CIRCUIT COURT OF THE SIXTH JUDICIAL CIRCUIT
STATE OF FLORIDA IN AND FOR PINELLAS COUNTY
PROBATE DIVISION
CASE NO. 90-2908-GD3

IN RE: THE GUARDIANSHIP OF
THERESA MARIE SCHIAVO,

Incapacitated.

MICHAEL SCHIAVO, AS GUARDIAN OF THE
PERSON OF THERESA MARIE SCHIAVO,

Petitioner,

APPEAL

vs.

ROBERT SCHINDLER AND MARY SCHINDLER,

Respondents.

BEFORE: GEORGE W. GREER
Circuit Court Judge

PLACE: Clearwater Courthouse
Clearwater, FL 33756

DATE: January 24, 2000

TIME: 3:00 p.m.

REPORTED BY: Beth Ann Erickson, RPR
Court Reporter
Notary Public

TRIAL

ROBERT A. DEMPSTER & ASSOCIATES
501 South Fort Harrison
Clearwater, Florida 33756
(813) 464-4858
Volume II Pages 176 - 324

ORIGINAL

APPEARANCES:

GEORGE J. FELOS, ESQUIRE
CONSTANCE FELOS, ESQUIRE
640 Douglas Avenue
Dunedin, FL 34698

Attorneys for Petitioner

PAMELA CAMPBELL, ESQUIRE
The Alexander Building
535 Central Avenue
Suite 403
St. Petersburg, FL 33701

Attorney for Respondents

INDEX

PROCEEDINGS

MR. FELOS: Call Father Murphy.

THE BAILIFF: Stand here, raise your right hand to take the oath.

(THEREUPON, THE WITNESS WAS SWORN ON OATH BY THE COURT.)

DIRECT EXAMINATION

BY MR. FELOS:

Q State your full name, please.

A Gerard Murphy.

Q Father Murphy, are you an ordained priest in any particular faith?

A Yes. Roman Catholic.

Q To what work are you assigned in the church at this time?

A At present, I am the pastor of St. Ann's Church, Ridge Manner, in Hernando County.

Q Can you tell us about St. Ann's parish?

A Very small. A country parish. About 400 families. Mostly elderly. People are sick. On the edge of life.

Q Father Murphy, can you please tell us your educational and clerical background?

A Well, I graduated from college, seminary college. Then went to graduate school. Four

years of theology. Also graduated with six units of clinical pastoral education, which is an international movement of supervised pastors ministry. Each unit was 400 hours of supervised ministry in the health care setting. So I achieved 2400 hours of intensive supervised training.

Q What degree did you obtain in graduate school?

A Masters of Divinity.

Q Your undergraduate degree was in?

A Bachelors of Philosophy.

Q Father Murphy, when were you ordained?

A 1979. May.

Q I'd like you to describe for us, chronologically, your work in the church since that time.

A Okay. The first eight years I was an assistant pastor at Most Holy Name in Gulfport Florida. From there I went for a year to Bayfront Medical Center, actually St. Mary's in downtown St. Pete, to be the Catholic chaplain at Bayfront Medical Center. I went back to Most Holy Name for a year-and-a-half, two years. Then I was employed by Sarasota Memorial Hospital as a Catholic

chaplain for three years. Back to St. Petersburg as Director of Pastoral Care at St. Anthony's. And several more years as assistant pastor helping out in parishes throughout the dioceses where needed. And three years in my present assignment as pastor.

Q Let's talk first about, it was Holy Name parish in Gulfport?

A Yes.

Q You were there about eight years?

A Eight years.

Q Please describe the nature of your clerical work there.

A Ninety percent of my parish work was at the hospital. Palms of Pasadena is small, but very active. Virtually all the census was Catholic. Ninety percent of my time was there.

Q With your work at Palms of Pasadena while at Most Holy Name parish, did you have the opportunity to work with families and counsel families who were faced with end of life care and medical treatment decisions?

A Definitely.

Q Removal of life support decisions?

A Definitely.

Q I believe you mentioned that during that period you were the chaplain at Bayfront Medical Center?

A I was assigned to St. Mary's Catholic church downtown, but I covered Bayfront for them.

Q Please describe your duties as chaplain at Bayfront.

A Well, you know, certainly it's administration of the sacrament, but a much larger role than that today. Simply because there are so many questions, moral questions. It is not as easy to die as it used to be. So there are an awful lot of questions that come up. It is a matter of helping families work their way through it.

Q How many families would you say you counseled and worked with in that area when you were chaplain at Bayfront?

A At Bayfront for that year, a hundred probably.

Q And before at Most Holy Name parish, how many?

A Hundreds.

Q I believe you mentioned that after, after your service at Most Holy Name parish, you

were the Catholic chaplain at Sarasota Memorial Hospital?

A Yes.

Q And how long?

A Just under three years.

Q Tell us about the nature of your duties at Sarasota Memorial Hospital as chaplain.

A Same as at the previous hospital. However, this time I was employed by the hospital, so my time was exclusively theirs. At Sarasota, I was co-chairman of the Violation Commission and virtually all my work was in bioethical consultations with families and physicians.

Q Please describe the workings of the Bioethics Committee at Sarasota Hospital.

A A large group of people from all the disciplines in the hospital. Social workers. Physicians. Attorneys. Risk management. Everyone who has any input into the hospital system. And presenting from that large group was a small group that made consultations. So if there was a family that had a problem, a physician that had a problem, or nurse, they had access to the consultation.

They would call us, and then a

representative group of us would meet with them, everyone, and try to resolve the situation.

Q Is it fair to say that the situations where cases were presented to the Bioethics Committee regarding removal of life support were the tough cases?

A Sure. By all means.

Q After Sarasota Memorial, I believe you mentioned you were the Director of Pastoral Care at St. Anthony's Hospital?

A Yes.

Q Is that a religious -- does St. Anthony's have a religious affiliation?

A It's run by Franciscan Sisters of Albany.

Q Is that a Catholic hospital?

A Yes.

Q How about Sarasota Memorial?

A No. County.

Q Please tell us your duties as Director of Pastoral Care at St. Anthony's

A It was more administration, although I did keep my hands in ethics. I was the co-founder of their first bioethics committee. It was just starting. It was getting it off the ground,

rather than real well organized like Sarasota.

Q Father Murphy, is it possible for you to tell us on how many occasions you have rendered pastoral clinical care regarding the subject of life care?

A Over the course of my priesthood?

Q Yes.

A I would say hundreds.

Q Father Murphy, have you done any research or writing regarding the opinions of the Catholic church as it concerns end of life care and treatment issues? The religious and moral implications of that?

A Yes. I do quite a bit of writing and publishing. I have written a series of pamphlets. I have published articles in clerical journals. Mostly because of my desire to educate. I find that most people have no idea what the Catholic church teaches. Even Catholics. And I think that is gives rise to grave misunderstandings and I have real fears about that.

So I have taken to writing and public speaking about it. We give talks around the dioceses. I take that very seriously and I do quite a bit of that.

Q You mentioned you had written a number of pamphlets on this subject. Are they used and distributed to any particular audiences or groups?

A Sure. Everywhere I can. I sent one, two of them, to a priest in one of the magazines I publish in frequently. He put a thing in his column. So I was deluged all over the country, but mostly in the State of Florida we distribute them to parishes wherever we can. Hospitals.

Q Is the distribution of those pamphlets authorized by the church authorities?

A Yes.

MR. FELOS: Your Honor, at this time we offer Father Murphy as an expert in the area of the Catholic church's position on end of life care and treatment issues and clinical counseling on end of life care and treatment issues.

THE COURT: Do you wish to voir dire?

MS. CAMPBELL: Yes. I do. Thank you.

VOIR DIRE EXAMINATION

BY MS. CAMPBELL:

Q Father Murphy, which diocese are you with?

A I am secular as opposed to being a Jesuit or Dominican or Franciscan, which follow

the rule of that particular saint. I was just ordained to a diocese and obey a bishop.

Q You said you went to four years of theology. Where was that?

A Seminary of St. Vincent De Paul. Boyton Beach.

Q Do you have any education as a medical ethicist?

A No. Not formal training.

Q Do you have any education as a moral theologist?

A From my training, I mean seminary training, sure. We take courses in that.

Q So that would be included in the four years of theology?

A Yes, ma'am.

Q Are you considered a moral theologian?

A It depends in whose eyes. I'm the one they call in the diocese of St. Petersburg when they have questions.

Q Do you function in any official capacity to the diocese?

