

IN THE DISTRICT COURT OF APPEAL, SECOND DISTRICT
LAKELAND, FLORIDA

Case No.: 2D02-5394

L.T. No.: 90-2908 GD 003

I. In re GUARDIANSHIP OF
THERESA MARIE SCHIAVO,
Incapacitated

ROBERT and MARY SCHINDLER,
Appellant/Petitioner(s)

v.

MICHAEL SCHIAVO,
Appellee/Respondent

On Appeal from Final Judgment Entered in the Sixth Judicial Circuit
Honorable George W. Greer, Presiding

**BRIEF *AMICUS CURIAE* OF
INTERNATIONAL TASK FORCE
ON EUTHANASIA & ASSISTED SUICIDE
IN SUPPORT OF APPELLANT/PETITIONERS**

Filed by Leave of the Court

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IDENTITY AND INTEREST OF AMICUS CURIAE

Amicus curiae, the International Task Force on Euthanasia and Assisted Suicide (ITF), is an international leader in the debate over assisted suicide and euthanasia. ITF is the operating name of the Family Living Council, a non-profit corporation formed in 1976 to provide education related to issues impacting on the family. It addresses legal and public policy issues related to death and dying, health care delivery and pain control, the rights of the terminally ill, the chronically ill, the elderly, persons with disabilities and the impact of such issues on individuals and families. The ITF has particular expertise in analyzing the practical implications of and specific information related to withholding and withdrawing food and fluids from conscious patients, as well as expertise regarding the broader legal and societal impact of attempts to do so. The ITF believes that its perspective and arguments will not be adequately presented by others and will be of assistance to this Court.

ARGUMENT

I. The Trial Court Erred When It Redefined The Meaning Of Persistent Vegetative State (PVS).

At issue in the case before this court is whether Theresa Schiavo ("Terri") is in a persistent vegetative state (PVS). Under Florida law, "'Persistent vegetative state' means a permanent and irreversible condition in which there is: (a) The absence of voluntary action or cognitive behavior of any kind, (b) An

inability to communicate or interact purposefully with the environment."¹

The trial court disregarded that definition and found that Terri was PVS because if she were conscious, "cognitive function would manifest itself in a constant response to stimuli." App. I: 156 (emphasis added)

A. Redefining words is a means to achieve social change.

In few social movements has the interpretation of words been as important as in the debate over euthanasia and assisted suicide. Furthermore, in few social movements have words ever been so effectively used to first blur, then completely obliterate, the line between the acceptable and the repugnant.

Euthanasia activists have long recognized the importance of language in furthering their goals. In 1939, the Euthanasia Society of America² drafted a bill to "legalize painless killing" in New York.³ At that time Charles E.

Nixdorff, the group's treasurer took issue with a newspaper report that called the proposal a "mercy death" bill. In a letter to the editor, he wrote that words like

¹ *Fla. Stat. §765.101 (12)* (emphasis added).

² The group changed its name from Euthanasia Society of America to Society for the Right to Die (1975), to National Council on Death and Dying (1991), and to Choice in Dying (1992). It never amended its stated corporate purpose: "To disseminate information to the public by all lawful means of the nature, purpose, and need of euthanasia, and to foster its general adoption. By the term 'euthanasia' is to be understood the lawful termination of human life by painless means for the purpose of avoiding unnecessary suffering and under adequate safeguards." *Dying for the Cause: Foundation Funding for the 'Right-to-Die' Movement*, *Philanthropy*, 26, 28 (Jan./Feb. 2001), at <http://www.philanthropyroundtable.org> (last visited Feb. 6, 2002).

"killing" and "death" had sinister connotations. He suggested it would be better to describe euthanasia as "merciful release" so the public would not fear the Society's proposal.⁴ His lesson about the importance of words has been heeded.

In 1990, Dr. M.A.M. Wachter, ethicist/director for the Institute of Health in the Netherlands, told an international euthanasia gathering, "[t]he definition builds the road for euthanasia." "Definitions are not neutral," he said. "They are not just the innocent tools that allow us to describe reality. Rather they shape our perceptions of reality. They select. They emphasize. They embody a bias. Therefore definitions constantly need redefinition."⁵

Indeed, all social engineering is preceded by verbal engineering. The way in which specific types of treatment and care are defined and the manner in which a patient is labeled can mean the difference between life and death.

