right to privacy requires the result we have here reached, we are also persuaded that this result is dictated by ethical concerns as well.

The ethical question implicit in the decision whether to discontinue life-sustaining measures has traditionally been expressed by the distinction between "ordinary" and "extraordinary" treatment. The standard definition of these terms is given as follows:

> Ordinary means are all medicines, treatments, and operations which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconvenience. Extraordinary means are all medicines, treatments, and operations which cannot be obtained or used without excessive expense, pain, or other inconvenience, or if used, would not offer a reasonable hope of benefit. [*G. Kelly, Medico-Moral Problems* 129 (1958).]

An alternative formulation is proposed in Lewis, "Machine Medicine and its Relation to the Fatally Ill," 206 *J.A.M.A.* 387, 390 (1968), as follows:

> Ordinary measures of patient care are recognized as elements of essential care. They represent obligatory, proven, and justified therapies and procedures.... They further represent measures which [the patient] can reasonably undergo with only minimal or moderate danger and maximal effectiveness. Such measures are also not an impossible or excessive burden.
>
> Extraordinary measures ... are complicated methods. They are impossible for the patient to use or apply by himself and present a costly and difficult burden.... [T]hey represent a high level of danger, and the results expected are not predictable, i.e., the effectiveness is minimal or moderate while the dangers are maximal.

Thus, the definition of "extraordinary treatment" is fluid, and depends on both the nature of the treatment and the patient's

prognosis.[6] As the Supreme Court said in *Quinlan*,

> ... [o]ne would have to think that the use of the same respirator or like support could be considered "ordinary" in the context of the possibly curable patient but "extraordinary" in the context of the forced sustaining by cardio-respiratory processes of an irreversibly doomed patient. [70 *N.J.* at 48.]

There is substantial disagreement among ethicists whether the provision of food and water should ever be considered extraordinary treatment. It is in fact recognized that the terms "extraordinary treatment" and "ordinary treatment" elude certain definition. To some, the natural and ordinary quality of feeding dictates that it should never be withdrawn. *See Healy Medical Ethics* 61–77 (1960); *McFadden, Medical Ethics* 227–247 (1961); *O'Donnell, Morals in Medicine* 57, 66–68 (1959). A code of treatment for severely ill children, drafted by the Nassau (N.Y.) Pediatric Society Committee on Ethics and Survival provides that "ordinary measures are food, fluids, oxygen, antibiotics and pain killers." Waldman, "Medical Ethics and the Hopelessly Ill Child," 88 *J.Ped.* 890, 892 (1976). This position recently was summed up by Surgeon General C. Everett Koop as follows: "Withholding fluids or nourishment at any time is an immoral act." *Time*, April 11, 1983, at 69.

Nevertheless, several scholars are of the opinion that if the patient is beyond all hope of recovery, the burden of continued feeding is disproportionate to the benefit it will effect. *See Wilson, Death by Decision* 70–71 (1975); Ramsey, "Prolonged Dying: Not Medically Indicated," 6 *Hastings Ctr. Rep.* ___ 1 (1976). The American Medical Association Judicial Council, in Opinion 2.11 (Jan. 10, 1981), reprinted at 45 *Conn.Med.* 72 (1981), concludes that when a patient is irreversibly comatose o

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[6]The terms "extraordinary treatment" and "ordinary treatment" do not admit to certain definition. As the President's Commission has pointed out, the term "extraordinary treatment" is "more of an expression of the conclusion than a justification for it." The trial judge in the present case found the distinction "not ... particularly helpful." 188 *N.J.Super.* at 528. The *Quinlan* court, at least on the record before it, found the distinction "somewhat hazy." 70 *N.J.* at 48. Nevertheless, these terms have come to have widely accepted meaning.

in a permanent vegetative state, "*all* means of life support may be discontinued."[9] Similar is this passage from the report of the President's Commission:

> Most patients with permanent unconsciousness cannot be sustained for long without an array of increasingly artificial feeding interventions—nasogastric tubes, gastrotomy tubes, or intravenous nutrition. Since unconscious patients are not aware of nutrition, the only benefit of such increasingly burdensome interventions is the remote possibility of recovery. The sensitivities of the family and the care-giving professionals ought to determine whether such steps are undertaken.

The present appeal is not the proper vehicle by which to resolve this issue, and we expressly decline to do so. Even those ethicists who advocate the withdrawal of nourishment do so only when nourishment would offer no benefit to the patient, as when the patient is irreversibly comatose or permanently vegetative. In the words of *Ramsey, supra*, 6 *Hastings Ctr. Rep.* at 14:

> I suggest that in a proper understanding of [the terms "ordinary means" and "extraordinary means"] (which are objectively relative to the patient's condition) the IV is as aimless as the respirator. It, too, is only prolonging Karen's dying. Surely it is not hunger that Karen feels now. To be on the safe side, perhaps we should say that she might experience dehydration. That is now the purpose of a glucose drip: to give the comfort of a cup of cool water to a patient who has entered upon her own particular dying. If a glucose drip prolongs this patient's dying, it is not given for that purpose, or as means in a continuing useless effort to save her life.

If, as here, the patient is not comatose and does not face imminent and inevitable death, nourishment accomplishes the substantial benefit of sustaining life until the illness takes its natural course. Under such circumstances nourishment always will be an essential element of ordinary care which physicians are ethically obligated to provide.