A Yes. The diocese chaplain for the Catholic Medical Association. The statewide chaplain for the Catholic Medical Association. I

am a member of Dioceses and Task Force in assisted suicide. Formerly certified as a national chaplain. I let my membership lapse.

MS. CAMPBELL: I have no objection. Thank you.

THE COURT: Thank you. Proceed, Mr. Felos.

Q (By Mr. Felos) Father, in the Catholic church, do papal teachings or pronouncements hold primacy as compared to the teachings and pronouncements of bishops or cardinals?

A Yes. The pope sets the tone.

Q Are there any papal pronouncements or teachings in the area on use or removal of artificial life support?

A In 1953, Pope Pius the IV met with a group of physicians who considered those questions in conference. Pius was almost prophetic in foreseeing what would happen fifty -- forty years later. The teaching that he taught was that Catholics are mortally bound to respect life and to care for life, but not at all costs.

He introduced the concept of extordinary versus ordinary means. A Catholic is mortally bound to take advantage of ordinary,

proportionate or disproportionate.

Q Has the phraseology proportionate or disproportionate, as opposed to ordinary, been explored more prevalent in the Catholic church as of late?

A Yes. Sure. Because of the problem it is not as easy to die as it used to be. Nature would have taken care of a great many situations 30 or 40 years ago. My belief in the health care system is that technology is a two-edged sword. The wonderful technology meant to heal and save people and get them back on the road can also interfere with nature.

Q What factors does the Catholic church take into consideration in determining whether a treatment is an ordinary action as opposed to extraordinary or proportionate as opposed to disproportionate?

A It's not the procedure. It's the perception of the patient. Is the procedure, is it too emotionally draining? Is it too psychologically repugnant? It is too expensive? Does it offer no hope of treatment -- of recovery or little or no hope? Based upon all those factors, then you make your moral decision based

upon those issues.

Q So as I understand it, the standard by which those moral criteria are examined is the subjective standard of the patient?

A Yes.

Q In some of the literature I've read, I've come across the terms burdensome and useless. That is, a Catholic is not required to have a medical treatment if it is burdensome or useless. How do those concepts fit in with the ones with what you just mentioned?

A Maybe if I gave an example it might be easier. You look like kind of a healthy guy. Say you caught pneumonia this flu season. You go to your doctor. He would prescribe a course of antibiotics for you. You would be better soon and back on the road.

But as a case I actually handled in Bayfront, St. Petersburg, many years ago, a woman in her late seventies was filled with cancer in the bronchial tree. She was dying. She came down with that pneumonia and the daughter insisted that the mother be treated for that pneumonia. I said why are you doing this? What do you hope to accomplish?

What you always have to do is weigh the proportion. What do you hope to accomplish against what it is going to take to get there. In that case, all she was doing was keeping the mother alive for an extra three or four weeks in order to die. So that was clearly a case of prolonging the inevitable, as opposed to someone like you who comes down with that pneumonia.

Q Does the church then permit the consideration of whether or not the patient has any hope of recovery in whether the treatment may help the patient recover in considering whether it is ordinary or extraordinary?

A Yes.

Q Let's take a case that medical treatment or artificial life support may be medically beneficial. If artificial life support may be medically beneficial, if the patient deemed it too psychologically or emotionally burdensome for himself or herself, could such a patient refuse artificial life support and still be in compliance with the church's teachings?

A Yes.

Q Father Murphy, what materials did you review in preparation for your testimony in this

case?

A The depostions of the family. The depositions of the -- the deposition of the husband. I'm not sure about that. I'm not sure. I know I reviewed the family and the report of the physicians.

Q I want you to assume, Father Murphy, for purposes of this question that Theresa Schiavo told her husband that if she were dependent on the care of others she would not want to live like that. And also Theresa Schiavo mentioned to her husband and to her brother and sister-in-law that she would not want to be kept alive artificially.

Assuming that information to be correct, Father, would the removal of Theresa Schiavo's feeding tube be consistent or inconsistent with the position of the Catholic church?

A After all that has transpired, I believe, yes, it would be consistent with the teaching of the Catholic church.

Q How would you define, Father Murphy, a practicing Catholic?

A Off, that's a tough one.

Q Let me rephrase it. Does the church have any particular definition of what a

practicing Catholic is?

A Certainly. We have what we call Easter duty, which means sometime from Lent to Trinity Sunday, in that three or four month window, a Catholic is required to receive holy communion. If necessary, confession. Catholics are mortally bound to assist at mass. Attend mass every Sunday. Every holy day of obligation. Certainly those are all criteria for a practicing Catholic.

Q If Theresa Schiavo had not taken communion over a two year period before her medical incident and not participated in confession, would she be considered by the church to be a practicing Catholic?

A Not according to the criteria. No. Practicing, no.

Q Now Father Murphy, if a patient is in a permanent vegetataive condition, maintained by artificial life support, and the patient's intent is not known, can a loved one who has the best interests of the patient at heart authorize removal of artificial life support consistent with church teachings?

A I think in a case like this where so much time and effort has elapsed, I think, yes, it

would be consistent. You have to remember, the church will always uphold the ideal. One of the things they will do is hit the brakes, as it were, to make sure nobody is rushing into judgment. Trying to push the patient out of the picture.

In view of the length and effort here, I would say yes. What you would hope for is somebody who cared about the best interest of the patient to make the decision for them.

Q And such a decision by that -- a decision to remove the feeding tube by such a person would be consistent with the church teachings?

A I believe so, from my understanding of the church teachings.

Q You mentioned you reviewed the depositions of Theresa's parents and siblings?

A Yes.

Q I want to ask you some questions about those.

A Yes.

Q There are statements by Mr. and Mrs. Schindler and their siblings that if they were in a permanent vegetative or unconscious state, with no hope of recovery, that they would want all

medical treatments and procedures to keep them alive. Do you recall those statements in the depositions you read?

A Yes.

Q Is that the position of the Catholic church?

A Well, they would certainly be able -- certainly be permitted to do that.

Q Um-hmm.

A The church would not tell them what they should do, only what they may do. If that is their wish, then that would certainly be permissible.

Q But does the Catholic church require, require someone to have all medical treatments and procedures to keep them alive?

A No. In fact, Pope Pius said that in 1953. It was a direct quote. He said that kind of suffering may be admirable, but certainly not required.

Q In fact, even if a patient is not vegetative, does the Catholic church require all medical treatments to keep the patient alive?

A No.

Q There were also statements in the

deposition also to the effect -- and these are statements by the mother and the brother and sister -- that if they were in that permanent unconscious statement with no hope of recovery and had gangrene and their limbs had to be amputated that they would choose that rather than to die. Do you recall reading that?

A Yes.

Q Does the Catholic church require any such action --

A No.

Q -- by a person like that?

A No.

Q In all your years of pastoral clinical counseling, Father Murphy, have you ever come across such extreme opinions?

A With all due respect, no.

Q Have you, from your pastoral clinical experience, have you come across any dynamic which would explain such a viewpoint?

A I think grief is a large part of it. And I think there is a healthy versus unhealthy grieving process. I think everybody goes through it in a different way and at a different time speed. There is no set time frame, I think, for

grief.

I was just reminiscing yesterday about my own grief for my mother. I concluded it just two weeks ago. When I was ordained, I bought myself this ring, or a copy of the original, which is envisioned as a commitment to Christ. Kind of like my wedding ring for the church.

When my mother died a year-and-a-half ago, I put it on her finger in the casket and wore her anniversary ring from my father. About two weeks ago, it was time to let go. I got this copy and put her ring away. I think that is an example of the grieving process.

I knew of a little old lady in Sarasota, after 60 or 70 years of marriage, every night she set a place at the table for her deceased husband, and eventually stopped about a year later. I think that is a healthy kind of grieving. But the other side is not being able to let go at all. I think that is very problematic.

Q In the Catholic faith, is death something that a practicing Catholic need fear?

A No. No. In fact, that is a fundamental part of the Catholic faith. We call ourselves a pilgrim people. Life here on earth is really seen

as a temporary stay. Catholics believe that our destiny is Heaven. Therefore, you can't do everything to prevent yourself from getting there.

What is so hard to deal with in educating Catholics in these issues is that death is a part of life. It is a part of life. It's part of the process. No, Catholics should not fear death.

Q There was a statement in Mrs. Schindler's deposition that, in addition to wanting every type of medical treatment to preserve herself in a permanent unconscious state, should hypothetically she be in that state, that she would, if medical treatment impoverished her family, that she would still want that treatment.

Is there any recognition in the Catholic faith in this area about the cost of treatment? Is the cost of treatment ever a factor?