B. Some who seek to achieve social change advocate removal of all food and fluids, no matter how provided, from certain patients.

Amicus does not claim that everyone who has used new interpretations or new labels is an advocate of assisted suicide or active euthanasia. However the following discussion summarizes the transformation of the way in which food and fluids are viewed, the manner in which medically vulnerable individuals are

³ "Mercy Death" Law Proposed in State, N.Y. Times, Jan. 27, 1939, at 21.

⁴ Charles E. Nixdorff, "Explaining Euthanasia," Letter to the Editor, N.Y. Times, Jan. 30, 1939.

depicted and how advocates of assisted suicide and euthanasia have used these new perceptions to create a disposable caste of people.

When serious consideration of removing food and fluids began twenty years ago, it was not due to any new or innovative means to provide patients with nourishment. In fact, tube feeding had been in common use since the end of the 19th century.⁶ Rather, the debate was largely social, rather than medical. In 1983, reflecting on the outcome of that debate, Daniel Callahan, then Director of the Hastings Center, wrote that "...a denial of nutrition, may, in the long run, become the only effective way to make certain that a large number of biologically tenacious patients actually die."⁷ He noted that there still was a "deep-seated revulsion"⁸ to withholding or withdrawing food and fluids from patients. Then, providing food and fluids for patients was still largely viewed as basic care, not treatment.

In little time, however, tube feeding was categorized as a "life-prolonging procedure" that was no different from other types of procedures that sustained life and that a competent adult could provide, in advance, a written declaration

⁵ Rita L. Marker & Wesley J. Smith, *The Art of Verbal Engineering*, 35 Duq. L. Rev. 81, 83 (1996).

⁶ See Lewis S. McMurtry, *Modern Gastrostomy for Stricture of the Esophagus, with Report of a Case*, 5 Transactions of the Kentucky Medical Society 123 (1896); and M.F. Coomes, *Gastrostomy, with Report of a Case*, 5 Transactions of the Kentucky Medical Society 135 (1896).

⁷ Daniel Callahan, *On Feeding the Dying*, Hastings Center Rep., 22 (Oct. 1983).

or otherwise clearly indicated wishes directing that it be withheld. Furthermore, tube feeding could be removed from PVS patients under certain conditions.⁹

The "deep-seated revulsion" described by Callahan had evaporated.

Some euthanasia advocates seized upon the gruesome nature of death by dehydration¹⁰ as a means to promote active euthanasia. For example, Helga Kuhse, a philosophy professor from Australia's Monash University who is a frequent speaker in U.S. academic and right-to-die circles, described a scenario in which a woman died after her life-sustaining treatment – a feeding tube – was withdrawn. Dr. Kuhse decried the slow and distressing nature of death by dehydration, and said, "The woman could have died quickly and painlessly had she been given a lethal injection." She took aim at those "blinded by the myth"

⁸ *Id.*

⁹ *Fla. Stat. §§765.101 – 765.404.*

¹⁰ Advocates of withholding food and fluids acknowledge the unpleasant symptoms associated with death by dehydration. According to Dr. Ronald Cranford, loss of body fluid results in increased respiration and "the hands and feet become extremely cold.... And the mouth dries a great deal, and the eyes dry a great deal and other parts of the body become mottled." Wesley J. Smith, *Culture of Death: The Assault on Medical Ethics in America* 76 (Encounter Books 2000). Dr. Cranford explained that symptoms of dehydration can be addressed by providing an "arbitrary" dose of morphine because "you don't know how much he's suffering, you don't know how much aware he is... You're guessing at the dose." Wesley J. Smith, *Forced Exit* 50 (Times Books/Random House 1997).

that such a death is "somehow morally different and 'nicer' than killing."¹¹

It would be inaccurate to assume that the evolving meaning of treatment as it pertains to food and fluids has been confined to that provided by tube. Dr. Cranford has included spoon-feeding in the category of what might be considered artificial feeding. "There is a legitimate difference of opinion concerning spoon-feeding," he said, and "it is not fair to say that artificial feeding would only characterize what we call gastrostomy and so forth."¹² He explained that spoon-feeding is denied to certain patients since, to feed them "would be totally inconsistent" with what is wanted (i.e. the patient's death).¹³