There are involved here, moreover, ethical considerations which far transcend the ordinary-extraordinary dichotomy and its implications. In *Quinlan* the court reaffirmed the concept of the nondelegable judicial responsibility to determine issues involving the underlying and competing human values and rights here implicated. It also acknowledged that these determinations "must, in the ultimate, be responsive not only to the concepts of medicine but also to the common moral judgment of the community at large." 70 *N.J.* at 44. Thus, *Quinlan* made clear that when the medical issue is no longer "curing the ill but conforting and easing the dying" (*id.* at 47), the medical judgment is entitled to deference by the courts and society only those cases in which, because of the condition of the patient and the nature of the life support system, the issue of sustaining life is not readily amenable to judicial resolution but is a matter for medical consensus based upon prevailing standards of practice and ethics. *Id.* at 47–48. *Quinlan*, involving an irreversible comatose patient sustained by sophisticated and complex devices, presented just such a situation. This case does not. In our view, withdrawal of a nasogastric tube from a noncomatose patient not facing imminent death is not a method of "comforting and easing the dying" which either the courts or society can tolerate.

We are further convinced that the withdrawal of the feeding tube here would also violate medical ethics. It is clear that the physician's primary obligation is *primum non nocere:* First

[9] Opinion 2.11 reads in full:

> Terminal Illness
>
> The social committment [sic] of the physician is to prolong life and relieve suffering. Where the observance of one conflicts with the other, the physician, patient, and/or family of the patient have discretion to resolve the conflict.
>
> For humane reasons, with informed consent a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to let a terminally ill patient die, but he should not intentionally cause death. In determining whether it is in the best interest of a terminally ill incompetent patient to administer potentially life-prolonging medical treatment, the physician should consider what the possibility is for extending life under humane and comfortable conditions and what are the wishes and attitudes of the family or those who have responsibility for the custody of the patient.
>
> Where a terminally ill patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis, all means of life support may be discontinued.
>
> The Council believes that these guidelines should apply as well, to the care of the patient in a permanent "vegetative" state.

no harm. The Hippocratic Oath provides in part: "I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone." *Pierce v. Ortho Pharmaceutical Corp.*, 84 *N.J.* 58, 74 (1980). As an extension of these maxims, medical ethicists have long distinguished between killing and letting die. Hyland and Baime frame the distinction as one between euthanasia ("the deliberate easing into death of a patient suffering from a painful and fatal disease") and antidysthanasia ("the failure to take positive action to prolong the life of an incurable patient"). Hyland & Baime, "*In re Quinlan:* A Synthesis of Law and Medical Technology," 8 *Rut.-Cam.L.J.* 37, 52 (1976). While the latter has gained acceptance in the medical community, the former always has been considered unethical. *See* Kary, "A Moral Distinction Between Killing and Letting Die," 5 *J. Med. & Phil.* 326 (1980); Dinello, "On Killing and Letting Die," 31 *Analysis* 83 (1971); *but see* Bennett, "Whatever the Consequences," 26 *Analysis* 83 (1966).

Thus, the American Medical Association Judicial Council has recommended that the following standard be adopted by courts and legislatures faced with issues of euthanasia or terminal illness:

> The intentional termination of the life of one human being by another—mercy killing or euthanasia—is contrary to public policy, medical tradition, and the most fundamental measures of human value and worth. [*Judicial Council, American Medical Association, Opinions and Reports* para. 5.17 (1979).][10]

[10]The entire relevant portion of para. 5.17 reads:

> Although the AMA cannot prevent courts or legislatures from considering issues of euthanasia or terminal illness, recent experience indicates that these governmental bodies may not provide the best forums for such discussions. Even so, this cannot stop such discussions from taking place.
>
> Accordingly, if a court or legislature is faced with this issue in the future, the Judicial Council recommends that the following statement be authorized or enacted:
>
> (1) The intentional termination of the life of one human being by another—mercy killing or euthanasia—is contrary to public policy, medical tradition, and the most fundamental measures of human value and worth.
>
> (2) The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family and/or his lawful representative, acting in the patient's best interest.
>
> (3) The advice and judgment of the physician or physicians involved should be readily available to the patient and/or his immediate family and/or his lawful representative in all such situations.
>
> (4) No physician, other licensed health care providers, or hospital should be civilly or criminally liable for taking any action pursuant to these guidelines, nor should there be any criminal or civil penalties of any sort imposed for conduct pursuant to these guidelines.
>
> (5) Except as stated above, all matters not in the public domain relating to a patient's terminal illness are the private right of the patient and are protected from public scrutiny by the privacy and confidentiality of the physician-patient relationship.

Similarly, the Judicial Council's Opinion 2.11, quoted above, states, "For humane reasons, with informed consent a physician may do what is medically necessary to alleviate severe pain, *but he should not intentionally cause death*," (emphasis added).

The trial judge in the present case in effect authorized euthanasia rather than antidysthanasia. At the time of trial, Conroy, unlike the patients permitted to discontinue treatment in the other reported cases, was neither terminally ill nor critically injured and kept alive only by artificial means. She suffered from no specific life-threatening illness or injury, and she was not, apparently, suffering any pain. Her treatment consisted basically of providing the comforts of routine nursing care. If the trial judge's order had been enforced, Conroy would not have died as the result of an existing medical condition, but rather she would have died, and painfully so, as the result of a new and independent condition: dehydration and starvation. Thus, she would have been actively killed by independent means rather than allowed to die of existing illness or injury. Instead of easing her passage from life, the result of the judge's order would have been to inflict new suffering.

Such a result has frightening implications. When a patient, guardian or physician is permitted to decide that a nonterminal

patient's life is worthless and should be terminated rather than merely to decide that an artificially extended life should be allowed to expire naturally, the decision necessarily involves a judgment of the patient's quality of life. Such a precedent could be applied with equal force to circumstances much different from and less compelling than those present here. Therefore, we reject the extension of *Quinlan* to the active euthanasia of a patient.