A That's one of the criteria in deciding whether it's proportionate or disproportionate. Excessive or ordinary. What you would hope is that somebody is helping the patient work through those issues. That, you know, maybe you need to rethink that. You know, that again, the church

would not tell them what to do, but you know, a good bioethical consult or caring pastor I think would help somebody like that say, you know, maybe we need to take another look at this. You know, talk a little bit more.

Q So hypothetically, if a patient had a choice whether to receive a treatment or not, and the treatment let's say, let's say that offered no hope of recovery and the patient decided not to have it because they didn't want to place a financial burden on their family, would such a decision by the patient be consistent with Catholic teachings?

A Absolutely.

Q Now in the deposition of Theresa's siblings, do you recall there was discussion of God's will?

A Um-hmm.

Q I believe there were a number of statements. Well, Terri ought to remain alive because -- she should be treated -- she should have all type of medical treatment to keep her alive because it's God's will. If it was God's will that she die, she would be dead with medical treatment in place. Is such a position consistent

with Catholic teaching?

A No. I don't think so. I'll tell you why. When I mentioned the two-edged sword, God's will could have been easily done fifty years ago. I think this is a case where the wonderful technology, rather than being an act of health and recovery, has become the obstacle for nature taking its course. I think it's a good example.

You know, there's also the case of my father. My father, I found him crying in his bed one day. He was dying of cancer and it was hard to tell which was worse, getting up and going for chemo or the cancer. He wanted to know if it would be a sin if he stopped going to chemo. I said of course not. He did stop and he died peacefully thereafter.

I said there is another example of where chemo does wonderful things for people, or it can, but what is the good that you hope to achieve? For my father, it was only prolonging the inevitable. He was not going to get better. So in that case, the chemotherapy which was meant to be the agent of health, became the obstacle.

Q Father Murphy, I'd like to read you a portion from Mary Schindler's deposition of August

12, 1999. This is Page 39, Line 16.

Question. Well, in your mind, does there come a point in time when the experience of discomfort or pain on the part of the patient becomes a factor in deciding whether to remove life support?

Answer. No.

Under Catholic, under the teachings of the Catholic church, is the pain or discomfort of the patient, that the patient might feel, is that a valid factor to be considered --

A Yes.

Q -- in determining whether care is ordinary or extraordinary?

A Yes.

Q How does that become a factor?

A As you know, Catholics have an understanding of suffering as being redemptive. You know, Mother Theresa of Calcutta always said that. Certainly suffering had a higher redemptive value, but certainly you are not bound to take all the suffering that comes your way. That is -- that was my father's case. My father basically arrived at the notion that enough is enough. All we are doing is prolonging the inevitable.

Q Father Murphy, there was a section in the depositions of Mr. and Mrs. Schindler read in court already. You may remember them. Mr. and Mrs. Schindler were basically asked, just hypothetically, assume these were Terri's wishes. That she did not want to be kept alive artificially and that she did not want to be kept alive if she were a burden to others. Would that change your position in this case?

They both answered no.

My question is, is disregarding the intent of the patient consistent at all with Catholic teachings?

A No. It is the perception of the patient that determines the morality of the action. Not the family, not the doctor, but the perception of the patient.

Q In Terri's sister's deposition, she made the statement that taking away life support is murder. Is that the position of the Catholic church?

A Absolutely not. My father's case again. There are still people telling me that my father killed himself. Absolutely not true. Absolutely inconsistent with church teaching. All they do is

allow nature to take its course.

Q I believe the sister also made the statement in her deposition that a patient may have medical treatment, even if it's against his or her will, if it can keep the patient alive.

A Absolutely not.

Q Do you recall in the deposition of Theresa's brother his testimony that he believes his parents or his parents believe, Mr. and Mrs. Schindler, that Terri is aware of their presence, and he testified that Terri's continued life is a joy to him? A joy to him and his family to keep Terri alive in this condition?

He was even asked -- he was even asked if Terri needed -- if Terri needed a respirator to keep her alive, would it still give you joy to have her alive on a respirator? And he said yes.

He was asked if her limb had to be amputated, would it give you joy to have her alive in this condition? And he said yes.

My question is, Father, what are the teachings of the Catholic church regarding keeping a loved one alive for your own personal pleasure or benefit?

A I think that is contrary to the gospel.

We all take pleasure in relationships with people, family. People who get married. I think, you know, keeping someone around strictly for your own pleasure strikes me as very anti-gospal. Sounds more like using someone than loving someone.

MR. FELOS: I have no other questions. Thank you, father.

CROSS-EXAMINATION

BY MS. CAMPBELL:

Q Good afternoon. My name is Pam Campbell. I represent Mr. and Mrs. Schindler. Have you had the opportunity to meet Mr. and Mrs. Schindler?

A No. I regret that. I wish I were their pastor.

Q Have you had the opportunity to meet Theresa Schiavo in this case?

A No.

Q When you say you reviewed the depositions of the family, who were -- whose depositions were you specifically referring to?

A I remember Mr. and Mrs. Schindler. I remember a woman named Carr. And a brother.

Q The woman named Carr, Suzanne Carr, the sister?

A Yes.

Q Did you review any medical records of Theresa Schiavo?

A I read a summary of the physician who went and reviewed the case.

Q Do you recall the name of the physician?

A Karp.

Q Dr. Karp? K-a-r-p?

A As I recall, that is him.

Q It was about three pages long?

A Yes.

Q How did you get personally involved in end of life issues?

A That's a long story. I discovered early on in the priesthood, for me it was kind of a loveless marriage until I started visiting hospitals and taking care of the sick and dying. For me that resonated deeply. I was very, very sick as a child. Almost died as a child. So I felt a natural inclination -- empathy, not inclination -- for people in those circumstances.

So that really set the tone for my priesthood. And more and more in recent years, my interest has been fueled by what I see are very dark horizons in health care and the necessity to

help families get through.

Q Can you be more specific in what you mean, dark horizons?

A Yes. I think that Catholics particularly make no distinction between allowing yourself to die from an illness and actively killing yourself. That is why there are people to this day that think my father killed himself by removing chemotherapy. I think that is a tremendous factor.

And I think when assisted suicide passes in the State of Florida, as I believe it will, that they will not have to market it because the people I know, and I think with due respect, the reason I found this such an unusual situation is that virtually everyone I know is terrified of a case like this. That is why I believe they would line up to take a pill or shot and go to sleep.

My mother's death is a perfect example. She was a good Catholic. I think if she had a chance to review her last week on earth, I'm not so sure if she would have taken a pill and wanted to go to sleep. That is what I mean by dark horizons that fuel my attention.

I have stepped up my writing, works,

publishing, with the medical association to try to educate clearly what is morally necessary.

Q Do you support, personally, physician assisted suicide?

A Absolutely not.

Q Do you think that the church's teachings would be in support of physician assisted suicide?

A Absolutely not.

Q What would be the church's position on euthanasia?

A Absolutely not.

Q Suicide?

A Absolutely not, except that what the church would recognize is that a person who commits suicide is very likely in a diminished capacity, so in terms of judging the morality of their action, they would not be held morally accountable. In order to sin, you have to clearly want to do it and have the competence to be able to sin.

Q And the church, they have a position against abortion?

A Definitely.

Q You stated earlier that many Catholics are confused as to what the church's position

would be?

A Yes.

Q Is it understandable to you why that would occur when the church's position on euthanasia, suicide, and abortion is such a pro life stance? Do you understand my question?

A Um, that is a good question. Yeah. I'd say so, but I would think that the average, elderly Catholic is used to a Catholicism that tells them exactly what to do. I'd say you are probably right. There is merit in your question.

Q Would it be your understanding that probably, in general, practicing Catholics would believe that it would be the church's position to support artificial feeding, hydration, nutrition? That the church's position would be to support that?

A Probably. Just like my family, father, asked me if stopping chemo would be a sin.

Q Your father was Catholic?

A Irish.

Q Have you ever had your deposition taken?

A No, ma'am.

Q In reading through the deposition of Mr. and Mrs. Schindler and Terri's siblings, could you

get the sense of the room in the deposition when you were reading through those?

A A little bit.

Q Could you get the feel of the emotions past the black and white page?

A A little bit.

Q Could you sense that perhaps the people that were being deposed felt they were being backed into a corner?

A I don't think so. That was not my sense. Do you want to know how I felt?

Q Yes.

A The sense that I felt more was great empathy. Not just because I'm a good pastor, but I watched my parents bury two of their own children. I know it destroyed them. My mother never got over it. My father did. They were an interesting case in grief.