By the mid-1990s, language surrounding what constituted medical treatment had been turned on its head. In some quarters, there was no longer a distinction between treatment and care. Addressing the Senate Finance Committee in 1994, Dr. Eric Cassell of Cornell University Medical College

¹¹ Helga Kuhse, *Euthanasia – Again: "Letting Die" Is Not in the Patient's Best Interests: A Case for Active Euthanasia*, 142 *Med. J. Australia*, 610, 611 (May 27, 1985). Dr. Kuhse was among those who, at a 1987 California ethics conference, signed a statement calling for the end of food and fluids for PVS patients since it was only "sustaining metabolism." *It's No Longer Human Life, At a Point; It's Metabolism*, *L.A. Times*, Dec. 11, 1987 at B7. In 1990, she told an Iowa audience that parents should have until four weeks after the birth of a handicapped infant to decide if the child should live. At the end of that time, the child could be allowed to die or killed, whichever was more socially acceptable and painless. Peter Steinfelds, *70 Experts Tackle the Question*, *N.Y. Times*, Nov. 10, 1990, at 11.

¹² Rita L. Marker *et al.*, *Euthanasia: A Historical Overview*, 2 *Md. J. Contemp. Legal Issues* 257, 284 (1991).

stated, "Treatments are not merely technologies or drugs, virtually everything done to or for a sick person is part of the treatment."¹⁴

C. Words can change the appalling into the appealing.

Along with defining everything done to or for a patient as medical treatment, a new "treatment" was introduced when, in 1994, the state of Oregon approved the Death with Dignity Act.¹⁵ The law permits doctors to prescribe intentional lethal overdoses of drugs for the purpose of assisting a patient to commit suicide. Oregon's state Medicaid program pays for the new "treatment" and classifies it, for billing purposes, as "comfort care."¹⁶

Thus, in a span of twenty years, the deep-seated revulsion to withholding food and fluids had evaporated. No matter how provided, food and water can be considered optional medical treatment and an intentional lethal dose of drugs has been transformed into comfort care paid for by taxpayer dollars.

Just as words and definitions have great meaning when applied to

¹³ *Id.*

¹⁴ Eric J. Cassell, M.D. Testimony before the Committee on Finance, United States Senate, May 5, 1994, LEXIS, News Library, NewsFed. This expanded meaning of treatment was reflected in the trial court testimony of Dr. Melvin Greer, one of the two expert witnesses selected by Appellee. Dr. Greer said that changing and cleaning Terri after bowel and bladder functions constitutes "therapy" and that placing gauze balls in her hands to prevent abrasions is "treatment." App. VIII: 927-928.

¹⁵ Oregon Death with Dignity Act, ORS 127.800 -127.995.

¹⁶ Steve Woodward, *Oregon Will Cover Assisted Suicide*, Oregonian, Feb. 27, 1998.

treatment and care, their power is equally important when applying them as labels to vulnerable patients. Therefore, it is vitally important that the definition of "persistent vegetative state" not be stretched, shaped and distorted to encompass patients whom the Florida legislature intended to protect when it adopted a strict, concise definition of the condition.

D. Failure to have severely brain-damaged, but conscious, patients treated as though they are PVS has led activists to expand the meaning of PVS to make such patients death-eligible.

Florida and other states permit patients, through advance directives, to direct that all medical treatments, including artificial feeding, be withheld or withdrawn under certain conditions. Furthermore, most states, including Florida, also permit withholding or withdrawing food and fluids from PVS patients, even in the absence of an advance directive. However, in recent years, there have been attempts to widen the circle. Activists seeking to bring about social change have been involved in attempts to gain judicial approval for treating conscious brain-damaged patients as though they are PVS so that they can be denied food and fluids. Those attempts have been unsuccessful. Courts have considered, and rejected, the notion of removing food and fluids from patients who are not PVS.¹⁷

¹⁷ See: *In re Shumovic*, C.M. No. 5515 (Del. Ch. Sept. 27, 1988) LEXIS 167; *In re Visbeck*, 210 N.J. Super. 527; 510 A.2d 125 (1986); *In re Clark*, 210 N.J.