IV.

CONCLUSION

In sum, the trial judge erred in holding that a non-comatose, non-brain-dead patient not facing imminent death, not maintained by any life-support machine, and not able to speak for herself should be painfully put to death by dehydration and starvation. Accordingly, the judgment so ordering is reversed.

SUPERIOR COURT OF NEW JERSEY
CHANCERY DIVISION - ESSEX COUNTY
Docket No. P-32-83E

IN THE MATTER OF)
)
CLAIRE C. CONROY.)

STENOGRAPHIC TRANSCRIPT

OF

HEARING

Place:
Essex County Courthouse
Newark NJ 07102

Date: February 1, 1983

BEFORE: THE HONORABLE REGINALD STANTON, J.S.C.

TRANSCRIPT ORDERED BY: JOHN J. DELANEY, JR.

A P P E A R A N C E S:

MESSRS. DONOHUE, DONOHUE, COSTENBADER & STRASSER
ATTORNEYS FOR PLAINTIFF THOMAS C. WHITTEMORE
BY: WILLIAM I. STRASSER, ESQUIRE

MESSRS. YOUNG, ROSE & MILLSPAUGH
GUARDIAN AD LITEM
BY: JOHN J. DELANEY, JR., ESQUIRE

E. MICHELE HENLEY, C,S.R.
OFFICIAL COURT REPORTER
710 ESSEX COUNTY COURTS BUILDING
NEWARK NJ 07102

I N D E X

THE COURT: Now we're ready to get back to our trial, and we have Mr. Strasser appearing for the plaintiff and Mr. Delaney appearing as guardian ad litem.

Did you get me that presidential report?

MR. STRASSER: That's on its way down. We're trying to incorporate it into a supplemental brief. I have provided Mr. Delaney a copy and we should have it delivered down to you within the next 45 minutes.

MR. DELANEY: If it's not available, you can have my copy.

MR. STRASSER: One thing, sir, I would like to say on the record, and it will be indicated in the brief, the report which the Court would be receiving is entitled "The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research," and it's entitled "Deciding to Forego Life Sustaining Treatment."

Now the copy which the Court will be receiving, Judge, is the final typed script dated January 20, 1983. This will be printed and published next month.

This was provided to me by another attorney,

and I am prepared to represent to the Court that the final draft of this typed script will look like this, in this type of form, published by the U. S. Government.

As I say, Judge, since it's not published as of yet, we will incorporate, by reference as a type of supplemental brief, referring the Court to certain cases which we feel are pertinent and cited in the report.

THE COURT: I'll look forward to getting that later this afternoon; and if for some reason it doesn't get here, I'll borrow Mr. Delaney's copy.

Now you wanted to have testimony this afternoon?

MR. STRASSER: Yes, your Honor.

MR. DELANEY: Your Honor, I may be in a position to provide an additional witness. I'm sort of in a bind here; I searched around for a Catholic priest to come in last night--

THE COURT: -- Ms. Conroy was Catholic?

MR. DELANEY: Yes, this is what precipitated the witness coming in today. I reviewed the chart last night and told Mr. Strasser that I would be bringing in a Catholic priest.

I have been searching around for a priest

from the Morris County area, but it may require some jurisdictional clearance from the Bishop of Paterson for the Archdiocese of Newark. In the event your Honor is not inclined to have that kind of testimony--

THE COURT: -- I'll hear it. I don't know what the ultimate purpose is, use of it is, but I certainly think I should hear it for starters.

MR. STRASSER: Judge, just so the Court is aware, the witness who I will be presenting--and as I say, is outside on the telephone--is a Catholic priest and his name is Joseph Kukura. He is appearing here as an ethicist, not necessarily in his position as a priest. His position right now is ethical consultant to the Archdiocese of Newark; and as you will hear from his testimony, he does sit, right now, on three hospital medical ethics panel boards.

I'm not introducing him as a Catholic priest but as an ethicist first and, also, then as a priest, if the Court sees to accept his testimony as such.

THE COURT: I'll hear his testimony and then we'll figure out later on how I put it into the total picture.

What I thought I would do this afternoon is hear the testimony this afternoon. I also thought I'd go up and see Ms. Conroy this afternoon after I finish with the testimony. I'm not going to make an on the record thing with my reporter; I don't think I need counsel. I simply want to go up and see this lady and see for myself what she looks like, whether she can reply to the stimuli that I would cautiously use, and my observations will be part of my findings. So I will record them in that way, but I won't make a stenographic record of what I'm doing as I do it.

MR. DELANEY: Your Honor, I called chambers, with the consent of Mr. Strasser. We feel that that's a very good idea and we thank the Court for taking the time.

THE COURT: Okay. I'm glad to do it. Call your witness.

MR. STRASSER. Father Joseph Kukura.

R E V E R E N D J O S E P H K U K U R A, Sworn.

DIRECT EXAMINATION BY MR. STRASSER:

Q. Father Kukura, could you tell us where you presently reside.

A. Yes. I teach and reside at Immaculate Conception Seminary in Mahwah, New Jersey.

Q Okay. And could you tell us what your present occupation is, if any?

A Yes. As a Roman Catholic Priest, I am assigned to the Seminary and I am an associate professor of Christian Ethics, with a specialization in Medical Bio Ethics. I also serve as Ethical Consultant in medical ethical affairs for the Archdiocese of Newark; and in that capacity I serve on a number of ethical boards in local institutions.

Q Could you tell us what institutions those are, please?