So my heart, without knowing them, my heart goes out to the Schindlers because this must be killing them. But, you know, it was awful for me to be a son and yet very good for me to be a son to my parents to help them work through it. I don't think most people have that. They have to rely on what they hear on radio or see on

television or something.

Q In weighing the benefits and burdens of a position in making a determination with a family, you talked about cost --

A Yes.

Q -- being a factor. Are you aware of the financial circumstances of this particular case?

A Not really. That there is money involved. I don't recall dollars. Amounts.

Q Is it your impression that cost is a factor here? The cost of her care being a benefit or burden?

A Yes. But I think that would be my own surmise. Knowing what health care cost in general, years and years of health care must be astronomical, I would think. That is just a hunch on my part.

Q You have not reviewed her medical records to have assessments of her medical costs?

A No.

Q To your knowledge, has Theresa Schiavo's condition been evaluated by any bioethics committee?

A No. Not to my knowledge. That is, I think, probably a flaw in this case. It would

have been great if they had.

Q Generally, had she been at St. Anthony's, for example, and this case was presented through, would that have gone through the Bioethics Committee?

A You see, someone will have to call for it. Whether it is a family member -- I assume, given the dynamics of the situation, I assume one of them or the physician would have said could we sit down. Yes. It would have happened.

Q Are you aware whether or not there is a bioethics committee at Palm Garden in Largo?

A I have no idea. I don't even know where that is.

Q Generally, when this comes up in a hospital setting, in a Catholic hospital setting, does it not go through a committee?

A Yes. You would not have seen that five or ten years ago. Nowadays, I assume it's almost automatic.

Q So a number of people would be reviewing the benefits and burdens of Theresa Schiavo's personal case?

A Yes.

Q Have you discussed this case with other

Catholic colleagues of yours in the medical ethics area?

A Yes. Two of them that we work together on doing consultations in the diocese. I discussed in general the situation with the two of them.

Q But you have never talked to the Schindlers to receive their input?

A No.

Q In a committee setting, when a true committee would have been formed to review Theresa Schiavo's circumstances, would the husband's feelings have been taken into consideration?

A Everyone's feelings would have to be taken into consideration. That is one of the goals of the ethics connotation is to try to get everybody moving at the same pace.

Q So in this case, have you had the benefit of any of the other family's --

A No.

Q -- thoughts on this?

A No. If I recall, Mr. Felos told me that I was contacted by somebody in the family and I'm sure I told him whatever -- because I get calls all the time -- and I'm sure I told him what I

tell everybody. You have my home phone number. Private number. Cell number. I would be happy to sit down with you and the family. Call.

Q Do you recall maybe being contacted by a Richard Pearse of the guardian ad litem?

A I think that is the name.

Q Probably it was Mr. Pearse and not one of the Schindlers?

A Okay. I'm sorry.

Q Would that be your recollection?

A I recognize the name Pearse.

Q He was the guardian ad litem appointed in this case.

A Okay.

Q Are you familiar with the ethical and religious directives of Catholic Health Care Services published by the National Conference of Catholic Bishops?

A Yes, ma'am.

Q What would be your general thoughts concerning that publication?

A I think it's the teaching of the church. What the bishops teach.

Q Are you familiar with the specific detectives under issues for care and issues and

care for the dying?

A Yes, ma'am.

Q Would you specifically be familiar with number 58?

A No.

Q If I read that to you, would you tell me -- I would like to read that for you and tell me if that is within your same mind set. The directive 58 says there should be a presumption --

MR. FELOS: Excuse me. If she is going to be reading from a source like that, does counsel have additional copies so that I can follow it and perhaps Father Murphy as well?

MS. CAMPBELL: I do not have additional copies. I would be glad to let Mr. Felos look over my shoulder.

THE COURT: Very well.

Q (By Ms. Campbell) Number 58 says there should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit that outweighs the burdens involved to the patient. Does that sound familiar?

A Yes.

Q How would you square that directive with your earlier testimony concerning Theresa Schiavo?

A As I think I said earlier, the church will always take the high road. They will always uphold the ideal. They will always resist immediate action. I think they always want to slow down, take advantage of every possible opportunity, to make sure that the outcome is not promising.

So even Cardinal Bernadine, who taught us so much about how to die well, that was one of his most forceful arguments is that artificial hydration and nutrition is not mandatory in every single case. You have to go back and evaluate the proportion. Where are you going? What do you hope to achieve against what is it going to take to get there? What is the outcome that you are looking for?

Q Have you ever worked with one of the patients in many of the hundreds of families that you worked with that have received, or believed they have received, a miracle from God?

A Sure. My father.

Q Would they, would that involve continuation of life?

A Um-hmm. Yes.

Q In this case, if you witnessed Theresa Schiavo with her mother and there was an outpouring of love between the two of them, would that be something that would be a factor in your consideration of whether or not it would be acceptable to withdraw a feeding tube?

MR. FELOS: I object to that question for lack of foundation. I heard no testimony -- I deposed Mrs. Schindler. She has taken no depositions. I don't recall any testimony of an outpouring of love from Theresa. I would object on lack of foundation to that question.

THE COURT: I certainly have heard enough.

MS. CAMPBELL: I'll rephrase.

Q (By Ms. Campbell) If you witnessed Mrs. Schindler, Theresa's mother, with Theresa and watched her laughter, her smiling, on a, say a regular basis whenever Mrs. Schindler would visit, is that something you would consider?

A I would consider it.

Q How would that -- would that change your opinion in this case?

A It could.

Q Could you elaborate on how you think that could?

A Well, what I would look for is the lesson that one of the chiefs of intensive care at All Children's told me. He said, Father, you divide up the brain. There is a part of the brain that is who the person was. Then there is a part of the brain what the person was. Who the person was is gone and they are not coming back. But what the person was is still functioning.

So he described for me local stimuli. Things that appear to be cognizance, appear to be awareness. Again, I'm not a physician. I would want to talk to the physician about that. So I would give you a cautious yes, I could consider it.

Q But you would consider the physician's input?

A Well, that is his expertise. That is not mine.

Q Do you think that would do anything with any teaching of perhaps God's will and for a miracle?

A I don't mean this as flip as it sounds. If God is going to work a miracle, he does not

need machinery or technology. I think he will just do it. So I have never been persuaded by the argument that we have to keep all the machinery going so God can work his miracle. I don't believe God needs that.

Q Do you think there is a timetable that God expects you to consider one way or the other?

A No. I mean in terms of, I don't think it's six months or a year or whatever. But I think that when it becomes a long, long time, I think a good pastor would have to sit down with the principals involved and say maybe, maybe it's time to let go.

Q This would be a pastor that probably worked with the family?

A Yes. Sure.

Q It would be a pastor maybe that had witnessed any type of relationship between the incapacitated, or ward, and the people that are asking for the feeding tube to be maintained?

A Sure.

MS. CAMPBELL: I have no further questions.

THE COURT: Redirect?

MR. PELOS: Yes, Your Honor.

REDIRECT EXAMINATION

BY MR. FELOS:

Q In the portion of the ethical and religious directives which was read to you by opposing counsel, Father, it does state that providing nutrition and hydration is conditioned by the phrase "as long as this is of sufficient benefit to outweigh the burdens to the patient." That gets back to the factors we talked about on direct examination; doesn't it?

A Yes.

Q Those factors are looked at in the mind of the patient?

A Yes.

Q Let's assume again that Theresa Schiavo expressed an intent not to be kept alive artificially. Does the fact that her mother derives joy from being with Theresa, does that negate Theresa's intent?

A No.

Q Let's even assume for purposes of this question that Theresa does smile and laugh and her mother derives joy from that. Does that negate Theresa's intent?

A No.

Q As to Theresa and whether this continued life maintained artificially is burdensome, that was for Theresa to decide, not her mother; isn't that correct?

A Yes.

Q You were asked the question whether you talked to Mr. and Mrs. Schindler?

A Yes

Q Did you talk to Mr. Schiavo?

A No.

Q There was -- you mentioned Mother Theresa, by the way. Did you ever work in any of Mother Theresa's centers?

A Yes. I tried to volunteer as much as I could up at the Washington -- in Washington, DC. It's an AIDS Hospice right near Catholic U. I go there a couple times a year.

Q What type of work do you do there?

A Just loving the patients. Watching the nuns. They have taught me so much about the care of the dying. You don't see any machinery there. All you see is the nuns bathing these old people. Just loving them.

Q Have you ever participated in any patient care yourself?

A Sure. I never forget them. While talking about them, I was in DC last week. A black man dying of AIDS named Willie, I held Willie in my arms after I baptized him. One of the little nuns took a spoonful of Ensure. Took a piece of the communion wafer and poured it down Willie's throat. He died shortly thereafter. I can still feel Willie's skin and bones. To me, that is what compassion is all about. Suffering with people.