After encountering judicial resistance in a number of jurisdictions, a new strategy has emerged: If a conscious patient can't be treated as though she is PVS, then the only way to gain approval for removing her food and fluids is to expand the definition of PVS so that it encompasses her. This appears to have happened in the case before this Court. Since the video recordings which have been submitted to this Court clearly indicate that Terri responds and interacts with others, she does not fit within Florida's definition of PVS. Thus, the meaning of PVS was changed to one requiring constant response to stimuli. That new definition is broad enough that those who are seeking to do so can drive a hearse through it. Florida law, however, does not require a person who is cognitively impaired to perform tasks or exhibit certain behaviors on a constant basis before that vulnerable person can escape the label of PVS and be considered conscious.

II. By Raising The Bar To Require Constant Response To Stimuli From Theresa Schiavo, The Trial Court Ignored Florida Law And Placed Unreasonable Demands On Her.

Unbiased experts are clear in stating that constant response to stimuli is not a requisite for demonstrating that a patient is conscious.

Super. 548; 510 A.2d 136 (1986); *In re O'Connor*, 72 N.Y.2d 517; 531 N.E.2d 607; 534 N.Y.S.2d 886 (1988); *In re Martin*, 450 Mich. 204; 538 N.W.2d 399 (1995); *In re Edna M.F.*, 210 Wis. 2d 557; 563 N.W. 2d 485 (1997); *Conservatorship of Wendland*, 26 Cal. 4th 519; 28 P.3d 151 (2001).

Dr. Bryan Jennett is a Professor of Neurosurgery at Scotland's Glasgow University. His research was instrumental in defining PVS as a condition and, in 1972, he and Dr. Fred Plum coined the phrase "persistent vegetative state."¹⁸ Jennett is one of the world's foremost experts on PVS. He points out that experts caution against requiring constant responsiveness before determining that a patient is conscious. A patient who is not PVS may not respond constantly since "responsiveness can vary from time to time according to metabolic or toxic factors, drugs or fatigue."¹⁹

Responsiveness also can depend on the manner in which stimuli are administered or questions are asked. For example, Dr. Robert Kreitsch, who heads a Michigan rehabilitation center, has stated that, when a person with brain injury is questioned, a five to ten second lapse often occurs between the time the question is asked and the time the person responds.²⁰ Therefore, if a person simply asks a question or gives a command and waits only for the length of time that would be reasonable for a person with full capacity to respond before going on to the next question, one might erroneously determine that the patient

¹⁸ Bryan Jennett & Fred Plum, *Persistent Vegetative State after Brain Damage: A Syndrome in Search of a Name*, *Lancet* 734 (Apr. 1, 1972) is the recognized landmark article identifying PVS as a specific syndrome.

¹⁹ Bryan Jennett, *The Vegetative State* 20 (Cambridge University Press 2002).

²⁰ John H. Hess, *Looking for Traction on the Slippery Slope: A Discussion of the Michael Martin Case*, 11 *Issues in L. & Med.* 105, 114 (1995). Dr. Robert

cannot respond. What actually happens in such a case is that the patient does not have time to respond.

III. The Trial Court Unreasonably Relied On Testimony Of An Expert Witness Whose Activism Clearly Indicates Unacceptable Bias Against Brain-Damaged Patients.

In his latest book, Professor Jennett referred to the "subjective nature of the assessment of whether a patient exhibits evidence of consciousness."²¹ Included in this subjective nature can be the personal bias of the examiner that can greatly influence an expert's assessment of a patient's condition.

A. Appellee's expert witness is so well known for his right-to-die advocacy that Appellee described him as a "gadfly" in that area.

Dr. Ronald Cranford, an expert witness selected by Appellee, is a neurologist from Hennepin County Medical Center in Minnesota. He is well known for his right-to-die advocacy. Indeed, even the attorney for Appellee referred to him as a "gadfly in this area."²² App. X: 1362.

Dr. Cranford has often been in the forefront of attempts to break new ground related to the overall right-to-die debate. Many of his published articles are advocacy pieces. Some are extremely controversial. For example, in a

Kreitsch, a physiatrist and head of the Mary Free Bed Rehabilitation Center in Grand Rapids, MI, testified in the *Martin* case.