A Yes. I would be an ethical consultant to St. Michael's Hospital in Newark, to Holy Name Hospital in Teaneck, to Alexian Brothers Hospital in Elizabeth and to the Pediatric Ethical Committee of St. Joseph's Hospital in Paterson.

I'm also on the Human Research Committees of St. Joseph's at Paterson and Good Samaritan Hospital in Suffern, in New York.

Q Could you, please, give us the benefit of your educational background.

A Yes. I hold a M.A. in Moral Theology from the University of Levane (phonetic), Levane, Belgium; and at the present time I am a PhD candidate with three years of study from Catholic University in Washington, D.C.

Q What are your studies as a PhD candidate?

A In Ethics, specializing in medical moral matters, Bioethics. And, coincidentally, in the area of termination of life support.

THE COURT: Do you have any questions, Mr. Delaney, on educational background, qualifications?

MR. DELANEY: No, your Honor.

THE COURT: You may go ahead, please, Mr. Strasser.

MR. STRASSER: Thank you, your Honor.

Q Father, are you aware of the matter which is before this Court, that is, the matter of Claire Conroy?

A Yes.

Q And have you personally seen Claire Conroy?

A Yes, I have.

Q And when did you see the said Claire Conroy?

A I saw her approximately an hour ago in the nursing home in Bloomfield.

Q Would you tell us what you observed at the time you saw Claire Conroy.

A Yes. I observed a person that is obviously in a state of desperate health need. A person who is calling out to us for some type of human attention might be another way of expressing it.

Q Okay. Now at the time you personally saw

Claire Conroy, did you observe the nasogastric tube going into her body?

A Yes, I did.

Q Okay. And do you understand that the proceeding presently before the Court is that the guardian of Claire Conroy is requesting the termination of the use of the nasogastric tube?

A Yes, I do.

Q All right. From your observations of Claire Conroy and from your expertise in the field of ethics and life termination, could you tell us what you feel are the ethical and moral ramifications of the removal of the nasogastric tube?

A Yes. I can say that, obviously, the removal of the tube is going to hasten the approach of death and eventually bring about the death of the patient.

I can also see need of reflecting upon the proper human care to a person who is in such a state of declining health; and I feel comfortable with representing, as best as I can, what I would judge to be a majority ethical opinion, basically non-religious, in regard to such cases, although representing the Roman Catholic community. I could also speak on behalf of that tradition in regard to the same questions.

Q What is your specific opinion as to the

ethics of the removal of the nasogastric tube from Claire Conroy?

A. First, I need to speak of criteria that I think need to be used in the judgment as to the appropriateness of means of health care. One of those particular categories would be the category of burdensomeness. Another category would be the category of benefit to the patient.

A third category that I would want to speak about, but from a moral perspective, would be the category of extra ordinary.

It would be my judgment, based on the reasonableness of the medical knowledge that we have in this particular case, that the means of health care, the NG tube, have created a situation in which the burdensomeness of this particular person's life in the present state in which we find her outweighs the good that could ordinarily be achieved through such a means.

THE COURT: What do you mean, burdensome to whom, Father?

THE WITNESS: Burdensome to her. I think that, ultimately, the question really has to be her own particular person and value judgments made in terms of her as a person who has a right to live. So my particular conclusion would be that the life condition, the life style that she

is living as a result of those particular means is burdensome to her.

The second category that I suggested was the benefit to a person. Most ethicists would say that means that are not of benefit to a person, means that just prolong a state of hopeless illness, for instance, are not always appropriate, especially if we have some evidence as to the patient's wishes, if she were in a position of making a decision for herself.

The third category, if I can move on to that, and maybe we can come back to some of these, is the term that is used quite often; that is the term extraordinary. Unfortunately, I think that there are many people who make a jump from medical definitions to moral definitions and that is not always appropriate.

For instance, as an ethicist and as a moralist, I would understand extraordinary means as all procedures, operations or other interventions which are excessively expensive, burdensome or inconvenient or which offer no hope of benefit to a patient. I think such a definition would certainly be acceptable to the majority of ethicists and I would then use such a definition and make the

judgment that on a number of counts the means of care, the tubal feeding is extraordinary.

Q Father, you mentioned the other three factors, burdensomeness, the benefit to the patient and the extraordinary fact. Now you have personally viewed Claire Conroy, and we obviously are aware that you are not a physician with a medical degree.

Can you expound a little bit on the ethical ramifications of the benefit of the nasogastric tube to Claire Conroy?

A One of the things that I tried to ascertain, both from you and from the personnel who were present at the nursing home this afternoon was the condition of the patient, the hope of recovery, and I tried to ascertain the scientific medical evidence that gives us a clear picture of the patient that we are caring for. I would suggest that once that picture is formed, we look at the value of life, which is always present in any living individual, and draw some conclusion as to whether or not the means of care are adding substantially to that life factor or whether, in fact, we are creating a situation where the life condition is just continuing a life that is outweighed by, again, the burdensomeness of the surrounding aspects of that life.

Q From your observations, of Claire Conroy, and from your discussions with the nursing home personnel, as

an ethicist, how would you describe the value of life present?

A. I would describe the value of life as within that which the basic appearances of human existence are present. For instance, cardiac, pulmonary activity, some responsiveness, but I would judge at the same time that the higher levels of human existence, that those aspects of human existence that enable us to be cognitive beings, and in relationship with other people, at least to some basic extent, are not present, and so my judgment would be that we are dealing with a person who is alive but a person who has come to a point where a hope of recovery and return to cognitive life is not a reasonable possibility.

Q. Father, it's in the medical records which are in evidence for the Court that Claire Conroy was a Roman Catholic and there is--I am aware of certain views of the Roman Catholic Church with regard to the life termination aspects.