Q So your interest and knowledge in this area is not just purely theoretical?

A No. Certainly much more I'd say because I have been there.

Q There was some discussion about submitting this case to a bioethics committee.

A Um-hmm.

Q Isn't it correct that such a bioethics committee, or review process, is designed to bring a consensus among the participants in decision making?

A Well --

Q If you have, let's say a family dispute as to care, that the purpose of the review process is to try to reach a common ground?

A In terms of heart and mind, yes. But for example, as in the case of my mother, it took two or three days to work my two brothers. I was the surrogate. So it was my right to make the decision.

So if you mean consensus to validate my decision, no, but what you hope to do is get everybody emotionally on the road to recovery.

Q Were you aware that Mr. Schiavo proposed to the Schindlers to participate in hospice counseling?

A No.

Q You noted that the ethics committee -- in many cases like this in the hospital it may be submitted to an ethics committee. Do you know whether that is the case in nursing homes?

A Yes.

Q When you say a case like this, do you mean a case that involves a family dispute?

A Yes.

Q Isn't it true that feeding tubes are routinely removed from unconscious patients in hosptals and nursing home settings?

A Definitely hospitals. I'm not certain about every nursing home. Definitely hospitals.

Q Father, there was, you mentioned that something could be learned by how the patients are treated at Mother Theresa's Hospice. How are elderly nuns and priests treated in end of life situations like this?

A I often tell my own colleagues that we'd learn a lot if we went to these old nunneries and watched the way they take care of the old nuns. It's ice chips. Maybe a spoonful of soup or Gatorade, if they can tolerate it. Face clothes on the forehead. Holding their hand. That I think is dying with dignity.

The machinery and everything, that is what was heartbreaking about my mother's situation because there was not enough chance to give her the love like I knew she deserved. I could never get in the room.

Q There was some talk about assisted suicide and I just want to clear this up. How do you feel about physician assisted suicide?

A Absolutely against it. It is morally wrong to do anything to take your life.

Q Correct me if I'm wrong. Was the gist of your testimony that you believe that people might be given to physician assisted suicide

because they will receive medical treatment against their will?

A Absolutely.

Q That is why you are teaching people to let them know that under the Catholic faith you don't have to be treated at all costs?

A Absolutely.

Q And the consequence of people believing, that may force them, lead them, to take their own life?

A Absolutely.

Q That is the dark horizen in the medical system that you are afraid of today?

A In my view, yes.

MR. FELOS: I have no other questions.

THE COURT: Recross?

MS. CAMPBELL: One, please.

RECROSS-EXAMINATION

BY MS. CAMPBELL:

Q Would you consider the credibility of the statement -- for example, in this case you heard there was a statement made as to the wishes of Theresa Schiavo. Would you consider the credibility of circumstances around that statement in considering her wishes?

A Credibility? If you mean in terms of did someone want to DC everything in 36 hours or 72 hours, I certainly would say there is something wrong here. In view of the length of time here, yes, I would consider it. I would be concerned about factors, factors surrounding that.

MS. CAMPBELL: Thank you.

THE COURT: Anything further?

MR. FELOS: No, Your Honor.

THE COURT: Is Father Murphy under subpoena?

MR. FELOS: No. He is not.

THE COURT: Father, thank you very much. You are free to go. All right, Mr. Felos. Call your next witness.

MR. FELOS: Joan Schiavo.

THE BAILIFF: Stop here. Raise your right hand. Face the judge for me.

(THEREUPON, THE WITNESS WAS SWORN ON OATH BY THE COURT.)

THE COURT: Thank you. Have a seat.

DIRECT EXAMINATION

BY MR. FELOS:

Q State your full name, please.

A Joan Schiavo.

Q Where do you live?

A Philadelphia, Pennsylvania.

Q Are you married?

A Yes. I am.

Q To whom are you married, Mrs. Schiavo?

A William F. Schiavo, Jr.

Q Are you related to Michael and Terri Schiavo?

A Yes. I am.

Q How are you related to them?

A I'm married to his oldest brother, Bill.

Q When were you and Bill married?

A November 11, 1978.

Q Tell us, please, your educational background.

A I have twelve years of a Catholic education. Two-and-a-half years of college, but I did not finish college.

Q Do you have a family?

A Yes. I do.

Q How many children?

A Three. Two boys and a girl.

Q Tell us a little bit about your employment background. Where are you presently

employed?

A I worked at a place called Bets Laboratory for eleven years. I stopped working when I had children. Opened up --

Q What did you do at Bets Laboratory?

A I was a secretary. My friend and I opened up our own cleaning business after my children were a little bit older. I presently stopped working, doing that, and I start a new job next week as a medical secretary.

Q Do you know Theresa Schiavo?

A Yes. I do.

Q When did you first meet Terri?

A I met Terri at a party that my husband and I had years ago. She came to it. It was the first time she met us.

Q Was she married to Mike at that time?

A No. They were dating.

Q I notice you had a smile on your face when you said you met her at that party. Was there anything that happened at that party that was particularly --

A Terri and Michael had come in. Michael had introduced us to her. She was sitting beside me at the time. My husband was out front at the

time. Everybody was drinking. And he was somewhat loaded at the time.

He came walking in the house goofing around. He told everybody -- there was a song or something on the radio. He came in dancing. He yelled out, "Everybody drop your pants," and Terri cracked up laughing. I knew then that we were going to get along just fine.

Q In the time period that Terri and Mike lived in Philadelphia, which was I think about the beginning of '86 -- let me backtrack. Do you recall when it was you first met Terri?

A Well, I was married at the time. I don't recall the year. I had already had B. J. '84. Maybe '82, '81. I don't recall the definite year.

Q In the years that you lived in Philadelphia after you met Terri, how often would you see Terri?

A In the beginning, I did not see her that often because I didn't know her that well. I would run into her every once in a while at my inlaw's house. Every once in a while her and Michael would come down on the weekend to see us, and at that time, my son, B. J.

Q As you got to know Terri a bit more, did you start to see each other more often?

A Yes. Saw her a lot on the weekends. Talked to her a lot on the phone and saw her during the week.

Q Did a friendship develop between the two of you?

A Yes.

Q How would you describe your friendship with Terri?

A Terri was my best friend and like a sister that I never had.

Q When that friendship developed, how often would you speak to each other on the phone?

A On the phone I would say maybe, out of seven days, we talked to each other four or five.

Q Um-hmm. How often during the week would you see her when you were best friends?

A Mostly on the weekends. Maybe two times. Two or three times out of the week she had either come to see us or I'd go down to her family's house.

Q Between talking to her on the phone and seeing her, would it be fair to say you had contact with her almost everyday?

A Yes.

Q How would you describe Terri's personality?

A She was great. She was a lot of fun. Very caring. Was always there if you needed her. Always there to listen if you had a problem. She would do anything for you. She was a good person.

Q Did you ever -- would "shy" be a word you would use to describe Terri?

A No.

Q Would "reserved" be a word that you would use to describe Terri?

A No. Real outgoing. Always smiling.

Q Did she ever seem to be afraid to speak up or tell her mind?

A No.

Q What type of things, when you became best friends, what type of things did you talk about?

A Did we talk about?

Q Um-hmm.

A Kids. Shopping. My husband. Michael. Just general conversation.

Q Did you ever confide in each other?

A All the time.

Q What type of things -- did you and Terri ever go out together?

A Yes.

Q What type of things did you do?

A Went to the movies. We went to the mall a lot. Sometimes we went to the movies. We went clubbing.

Q You mean nightclubbing?

A Yes.

Q Did you take your husbands?

A Sometimes. Not all the time.

Q Now I think you mentioned before that sometimes Terri would come over to your house?

A Yes.

Q Did you ever go over to Terri's house?

A Um-hmm.

Q Before Terri was married, do you know whether she lived with her parents?

A She lived with her parents. Yes.

Q Did you ever go over to Terri's parent's house?

A Yeah. I would just walk in.

Q Did you and Terri ever have a conversation about the subject of artificial life support?

A Yes.

Q Tell me, please, how that came about.

A A friend of mine and her husband had a baby. It was their first baby, and the baby was born sickly. They had to put the baby on a ventilator or machines to keep the baby alive. And they had to make that decision if they wanted to take the baby off the tubes and all.

So during that time, I had talked to Terri about it a lot because I was upset for my girlfriend. They finally made that decision to take the baby off the machine.

Q How long of a time was that from when that first came up for your girlfriend until the situation resolved for your girlfriend?