²¹ *Supra* note 19.

²² A "gadfly" is one who "stimulates or provokes to activity," is "buzzing with ideas" for "political strategy" or "acts as a provocative stimulus." *Webster's*

1987 article, he described PVS patients as indistinguishable from other forms of animal life. He said such patients lack personhood and, therefore, they no longer should have any constitutional rights. He called for treating PVS patients in the same manner as one would treat the dead and raised the possibility of their being used for medical experiments and organ retrieval.²³ Although these radical positions have not become public policy, he told the trial court he still stands by the concepts expressed in the article. App. IX: 1173.

In 1989, he was one of twelve physician-authors who wrote that it was moral for a physician to assist a patient's suicide.²⁴ The article was described as "the strongest public endorsement of doctor-assisted suicide ever published in a major medical journal."²⁵ Dr. Cranford, serving as a spokesperson for the authors, said, "[W]e broke new ground and, at the time we did it, we were very aware that this was very controversial.... We've said that physician assisted

Third New International Dictionary, Unabridged, 927 (G.C. Merriam Co. 1981) and *American Heritage Dictionary*, 739 (Houghton Mifflin Co. 1992).

²³ Ronald Cranford & David Randolph Smith, *Consciousness: The Most Critical Moral (Constitutional) Standard for Human Personhood*, 13 Am. J.L. & Med. 233-248 (1987).

²⁴ Sidney Wanzer *et al*, *The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look*, 320 New Eng. J. Med. 844, 848 (Mar. 30, 1989). As noted in the publication, the article was formulated at a meeting under the auspices of the Society for the Right to Die. (Until 1975 the Society for the Right to Die was known as the Euthanasia Society of America.)

²⁵ The MacNeil/Lehrer NewsHour, Transcript No. 3399, March 30, 1989, LEXIS, News, Transcripts.

suicide may be done in some situations."²⁶

B. Appellee's expert witness has a pattern of demeaning the abilities of severely brain-damaged patients.

Two recent cases in which Dr. Cranford testified as an expert witness are illustrative. In those cases, he described the patients as "minimally conscious,"²⁷ but his testimony and the facts bear striking similarity to the case before this Court. Writing about the two cases, he argued that, whether patients are called PVS or minimally conscious, they should be dealt with in the same manner.²⁸

1. Smiles declared meaningless.

In 1987, Michael Martin sustained irreversible brain damage after the car he was driving was struck by a train. Five years later, Mary Martin, his wife and guardian, petitioned the Michigan probate court to authorize the withdrawal of his gastrostomy tube. She said that, from her own tests of her husband's comprehension, she was convinced that he did not have the ability to communicate meaningfully.²⁹ Mr. Martin's mother and two sisters disagreed.

²⁶ *Id.*

²⁷ "Minimally conscious" was not then, nor is it yet, an accepted medical classification. According to Dr. Jennett, diagnostic criteria for the minimally conscious state "have recently been proposed" so that there will be a way to categorize patients who have extremely low levels of functioning but are not PVS. *Supra* note 19 at 23. (emphasis added).

²⁸ Lawrence Nelson & Ronald Cranford, *Michael Martin and Robert Wendland: Beyond the Vegetative State*, 15 J. Contemp. Health L. & Pol'y 427 (1999).

²⁹ Tamar Lewin, *Bitter Fight to Supreme Court over the Life of a Man Who Can Only Smile*, N.Y. Times, Feb. 19, 1996.

During proceedings in September 1993, Dr. Cranford testified on Mary Martin's behalf. He said that he had determined that Michael's level of functioning was such that Michael could not be measured by any neuropsychological tests. During his testimony, Dr. Cranford admitted that he was not able to administer a battery of neuropsychological tests regarding cognition and that he had never worked in a long-term brain injury rehabilitation setting. Nonetheless, he claimed that his knowledge of the biomedical processes made him better qualified than others to assess Michael's level of cognition.³⁰

According to recreation therapy records, Mr. Martin was able to smile, participate in simple card games, choose a color when asked and do a number of other simple tasks.³¹ Yet, Dr. Cranford denigrated those abilities. He even declared that Michael Martin's smiles were meaningless:

I know that everybody says that he's smiling related to happy events and I know that's just totally false. He's not – he's not – when he's smiling that is not pleasure.³²

The Michigan Supreme Court refused Mary Martin's request that she be authorized to end her husband's life by removing his feeding tube.³³

³⁰ *Supra* note 20 at 111.