Will you please expound a little bit on the premise of the Church with regard to a situation like this as you see it.

MR. DELANEY: Your Honor, this is the problem that we had when we were in the hallway; and the thing I wanted to raise to the Court.

Father has testified and he's testifying here

as an expert here in philosophy. I'm not going to object to having testimony as to the Roman Catholic's position but I want to bring that to the attention of the Court, it was represented the witness would be testifying as a philosopher not as a priest and I would like the opportunity to, at least, possibly bring in another view or at least have the Court have the opportunity to bring in another view as to the Catholic Church

THE COURT: Well, if you wish to bring someone else in, I'd certainly be glad to hear him if you can do it within a reasonable time.

MR. DELANEY: Okay.

THE COURT: I'm not sure how a specifically religious view should impact. The Court, of course, cannot make judgments which are not secular because of the requirements of separation of church and state, and it happens, in general, to be a very efficacious requirement. So we can't ask the Court to make a specifically religious judgment about a situation. We can, however, it seems to me, consider what impact a specifically religious view might have in terms of what this patient might have wanted.

Now I don't know. She's a simple lady, I

gather from the testimony I have heard, probably not very sophisticated from the viewpoint of higher level teachings of the Church, I would guess, but I suppose it's at least open to argument that as a member of the church she might be expected to hold certain views. That, of course, you know, that itself is problematic. There is, in many of these areas, no such thing as a Catholic view.

MR. DELANEY: My point, your Honor, is that in the event I do have problems getting access to a priest because I live in Morris County, I think if you had access to a priest you might even be willing to draw upon your experience, because the problem does exist.

THE COURT: I hesitate to do that, I think, but--

MR. STRASSER: -- Judge, maybe I can assist here. I would ask Father Kukura to restrict all testimony to just certain writings which have been published by either popes or the church itself without going into any personal observations.

You know there have been certain encyclicals of Pope Pius XII, I believe, and Pope John Paul just came out with certain comments and extra-ordinary means which have been published.

I'm offering this, basically, for informational purposes to the Court; I accept the Court's comments with regard to the religious aspect and, basically, since Claire Conroy was a Catholic, I'm just offering it as additional information to place before the Court on this decision.

THE COURT: I'll hear the testimony.

MR. DELANEY: Your Honor, may I approach the Bench off the record?

THE COURT: Yes, fine. Certainly.

(Whereupon, there was a side bar discussion off the record.)

THE COURT: As I was just telling counsel at side bar, I'll be glad to hear the testimony. The analysis of the testimony may also have some value, in the sense that it might be something that would have impressed itself upon the actual psychology of this lady and may reflective of her views, although I think one has to be cautious in saying that because a view is held and promulgated by a Catholic authority, even the most distinguished Catholic authority doesn't necessarily mean that it would be a view subscribed to by the majority of Catholics, and, certainly by this particular Catholic. But I think it's something that can be

part of the total picture, and we'll hear it.

Would you go ahead, Father, and answer the question.

A. I just wanted to make one clarification, as far as my credentials are concerned. I tried, in the last few minutes, to speak as a philosopher but I would also maintain that my credentials as a theologian are just as valid as my credentials as a philosopher. That really is my expertise and my teaching.

THE COURT: All right, fine.

Now, do you remember what the question was?

Repeat the question, please.

(Whereupon, the previous question was read back by the reporter.)

A. Yes, I'd like to say that the Catholic tradition has been very much involved in the whole question of terminating means of care for many hundreds of years, has been most especially involved in it during this present century.

I'd like to call to the Court's attention a document entitled "Declaration on Euthanasia" that was published June 26th, 1980 by the Vatican Congregation for the Doctrine of a Faith. This would be a congregation that would present to the Roman Catholic community what it considers as acceptable church teaching.

In this particular document, the Congregation clearly states that at times the burdensomeness of a particular means of health care can outweigh the benefit to the patient; and when such a condition exists, those means should be judged to be disappropriate, disporportionate, excuse me, more than optional. Commenting from Washington, from the Office of Pro-Life Affairs, Father John Connery, an eminent Roman Catholic theologian, in a manuscript entitled "The Duty to Preserve Life" defines extraordinary means in this particular fashion.

Extraordinary means are those which will impose too heavy a burden on the patient before, during or after use. He goes on to say, the above distinction between ordinary and extraordinary does not coincide with the distinction between artificial and natural or routine or unusual from the standpoint of medical practice. It will vary according to time and place.

For instance, major surgery at a time or place where anesthesia is not available would be considered extraordinary means. Also, certain means, oxygen, I.V. feeding, blood transfusions would be considered ordinary means to bring a patient through a crisis, but longterm use would make them extraordinary.

Following the sound reasoning of Father Connery, my judgment would be that in the particular case at hand,

the means that are being used, that is, the tubal feeding, are extraordinary considering their longterm use and their inability to provide anything other than continued basic assistance for the patient.

Q Father, as you're aware, the question before this Court is to determine if, in fact, the nasogastric tube should be removed from Claire Conroy. Would you consider the removal of the nasogastric tube ethically wrong and, if so, why, and if not, why?

A Presuming the adequacy of the medical facts that have been presented to me, it would be my judgment that the removal of the tube would be ethical and moral from the standpoint of the burdensomeness of the life that these means are providing for the patient.

Secondly, on the lack of benefit to the patient and, thirdly, since they fall, very definitely, into the category of extraordinary means as commonly understood in the moral community.

MR. STRASSER: I have nothing further of this witness right now, your Honor.

THE COURT: Mr. Delaney.