A Well, they didn't know anything was wrong with the baby until after the baby was born.

Q Um-hmm.

A I would say only within a few months. Maybe not even.

Q I guess my question was, was this an ongoing subject that you talked to Terri about? In other words, did it take a while for the parents of the baby to make that decision and

implement it?

A It took -- I guess for the parents it took a little bit of time to make that decision because it was their first born baby, and nobody wants to see that happen. But they knew, for the baby's sake, there was not anything they could ever really do for the baby. I would say within, maybe within a month's time.

Q How many times would you say you talked to Terri?

A About that?

Q About that situation with your girlfriend and her baby.

A When it first happened, it seemed like we talked about it a lot. When I talked to her.

Q What did Terri have to say in response to your telling her about that?

A She had said that if her and Michael were ever put in that kind of a situation that that would be a situation that she really would not want to have to deal with, but she knows that her and Michael would make the best decision and that would be to do the same thing my girlfriend and her husband did because she would not want to put the baby through anything like that.

Q What was the decision the parents made?

A They took all the tubing and everything off the baby.

Q Did you ever have occasion to discuss with Terri, when talking about the girfriend, what your personal preferences may be regarding artificial life support?

A Yeah. We had watched a movie one time on television. It was about somebody. I don't remember. I don't remember the movie. It was about a guy who had an accident and he was in a comma. There was no help for him. We had stated that if that ever happened to one of us, in our lifetime, we would not want to go through that. That we would want it stated in our will we would want the tubes and everything taken out.

Q When you say "we" had stated it --

A Myself and her.

Q As best you can recall, what did Terri say in response to seeing that movie?

A She did not like the movie. Just the whole aspect of family and friends having to come and see their son or friend like that, she thought it was horrible.

Q Do you know what type of life support

the person in the movie was on? Do you recall?

A No. I don't know all the different -- I just know there was some tubes in him. Like what you call the breathing machine. The feeding machine. I don't know all the different names of the machines.

Q About how well do you recall these conversations with Terri?

A Well --

Q I mean, are you sure Terri did not say something like, "Gee, if that is me, don't pull the plug. I want to stay alive like that."?

A No. No. I know she didn't say that.

Q Did Terri say anything about being afraid to die and not wanting to let go?

A Hm-umm. You mean if she was on those machines or in general?

Q Talking about those machines.

A No. She did not want to live like that. She didn't want to go through that. Have people come and see her like that. Do that to her family and friends.

Q That is what she said?

A Um-hmm.

Q Mrs. Schiavo, when did you first relay

this information to either me or Mr. Schiavo? Do you know when you first told somebody about this information about Terri?

A It was you.

Q Do you recall when that was in?

A September. The fall.

Q Did you ever tell Mike about it?

A No.

Q Regarding the conversations stimulated by the friend's baby, how many times would you say Terri expressed her agreement with the parent's decision not to continue life support?

A She agreed with it.

Q My question is you said you talked to Terri about that a number of times?

A Um-hmm.

Q Did she express her opinion about it once, or did she express her opinion about it more than once?

A More. Several times. I'd say if I talked to Terri maybe 14 days about it, she probably expressed her opinion 12 out of the 14.

Q So this was not an isolated comment on her part?

A No.

Q When Terri and Mike moved to Florida, did that affect your friendship with her?

A It did not. I talked to her every day.

Q How --

A I didn't see her, but talked to her all the time.

Q As time went on, after she moved down here, did you get a chance to visit her?

A No. I did not have the finances to get down to visit. I wanted to. Just did not have the finances.

Q After she was here for a while, about how often would you talk to her?

A Maybe, out of seven days a week, maybe five.

Q How long would the two of you talk on the phone?

A Well, when she called me, we talked a little bit longer. When I called her, it was maybe a little bit less.

Q In your testimony, you made some reference to making wills. What was that again? You mentioned something about you and Terri talking about making wills?

A We had said during the time with that

movie, at one time we had said that if, that we had always wanted stated, my husband and myself, make up a will. She would want it stated, and myself, I would, if it came down to something like that, we would not want any kind of life support.

MR. FELOS: Okay. Thank you.

THE COURT: Cross-examination?

CROSS-EXAMINATION

BY MS. CAMPBELL:

Q Good afternoon, Mrs. Schiavo. My name is Pam Campbell. I'm the attorney representing Mr. and Mrs. Schindler in this case.

A Hi.

Q Can you tell me approximately when was the circumstances with your friend's baby? What year?

A What year? Maybe '85 or '86.

Q It was before or after Terri and Mike were married?

A After.

Q After?

A Um-hmm.

Q Were her comments in response, in your conversations pertaining to the issue with the baby, were they mostly surrounding if she and

Michael had a baby that this is what they would want to do with the baby?

A Could you rephrase?

Q Um-hmm. When you were having this conversation with her about your friend's baby --

A Right.

Q -- you are saying Terri made comments about that. Were her comments based on what she, what she would want to do if she and Michael's child were in a hypothetical setting?

A You mean as far as she stating what her and Michael would do in that situation?

Q Right. Right. With a baby.

A She told me what her and Michael would want to do if it was her and Michael in that situation.

Q So her comments were more for a child as opposed to herself?

A At that time.

Q When was it that you were watching this movie, approximately, from a time frame?

A It was after that happened with my friend's baby. I don't know how many years or months or days. But I would say within a two year period maybe.

Q Had they moved to Florida yet?

A No.

Q So they were still living in the Philadelphia area?

A Um-hmm.

Q Can you describe the scene in the movie with the man and the tubes?

A He was a younger man. I don't remember the movie. If I'm not mistaken, it was a diving accident into a pool. He passed away at the end of the movie. I don't remember the movie. I really don't remember the movie.

Q Okay. Do you remember what the man looked like? Whether or not he was in a hospital setting?

A In the movie he was in a hospital setting.

Q Do you recall where the tubes were coming from?

A His mouth. He had some in his arm.

Q Was it the graphic recitation of that picture in the movie which stimulated the comments from Terri?

A I think it was the whole situation of the movie. I don't think that was, it was just

that part. That part was very upsetting, but the whole situation of the movie.

Q Was there a long period of time between his accident and then his hospital stay and his death in the movie?

A What is a movie? Everything is done within a two hour period anyway, so -- he had the accident. He was in the hospital. He passed away. I'm trying to remember. Maybe months to a year. I forget how long.

Q Do you remember when Terri and Mike moved to Florida?

A Yeah.

Q When was that?

A I don't remember the year. I remembered it. I didn't want them to go.

Q Did you talk to Terri -- you were testifying about how frequently you talked to her. Five out of seven days?

A Um-hmm.

Q Was that right up to the time of the accident?

A Um-hmm. I talked to her two days before it happened.

Q Did she ever discuss with you problems

that she and Mike were having?

A No. I mean, no marriage is perfect. Mine is not. It was nothing out of the ordinary.

Q Did she discuss with you her desire to become pregnant?

A She wanted children.

Q Do you know that she was going to a doctor concerning fertility issues?

A I'm trying to remember. Yeah.

Q Do you recall how long of a period she had been trying to get pregnant?

A No. That I don't remember.

Q After she came, after she and Michael moved to Florida, did you get to see Terri after that?

A No. I had three children. My husband had a new job. The money was not there. But I would have loved to have gone to see her.

Q Since the accident which occurred to Terri in February of 1990, did you see Terri during that time frame?

A Hm-umm. I questioned my inlaws all the time about it. My brother-in-law. Everybody kept me informed on what was going on.

Q Have you seen Terri recently?

A No. But I intend to see her while I'm here.

Q Do you know what type of life sustaining measures are being taken for Terri?

A What do I understand the update of her condition is? Is that what you mean?

Q Do you -- is it your understanding that Terri is on a ventilator?

A Um --

Q The thing that makes her chest go up and down like you described in the movie?

A No. I don't know. I thought it was just the feeding machine. Feeding tube.

Q Do you know what a feeding tube would look like?

A No.

Q So you have not seen Terri as to what she looks like?

A No.

Q You don't know if she has, is connected to tubes or anything like that?

A No.

Q When this first happened to Terri, were you aware of what type of life support she was having then?

A When it first happened?

Q Um-hmm.

A Yeah. Breathing machine. Feeding tube.

Q Did you tell Michael any of her comments before?

A Hm-umm.

Q Did you relay any of the comments about Terri's not wanting to live in a condition like that to Michael during that time frame?

A Not at all. He was going through too much at the time. I didn't mention it.

Q So during this nine year period, you still have never told him about it?

A No.

Q Doesn't it seem odd that you would not tell him?