³¹ *Id.* at 106.

³² Andrew J. Broder & Ronald E. Cranford, *Mary, Mary, Quite Contrary, How Was I to Know?: Michael Martin, Absolute Prescience, and the Right to Die in Michigan*, 72 U. Det. Mercy L. Rev. 789, 820, n. 203 (1995), citing Cranford's testimony on remand in *Martin* (Nos. 99699 & 99700).

³³ *In re Martin*, 450 Mich. 204; 538 N.W. 2d 399 (1995).

2. Operating a wheelchair deemed no indication of cognitive consciousness.

More recently, Dr. Cranford was involved in the case of Robert Wendland. In 1993, Wendland rolled his pick-up truck in a high-speed, one-vehicle accident. Emergency personnel on the scene found him alive, but unresponsive. After being in a coma for sixteen months, he regained consciousness but his injuries left him unable to care for himself. He received food and fluids by tube. In July 1995, Wendland's wife, Rose, sought to have his food and fluids withdrawn. Robert's mother and sister opposed her.

Throughout the more than five years of legal proceedings, Rose claimed that her husband had died in the accident and that all that remained was a "shell" that could not recognize her or their children.³⁴ His mother, Florence, who regularly visited him several times a week, said that Robert was responsive and able to perform simple tasks. Dr. Cranford served as an advisor to Rose Wendland and testified as an expert witness in the case.

Videotapes of Robert's therapy sessions were introduced into evidence. On them, Robert could be seen performing many tasks. These included: operating a manual wheelchair by using his left hand or foot, operating an electric wheelchair by using a joystick, picking up specifically colored pegs or blocks and placing them in a tray or handing them to a therapy assistant upon

request. He was able, after practicing over time, to write the first letter of his name, turn pages, and draw circles.³⁵ Yet, as in *Martin* and as in the case before this Court, Dr. Cranford declared Robert's abilities meaningless.

Medical experts testifying on behalf of Robert's wife, maintained that Robert could respond only if cued or coached heavily, not unlike a dog that is trained. Dr. Cranford said that Robert had no cognitive consciousness and that he did not respond in a consistent manner. He described Robert's abilities as bizarre. When queried as to whether Robert would ever again communicate in a meaningful manner, Dr. Cranford answered, "No."³⁶

Asked if it wouldn't be better to err on the side of caution, since there was dispute about Robert's condition, Dr. Cranford said permitting him to live wouldn't be harmful to Robert himself, but his wife and children needed to get on with their lives. "Robert should be allowed to die so the family can grieve."³⁷

The California Supreme Court did not rely on Dr. Cranford's assessment.

³⁴ Maura Dolan, *Out of a Coma, Into a Twilight*, L. A. Times, Jan. 2, 2001.

³⁵ *Conservatorship of Wendland*, 26 Cal. 4th 519, 525; 28 P.3d 151,154 (2001).

³⁶ Mike McKee, *Doctor Testifies Semi-Comatose Man Should Die*, The Recorder, Oct. 29, 1997 and Maura Dolan, *Court Hears Bid to Let Man Die*, L.A. Times, May 31, 2001. Dr. Cranford now mischaracterizes that testimony. While testifying in the case before this Court, he was asked about the way in which he had depicted Robert Wendland's abilities. He said, "I testified that he was in the condition that he was in. Whether it was minimally conscious or not, he clearly had cognitive interaction with the environment." App. X: 1236-1237.

³⁷ Barbara Olevitch, *Protecting Psychiatric Patients and Others from the Assisted-Suicide Movement*, 84 (Praeger Publishers, 2002).

In its decision, the Court made specific reference to video recordings of Robert's abilities.³⁸ The Court saw that, contrary to Dr. Cranford's assertions, Robert was responsive and that he did have cognitive consciousness.