CROSS EXAMINATION BY MR. DELANEY:

Q Father, you testified that the woman was in desperate health need and she is calling out for human attention. What do you mean by that?

A I meant that she is at a stage of health where her condition would be described as, I hate to say the word, critical, I would describe her at a stage where she needs medical attention and if such medical attention is not provided to her she, most certainly, would die.

Q What kind of medical attention does she need, Father?

A From my particular advantage point, she needs medical attention that will look at her as a whole person who has a value that we call life but who is living that life in the conditions of declining health that she has, unfortunately, come to.

Q Do you know what will happen if the tube is pulled?

A Yes.

Q What will happen?

A She will, after a period of time, die through a lack of food nourishment.

Q And do you know how long that period of time will be?

A I have a general idea that it will be over a period of days.

Q And do you know that that would be very painful?

A Yes.

Q And you based your decision on the fact that it would be better for her to die in painfulness and from starvation as opposed to living the present condition that she has now?

A Yes.

Q In order to avoid the suffering that she is going through now, would you recommend a lethal dose of a destructive drug to kill her?

A No, I wouldn't.

Q And we're searching for the truth here, Father, and I don't mean to put you on the spot.

A I understand.

Q But I'm having trouble understanding the difference between letting a woman lead her normal life versus letting her starve to death over a week in great pain, isn't that being--weighing the choices?

A I think that any time medicine intervenes into our human personhood we are trying to ascertain how we can bring the greatest benefit to a particular person.

Q And wouldn't the greatest benefit here be by giving her a lethal drug of some sort to alleviate that pain that she was suffering if the tube is pulled?

A My own particular moral opinion, ethical reflection, is that within the realm of this particular question, to allow a person to succumb to a disease that that person

has somehow come into contact with is a different situation than directly intervening to bring about death. Ultimately, my judgment would be that such an intervention would be uncontrollable in our society that has such a different value judgment on life.

Q But, Father, aren't we intervening by pulling the tube?

A Moralist draw a distinction and talk about passive and active activity; and in this particular case the removal of the tube, while involving some action, is judged to be a passive intervention because of the fact that it is the disease that ultimately brings about the death.

Q But if we pulled the tube, the ultimate death would be caused by starvation and not by the disease?

A Yes. But my judgment would be that many times in sickness the ultimate cause of death is starvation. A person's inability to receive the nourishment that's necessary to sustain life.

For instance, most cancer patients, I think, ultimately, what causes the death is something other than the cancer itself. If cancer leads to a destruction of vital organs or leads to a basic inability of persons to receive nourishment.

Q Father, it seems from your testimony that you're saying that all medical treatment is extraordinary?

A All medical treatment can be extraordinary, depending upon the condition of the patient. In normal circumstances, the medical treatments that we have available to us in our American society are ordinary. When a particular person comes to a state of being hopelessly ill or when a particular person comes into a state where the means of care are excessively expensive, excessivly burdensomely, painful and excessively inconvenient, then such means can become extraordinary. That's why I was particularly concerned about the medical facts of this particular case, because it's only in light of those medical facts that the moral categories ultimately find their meaning.

Q Would you be willing to pull the tube if you had to do it?

A Yes.

MR. DELANEY: No further questions, your Honor.

THE COURT: It seems to me that the decision to withhold the use of the tube for this woman is based upon a decision that her life, as it now exists, is not worth prolonging. That's fundamentally what a major underlying value judgment, it seems to me, and although I can see that as a matter of fact, most of us will look at this lady and think it would be an acceptable relief for her to die.

I'm disturbed by the implications of withholding treatment because of our judgments about the quality of life being treated. And how can we get objective and readily follow the norms for distinguishing when we withhold treatment and when we don't when the judgment ultimately comes down to what we think of a person's life.

Let me just explain that a bit more and see if we can get your reaction to it, Father Kukura.

If we decide that somebody's life is hopelessly of poor quality and that this person, if she were competent to choose under her own circumstances and would prefer not to have her life prolonged, why shouldn't we then just terminate it with a lethal administration of drugs? Why do you think we should not?

THE WITNESS: I think that, ultimately, my feeling is that it is beyond the realm of our human stewardship, either philosophically or theologically to actively intervene to hasten the death.

My judgment would be that there is somewhat of a difference, granted not awfully clear and precise, between allowing a person to come to the end of their human existence and actively intervening to bring that about.

I think that, ultimately, my reason for maintaining the difference and the importance of the difference is somehow to put some control on what could happen if quality of life were the only criteria that was being used in the judgment of whether a person should continue or not.

THE COURT: All right. Now, will you tell me another thing that causes me some misgivings about the proposition that the tube should be removed.

We have in this country of progressing times, I'm informed, perhaps, well in the thousands of comatose patients, some of them quite young, who are off respirators but who are sustained by using tubes such as the present one and also by the use of catheters, very simple devices on both ends, but if we remove the tumbe that would be death due to dehydration or starvation. If we remove the catheter, there will, eventually, be renal failure; and something which troubles me is that if we decide that we can withhold what is mechanically so simple a treatment as the use of a nasogastric tube, then we have decided that at the option of families, every comatose patient's life can be terminated.

We look at crib babies, the ghastly heavily

retarded and reasonably grossly misformed children who become crib babies and now can live for 20, 25 years with fairly active supportive care. Most of them could surely be terminated by the simple withholding of antibiotics, and although there is a part of me who would see it as a good thing that their lives would not continue, there's also a part of me, I must say, that's horrified by the prospect.

How do you cope with controlling this so that it doesn't become an excuse to get rid of problems which are burdensome to us, the onlookers?