A I think if he questioned me, I would have told him. He never questioned me. It never came up in a conversation between him and I. If he would have said something to me, I would have.

MS. CAMPBELL: I have no further questions. Thank you.

THE COURT: Redirect?

REDIRECT EXAMINATION

BY MR. FELOS:

Q You were asked a question about Terri wanting to get pregnant and seeing a doctor. Did Terri ever mention anything to you about the frequency of her periods or not getting periods?

A They were not real frequent.

Q Now the opposing attorney asked you a question when did you have the conversations with Terri about the girlfriend's baby.

A Um-hmm

Q I believe you used the words "after Terri had moved". I want you to clarify that. Did you mean after she moved from her parent's home in Philadelphia or after she moved to Florida with Mike?

A The situation with my girlfriend's baby was when she lived here, not in Florida.

Q When she lived where?

A With Michael.

Q In what city?

A Pennsylvania. Philadelphia.

Q So the conversations you had with Terri about the girlfriend's baby was, I think you mentioned, was in Philadelphia?

A Um-hmm.

Q Do you know that Terri lived with her parents in Philadelphia and then, when she married, she moved and lived with Mike in Philadelphia?

A Um-hmm.

Q The movie on television was that, that occurred before or after the -- did you testify that occurred before the conversations you had about the baby? Let me ask it again. The conversation you had with Terri about a TV show and the diver not wanting be on life support, was that before or after the situation came up with your girlfriend?

A After.

MR. FELOS: No other questions, Your Honor.

THE COURT: Any re-cross?

MS. CAMPBELL: No thank you.

THE COURT: You can stand down. I assume she's not under subpoena?

MR. FELOS: She is not.

THE COURT: Anything else this afternoon?

MR. FELOS: Fortunately, or unfortunately, we have exhausted our witnesses,

too, and should be concluding tomorrow morning. So I want to mention that, so opposing counsel knows to have her witnesses ready for the start of her case.

THE COURT: Very well. Stand in recess until 9:00 a.m. tomorrow morning.

(THEREUPON, COURT RECESSED AT 4:35 P.M. ON 1-24-00 AND THE POLLOWING PROCEEDINGS WERE HAD ON 1-25-00 AT 9:00 A.M.)

THE COURT: Petitioner ready to proceed in this case?

MR. FELOS: Yes.

THE COURT: Respondent ready to proceed?

MS. CAMPBELL: Yes, Your Honor.

THE COURT: Call your next witness.

MR. FELOS: We call Dr. Vincent Gambone.

(THEREUPON, THE WITNESS WAS SWORN ON OATH BY THE COURT.)

DIRECT EXAMINATION

BY MR. FELOS:

Q State your full name, please.

A Victor Gambone.

Q Where do you live?

A Dunedin.

Q How are you employed?

A I'm a physician.

Q Are you a medical doctor?

A Yes. A medical doctor licensed in the State of Florida.

Q Can you tell us, please, your educational background?

A Yes. A graduate of Penn State University, where I did my undergraduate work and also my received my medical degree. I did my internal medicine training at the University of South Florida in Tampa. I'm board certified in internal medicine and I'm board certified in geriatric medicine. I'm also board certified in medical direction and long-term care. I'm also certified by the American Board of Quality Assurance and Utilization Review.

Q When you use the term "board certified", can you briefly explain what that means?

A Yes. This is one way of establishing core knowledge and expertise in a particular field, which is recognized nationally.

Q Again, you were board certified in geriatric medicine?

A Yes.

Q The last one you mentioned was?

A Quality Assurance and Utilization Review.

Q For long-term care?

A No. In general for medical quality assurance.

Q Can you explain briefly what that is?

A Yes. It's, I received special training in ways of assuring that quality exists in the work that is done in the medical profession. So I might be called on to be on committees or to review work of other physicians for quality.

Q Dr. Gambone, do you know Theresa Schiavo?

A Yes. I do.

Q Are you her primary treating physician?

A Yes. I am.

Q How long have you been Theresa's primary treating physician?

A For almost two years.

Q Can you tell us a little bit about your duties. As a primary treating physician, what do you consider your duties to be regarding Theresa?

A My duties are to assure that she receives proper medical care in the facility where

she resides.

Q How many times have you visited Theresa?

A I visit her at least every other month. Occasionally more often than that. I would estimate I have visited her probably ten times during the past year. There have been other physicians, or a physician who works with me, who visits her periodically in my absence.

Q Now describe for us, please, the procedure that you would undergo, the procedure you underwent on your initial examination of Theresa.

A An initial examination, it was a comprehensive examination and I review the prior records. I took a current history from those who would give me history. That is Michael, her husband, and also the care-givers at the nursing home. After reviewing the records, I performed a physical examination and then made a report of that examination.

Q In the course of your examination, did you talk to Theresa? Did you ask her questions?

A Yes. I tried to elicit some response from her, either verbally or visually. These are -- were some of the tests that I performed.

Q On each of your visits after your initial visit, did you try to elicit some response from Theresa?

A Yes. Whenever I would greet any of my patients, even though they may be comatose or unconscious, I would always greet them with their name.

Q In all your visits to Theresa, have you ever noticed any response by Theresa which would lead you to believe that she has cognition?

A No.

Q When is the last time you visited Theresa?

A The last time was, I believe it was a Friday. Probably was the 7th of January.

Q How would you describe Theresa's condition in medical terms?

A I would describe her condition as a vegetative state.

Q Dr. Gambone, do you know of any treatment, modality, or thing that can be done for Theresa which will improve her condition?

A No. I don't.

Q Now let's talk a little bit about the nursing home. Is there a nurse on duty that

supervises the care of patients when the physicians are not there?

A Yes. There are nurses on duty 24 hours a day.

Q If there were any change in Theresa's condition, such as Theresa said something or Theresa responded in some way, what would be the duty of the nursing home regarding communication to you?

A Any change in condition, and this would be considered a significant change in condition, should this occur, the nurse would immediately report this to the physician.

Q Has any nurse ever reported any such change in condition to you?

A No, sir.

Q Please describe Theresa's physical condition as opposed to her mental condition.

A Physically, I would describe her condition as very good. Excellent.

Q Does she have any physical problems?

A The physical problems that she has are related to her neurologic condition.

Q What are those physical problems?

A Contractures in which the stronger

muscles of the body would react against the weaker ones and so the flexor muscles -- so your hands would contract. She has contractions. They have worked with those contractions over the years.

Q We have heard some testimony about a dropped foot. Does she have a dropped foot?

A Yes. Because of the neurologic damage, that is another related condition.

Q When muscles become unused and contractured over a period of time, is there any permanent damage to the muscular system? In other words, if Theresa, hypothetically Theresa awoke and regained consciousness, would she have the use of those limbs?

A Over this period of time it would be unlikely because without activity, electrical activity of the muscles, death of the muscles occur. Death of the end plate which is, and I'll try not to be too technical here, but the nerve muscle inner connection. There is death of that area or destruction of that area without use, without the electrical chemical activity that is necessary to maintain it.

Q So is it fair to say that, if hypothetically Theresa Schiavo regained

consciousness, she would be a quadraplegic?

A I would say that she certainly would have serious impairments, and I could not tell you exactly what they are. But quadroplegia is a medical term and you know, it may appear the same to you -- to a lay person. Yes. The weakness that she would have would be similar to quadraplegia.

Q Um-hmm. Is a patient in a vegetative -- is a patient who has lost the swallow reflex -- or let me backtrack. Does Theresa Schiavo have a swallow reflex? Can she take in fluids?

A No. She cannot.

Q Does a patient who has lost the swallow reflex, are they subject to any greater incidents of any maladies such as infections or any particular problems?

A Yes. Without the swallow reflex, just the normal secretions in your mouth, your saliva could go into the lung. Because normally we just, when fluid collects in the back of her throat throughout the day, we just swallow and put it into the stomach. Without that reflex, it's more likely for that fluid to go into the lungs.

Q What happens when that occurs in such a

patient?

A Normally someone would cough to bring up the phlegm, but even with the cough reflex, still fluid can get down into the lungs. So she is at a high risk for what we consider the aspiration, which is allowing fluid or other contents to go into the lung.

Q We have heard some testimony before about that Theresa has had respiratory infections. Would that have any connection with the aspiration you mentioned?

A Yes. It could. During the two years I have taken care of her that has not been a problem that I recall, but there is history to suggest this was a problem in the past.

Q You mentioned that you found her in exceptionally good physical condition?

A Yes.

Q What do you attribute that to?