3. Three to five minutes of visual pursuit called unpersuasive.

Just as he refused to see meaningful response in the actions of Michael Martin and Robert Wendland when he was advocating their deaths by dehydration, Dr. Cranford does not acknowledge Terri's abilities.

During his brief examination of Terri, Dr. Cranford moved a shiny balloon from side to side. Terri tracked the balloon with her eyes, and she moved her head from side to side to keep it within her line of sight. As she did so, Dr. Cranford said, "Oh, you do see that, don't you? You do follow that a bit, don't you?" Exh. 97-C02. Later in the examination, Dr. Cranford remarked to Terri, "It's got to be in your field of gaze, doesn't it? You've got to see it first, then you can follow it a little bit. There we go! That's good! That's good!" Exh. 97-C02. Nonetheless, he characterized her responses as mere reflex. He told the court that "it looks at those particular moments that she is really looking...." App. IX: 1119. He said even a sustained visual pursuit of *three or five minutes* would *not* constitute the sustained visual pursuit necessary to determine that a patient is conscious. App. IX: 1187. He admitted that his

³⁸ *Supra* note 35.

examination of Terri had been incomplete. App. IX: 1187-1188. Yet he declared that she was PVS. App. IX: 1144. Furthermore, although he admitted that, in cases of this nature, one is basically never dealing with certainties, he said that, where Terri's condition is concerned, there is absolute certainty. App. IX: 1222. He contended that one who is not PVS would "do visual pursuit 95 to 100 percent of the time." App. IX: 1082. The trial court adopted this unreasonable threshold for consciousness when it found that "cognitive function would manifest itself in a constant response to stimuli." App. I: 156.

Contrary to the claims made by Dr. Cranford in the cases of Michael Martin and Robert Wendland, both men did have the ability to respond. Likewise, contrary to the claim he makes in the case before this Court, Terri has the ability to respond. In each of these cases, Dr. Cranford has asked that decision-makers believe him, rather than their lying eyes.

Dr. Cranford's testimony should be judged as that of an *advocate*, not as that of a dispassionate observer.

IV. The Trial Court Erred When It Found That The Most Compelling Testimony Was The "Agony And Soul Searching" Which An Expert Witness, Selected By The Court, Underwent To Arrive At His Opinion.

Dr. Peter Bambakidis, the expert witness selected by the trial court, is a neurologist in the Department of Neurology at the Cleveland Clinic Foundation in Ohio. Like Dr. Cranford, his examination of Terri was cursory. It lasted a

mere 30 minutes. App. VII: 786.

When asked for his opinion of Terri's condition, Dr. Bambakidis replied that he first wanted to stress what *he* goes through before arriving at a conclusion. App. VII: 734. He said that examining a patient in Terri's condition is "always very disconcerting and very sad." App. VII: 730.

While exploration of an expert witness's emotional status may be interesting, it should not be definitive. Yet, in his order that Terri should be dehydrated to death, Judge Greer wrote, "Perhaps the most compelling testimony was that of Dr. Bambakadis who explained to the court the agony and soul-searching which he underwent to arrive at his opinion...." App. I: 157. This is clearly troubling. It should be of great concern to this Court that the trial court based its ruling on the emotions of an expert witness.

V. Video Recordings Of Theresa Schiavo's Responses And Abilities Provide Incontrovertible Evidence That She Is Not PVS As Defined In Florida Law.

After objectively viewing the video-recordings of Terri, no one can reasonably claim that she is unconscious. No one can reasonably believe that she experiences nothing. The evidence clearly indicates her responsiveness. Videotapes that were viewed by the trial court have been provided to this Court. They show, without doubt, that she does not lack consciousness. They show that, *as a matter of Florida law*, she is not PVS.

CONCLUSION

Those who seek to cause Theresa Schiavo's death by dehydration know that, although she is conscious, they must label her as PVS in order to make her death-eligible in Florida.

Amicus respectfully requests that this Court find that Theresa Schiavo is not PVS as defined in Florida law. *Amicus* further respectfully requests that this Court reverse the order of the trial court and that it direct the trial court to enter an order denying Appellee the right to remove Theresa Schiavo's food and fluids.

Respectfully submitted,

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