THE WITNESS: I think one way of doing that is to set a frame of reference; and there's a very dignified ethicist at Princeton Theological Seminary, Paul Ramsey, who talks about always accompanying, always loving the person that is before us and then suggests that sometimes the loving thing isn't necessarily to take the latest technology that is available and use that technology on a person for whom that technology is not going to have any type of benefit, and he signals, in particular, the person who is in a permanent vegetative state.

Now I think that the control that you're speaking about, Judge, is maintained as we carefully

supply criteria that must be used in the judgment as to whether such a case is an appropriate case for the removal of life support systems or not.

For instance, in the Quinlan decision I think that it was rightly stated that such decisions ultimately involve the patient, when possible; or, really, in the case of a non-cognizant, the family, the doctor in consultation and reviewed by a prognosis committee that can establish whether in fact the criteria have been met in this particular case.

For instance, in the case that we're upon, I, very carefully last night and today, asked for the medical opinion, the consultation and the judgments that have been made on this particular case, trying to make a judgment as to their reasonableness, whether there had been a reasonable attempt to ascertain this particular person's future. Once that was ascertained, then it's my judgment that since society is progressing the way it is with the technological advances that we have, that there are going to be cases where we ought not use that technology and unfortunately sometimes we don't know that until after we have established one of those needs in the care.

For instance, someone comes into an emergency room and we don't have a reasonable prognosis and so we use life support systems until we get to a point where we have that reasonable prognosis. It seems to me at that particular point that a new moral ethical judgment has to be made now that we have the facts before us of what this person's life expectancy is.

THE COURT: Well, you mentioned the Quinlan case and the role of the patient, the role of the family and the patient and the physician. Now, of course, one of the things that the Quinlan opinion contemplated was that in many of these cases there would be available what the Court there referred to as a medical ethics committee in a hospital. Not all hospitals have medical ethics committees, as I understand it, and this particular patient is not in a hospital, in any event, she's in a small nursing home, a thirty-bed nursing home. There is no medical ethics committee in place; and if it were, I'm not so sure I'd be terribly impressed by it, and I don't say that as a put-down. But when you stop and think about it, what sort of a collection of experts might one reasonably expect to be assembled around this kind of an

institution. So we don't have that kind of a body to control it, we don't have a close family in this case.

We have a nephew who seems to be a decent well-meaning man, intelligent, sensitive, not approaching this selfishly, but he's not related to this woman the way a husband or a brother or a son or a sister or a daughter would be and some of the built-in desires to support life and to affirm life that we might routinely expect in close relationships such as that, I don't think we can routinely expect in a nephew, although they may happen to be present in this particular nephew.

I'm troubled by that aspect of it. I'm troubled that someone like a nephew who is in some ways almost a stranger to this lady should be the person who might end up playing their major role in deciding whether she lives or not, and I find that troublesome.

THE WITNESS: I'm not a person that advocates court review on all decisions that are made in various aspects of life, especially in the area of medicine, but I think we might have before us a case that ultimately needs some type of court review to ascertain the situation, the qualifications

of the person who is making judgments and the general, personal value perspectives of the individual who is the guardian. I think that that is a projection in our system that can serve good purpose.

THE COURT: Well, let me ask you this, do you happen to be aware of how many hospitals in this state have medical ethics committees or the equivalent of them?

THE WITNESS: Yes, unfortunately, I am.

THE COURT: And do you know what the figure is?

THE WITNESS: I would suspect it is a very small number, I'm not sure. All I can say to you, Judge, is that in my own particular work in the Archdiocese of Newark, which would take into account eight health care institutions, we have been about the business of establishing a health medical ethics committee for the last four or five years, and in each one of those institutions there is such a committee.

Now one of the important roles is to establish some type of group who will somehow review the cases that are at hand and that in these institutions is a possibility such committees are there.

THE COURT: Now let me tell you some other

things that trouble me about a case such as this. There are many people who are in a state that we might colloquially refer to as being senile, old people who are essentially suffering from an impairment of the flow of blood through the brain and if it gets bad enough they can be as impoverished intellectually as Ms. Conroy seems to be, but there are many people who are suffering from the same broad mental affliction that this lady is but who are at a very much higher level. And one can frequently see people of only borderline senility or fairly borderline senility who are nevertheless capable of considerable thinking, certainly are capable of loving reactions and reaching out to people, and I think that most of us would think that people at the upper ranges of senility may be quite a bit below the upper ranges but they do have lives that are worth protecting, that are worth the dedication of substantial medical resources but one is fearful that once we start saying you can withdraw certain rather simple techniques, it will be used as an excuse to get rid of people like this who are a burden.

It's not a new problem; I'm sure it's the book of Ecclesiastes that tells the middle aged man not to

revile his foolish father on the strength of his manhood. Old people are a burden, and one might too cheaply get rid of some of them, I'm afraid. How can we prevent that if we start withholding things like use of a tube?

THE WITNESS: I think that by establishing the criteria under which that withdrawal, that removal appears to be appropriate, and I think the basic criteria of judgment can be the non-cognitive ability of a particular person and the reasonable judgment that such cognitive activity can never return. It's a basic criteria that we start off from. Once we move beyond that, I think that we have to step very carefully and build into our guidlines resources, safeguards for society.

But let me just reverse the situation for a second and say that my fear is that in a technological society, such as the one that we have, we are not going to be able to care for persons as they would want to be cared for and we're going to force upon them prolongations of life that none of us who are in an adequate state of mind would choose and that somehow this right of choice works both ways, and my fear is that we are not going to be humanly present but just technologically present

and I think that somehow that humanness has to enter into our society; and I say that with fear and trembling, that we have to step very carefully lest the quality of life be the only determining factor and judgments as to what that quality is be not humanly fair, okay.

THE COURT: Any other questions, gentlemen?

MR. STRASSER: Yes, Judge, if I may.

REDIRECT EXAMINATION BY MR. STRASSER:

Q. Father, you mentioned you're familiar with the Quinlan decision. I'd like you to just discuss the ethical ramifications as you see them, of the use of the respirator versus the nasogastric tube.

A. Could you repeat that again, I'm sorry.

(Whereupon, the previous question was read back by the reporter.)

A. If I understand the question correctly, I would suggest that ordinarily both the tube and the respirator provide for the particular person a basic human--they supply a basic human need, they fulfill a basic human need. One, the ability to breathe and to live accordingly and, secondly, the tube provides basic nourishment without which life can be continued for a long period of time. It seems to me in both cases what we're making a judgment on is whether the particular means is appropriate to the life situation of

the particular person and I firmly believe myself that if we feel that in certain cases the respirator can be removed, the respirator that provides lung activity without which human survival is not a possibility, that if we say that in some cases that removal is appropriate then, certainly, in the area of the tube such a removal would also be appropriate, and my judgment would be, certainly, the ability to breathe
#1 is of equal importance as the ability to receive nourishment.

I'd like to, if I can just for a minute, describe something like this, that I think that there are certain cases whereas life is coming to an end and whereby it is extremely burdensomeness, we would hardly think of forcing a person to eat and continue that forced feeding as we saw a burdensome life continue. The presumption is that that life is in a state of termination, and so my feeling is that in a certain sense we have a sophisticated way of doing that in this nasogastric tube and I just think that there are times where that's not appropriate, that's not a loving thing to do, that's not the caring thing to do but rather to allow that life to end is more in the realm of the human and loving care.

THE COURT: Anything further, Mr. Strasser?

MR. STRASSER: Nothing further, your Honor.

THE COURT: Mr. Delaney?

MR. DELANEY: Nothing further.

THE COURT: Thank you, Father; you may step down.

Do you have any other witnesses you wish to call, Mr. Strasser?

MR. STRASSER: I have nothing further, your Honor. The petitioner rests.

THE COURT: Mr. Delaney, what is your thought?

MR. DELANEY: The last witness that I thought I would have will not be appearing; I received word right before you went on the bench and consequently--I'll see what I can do, but frankly in light of the word I received I don't think I'll be able to get another witness.

THE COURT: Okay. Now why don't you have a seat and let me try to figure out what our time schedule may be.

The evidentiary presentation has closed. I said yesterday that I thought I'd like to finish this case and render a decision tomorrow morning at 9, at which time I was going to ask for closing arguments. I think I'll change that time a bit, if it's convenient with the two of you, and move it to tomorrow at 1:30. Can you both be here then? Is that all right with you, Mr. Strasser?

MR. STRASSER: I'll make it a point to be

here, Judge.

MR. DELANEY: No problem, your Honor, I'll be here.

THE COURT: I'm going to go up and see Ms. Conroy this afternoon and then I'll plan to be back on this case tomorrow at 1:30, at which time I'll ask for your closing arguments and I believe I'll render a decision from the bench at that time.

MR. DELANEY: In all fairness to both the petitioner and the Court, I would make a suggestion to your Honor before you go to the nursing home.

THE COURT: Yes?

MR. DELANEY: I think you really should notify the nursing home in advance of your coming and, also, to fully appreciate her medical condition you might want to have them undress the wounds just so you get a full picture. The first time I was up there, your Honor, I saw her in a situation whereby I didn't see her fully exposed; the second time I went there with the doctor I had a full viewing. I realize it may be distasteful, but I think to get a full--

THE COURT: -- Well, fine, thank you. I don't think the physiology of the medical condition is as important to me as the level of cognitive

functioning. I don't think it is really particularly important for me to see, for example, the extent of the necrotic condition of the left leg or the ulceration of the hip in the back. I'm not particularly squeamish about those things; I'm one who also believes in looking at the patient and I have had a lot of cases, for example, where I had to continue civil commitments of crib babies. It seems almost silly in a way that you have to have a hearing about something like that, but they are civilly committed, at least, when they get to be over eighteen. I also make it a point to go see whether it be that kind of a person or whether it be an elderly senile person in the hospital or schizophrenic. So I'm used to seeing fairly gory things. It won't disturb me to do that; but I don't like the idea of having the wounds undressed unnecessarily, and I think it would be unnecessary because the critical question to me is not the physiology, I think I have a handle on that from the testimony as received from the two physicians and from the nurse, but I want to get some direct eyeball verification of the intellectual functioning of this lady; that's the real reason.

So I'll be going up later this afternoon.

We'll see you, then, gentlemen, at I:30 tomorrow.

MR. STRASSER: Will the Court be issuing a written decision tomorrow in this?

THE COURT: Well, what I will probably do is, I think I will issue a written decision but that may not be actually in final form tomorrow, so I may announce a decision from the bench and then replace it later with carefully articulated written opinion.

MR. STRASSER: Okay.

THE COURT: It depends on how quickly I can get my thinking organized, and I won't finalize it in any event until I have heard your closing arguments. I think I can pretty well anticipate what your closing arguments are and I won't put it in final form until I have heard that.

I'll see Ms. Conroy today and I'll see you gentlemen tomorrow.

# # #

C E R T I F I C A T I O N

I certify the foregoing to be a true and accurate transcript of the testimony and proceedings in the above entitled cause.

E. Michele Henley

Dated: _____

E. MICHELE HENLEY, C.S.R.