A Well, because I take care of many residents in nursing homes, a lot has to do with the care provided, because she is totally dependent on others to provide her care. By paying very close attention to detail in her care, this has allowed her to, at least during the time

period I have been taking care of her, maintain a very good physical condition.

Q Have you ever had patients or a patient's family complain that nursing home personnel just don't give that high quality of care on all occasions?

A Yes. I have heard of instances where there was some laxity in the care given.

Q What role does the family of the patient have regarding -- is there any role the family of the patient has in assuring the patient gets good nursing home care?

A My experience has been that the more attention the family gives to the care, the more visits that are made, minor things are brought to the attention of the staff and attended to before they become major problems. So it's very important for the family to be involved, or an interested party to be involved, in the care.

Q Have you found Mr. Schiavo to be involved in Theresa's care?

A Yes. Very much so. And Michael has requested that if there are any changes in treatments, any, even the slightest problems, that he is to be notified immediately. I have spoken

to him on various occasions about any changes I thought may be needed in her care.

Q Dr. Gambone, you previously signed an affidavit in this case. Let me show it to you. Do you have a copy of that in your file?

A Yes. I do.

Q If you can refer to the copy in your file. In paragraph three of your affidavit you state that Theresa Marie Schiavo is not competent to make medical treatment decisions for herself and does not have a reasonable probability of recovering competency so that she may exercise directly her right to withdraw or withhold life prolonging procedures.

Can you tell us how you reached the conclusion that Theresa is not competent to make medical treatment decisions and why there is no probability she can regain that capacity?

A Yes. I think this is part and parcel with her vegetative state in that she cannot, she does not exhibit any cognitive behavior. Any volitional movement. Any ability that I could perceive of her awareness of her environment or surroundings.

Q In your affidavit, you also state that

Theresa Marie Schiavo's condition is terminal. Let me, to refresh your recollection, read to you the statutory definition of terminal. Terminal condition means a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which without treatment can be expected to cause death.

Can you explain to us how you reached the opinion that Theresa's physical condition is terminal?

A Yes. She has a feeding tube which is placed into the stomach that allows us to provide her with nutrition and hydration necessary for life. Without this particular treatment, she would pass on probably in a matter of weeks.

Q Have you had any -- have you treated any patients in which feeding tubes were removed?

A Yes. I have.

Q Have you cared for patients who died as a result of removal of artificial provisions of sustenance?

A Yes. I have.

Q Can you explain, medically, how that occurs?

A Yes. Without food and nutrition, the body uses its own energy sources, and when they are exhausted, the vital organs shut down. Particularly the kidneys. When the kidneys deteriorate poisons, which are actually breakdown products of metabolism, accumulate in the body. We use the word uremia to describe this condition. Uremia is a condition which puts one into a deep sleep and they would pass on in their sleep.

Q I think you mentioned when a patient does not receive nutrition. Is that the same case for hydration? When a patient receives no hydration at all?

A Yes. It is the same condition. It would, I think, be difficult to give hydration and no nutrition because it would prolong the process of dying. It would extend it probably a month or maybe more.

Q Does Theresa receive her hydration through the gastric tube as well?

A Yes. She does.

Q If Theresa no longer receives nutrition and hydration through the gastric tube, in your estimation, how many days approximately would it

be before she died?

A It would probably be within a couple of weeks.

Q In your experience in treating patients who have so died, from a medical standpoint, was it a painful death? Did they require pain medications or significant pain medications as a result of withholding fluids and nutrition?

A No. I have never noted anyone to express pain or show signs of pain. Grimacing. Agitation.

Q Are you aware of any -- have there been any studies or articles written about the question of whether a death by that means is painful?

A Yes. There has been quite a bit of literature from the hospice organization. Also, there were recent medical articles in the Journal of the American Medical Association and also in the New England Journal of Medicine which discusses withdrawl of feeding tubes and the process of dying. In all the literature that I have reviewed, this is not a painful process.

MR. FELOS: Thank you, Dr. Gambone.

THE COURT: Cross-examination?

CROSS-EXAMINATION

BY MS. CAMPBELL:

Q Good morning, Dr. Gambone. My name is Pam Campbell and I represent Terri's parents, Mr. and Mrs. Schindler in this action. Have you ever had the occasion to meet Mr. and Mrs. Schindler?

A No. I have not.

Q Are you aware of their position concerning Terri's feeding tube, whether it should be maintained or not?

A Yes. I am.

Q How long have you been a practicing physician?

A I have been in practice in the State of Florida since 1976.

Q Is that when you also received your Florida license?

A Yes, ma'am.

Q Does Terri have a menstrual period?

A Yes.

Q Does that cause any extra problems for her?

A No more than any woman, but this is something that has to be attended to by the staff because she cannot care for herself.

Q Could she get pregnant?

A Yes. She can.

Q What would be Terri's life expectancy if the feeding tube were to be maintained?

A I cannot give you a definite answer. She is in good physical condition. As far as I know, there is not a lot of data on studies of individuals like this and how long they would live on a tube.

Q Do you recall what those articles suggest in the way of a life span?

A The articles suggest a shortened life span, but I could not give you a specific number because many of these people are starting at different ages. She's starting at a very young age and there just is not a lot of information about someone that young.

Q What is the average age of the patients that you treat?

A The average age is probably about 80, 85.

Q So Theresa is considerably one of your younger patients?

A Yes. She is.

Q In all the patients you have treated,

have there been any times when those patients, in a similar vegetative state as Theresa, have come out of that vegetative state?

A Not that I know of.

Q None that you specifically treated?

A Yes. That is correct.

Q You testified with Mr. Felos that you had not been contacted ever regarding a change in condition regarding Theresa. Could you elaborate on that a little bit more?

MR. FELOS: Your Honor, I object to the form of the question. I believe the testimony and question was were you ever contacted regarding a change of condition regarding Theresa's cognizance. He said no.

MS. CAMPBELL: It is my recollection it was not specifically to cognizance, so that is what I was trying to get to.

THE COURT: Well, the question had to do with if something happened, how would you handle it. The doctor said those type of changes, if significant, they would contact the physician. I think he simply testified as to procedure. I think your question is appropriate.

Q (By Ms. Campbell) Thank you. Doctor,

have you ever been contacted by any of the nurses in the two years you have taken care of Theresa regarding any change in her condition?

A Yes. I believe I have.

Q Would that be in regard to any laughter?

A No.

Q Would it be in regard to any twitching?

A Not that I recall.

Q Perhaps a fever?

A Yes. There was an instance where she had an upper respiratory infection that I recall.

Q So any medical type of change in Theresa, one way or the other, the nurses would contact you?

A Yes.

Q When you go to the nursing home, do you review the chart each time?

A Yes.

Q Do you specifically review the nursing notes?

A Yes.

Q Do you review the recreation notes?

A Not really.

Q Do you review the social service progress notes?

A From time to time I do.

Q Were you taking care of Theresa Schiavo since February 1997?

A 1998.

Q 1998 is when you first took over?

A Um-hmm.

Q Do you recall reading in there any progress notes concerning Terri laughing at jokes?

A No. I don't recall.

Q Would that make a difference to you in your opinion in the affidavit that you filed with this Court?

A I guess that this is very unusual information that I was not aware of.

Q I'd like to read to you some of the notes and see if that would bear a change on the affidavit that you have filed.

MR. FELOS: Your Honor, I object. We have gone through this objection et al before. Counsel is not introducing in evidence the medical records, social service notes of the facility, and because they are not being introduced into evidence, she can't read the contents of those documents in the proceedings, which in essence will make them evidence.

We object on those grounds. In addition, as a matter of fairness, Your Honor, there are probably a couple thousand pages of medical records for Theresa Schiavo which were subpoenaed and both sides had copies. Had opposing counsel mentioned there would be the introduction of some medical records in this trial, we then would have had an opportunity to have one of our witnesses comb the thousands of pages of records and specifically present to the Court the thousands of entries in those records stating the patient was nonresponsive.

But we have not done that because these records were not to be introduced into evidence. So I think it's unfair to now selectively take one or two lines of those thousands of pages and try to get them into evidence by reading them.

THE COURT: What is the basis of your statement that they are not coming into evidence?

MR. FELOS: Your Honor, we exchanged a list of documents that each party -- after the status conference, we exchanged a list of documents that the parties were going to introduce. We listed our documents. We were told the documents that the respondents were going to

introduce and the medical records were not listed.

THE COURT: Ms. Campbell?

MS. CAMPBELL: I think it would be proper under the impeachment process. This doctor has testified that he reviewed the records and came up with his opinion to render before this Court in the form of an affidavit. If there are records -- when he says he reviewed the records, they are voluminous, but the records that I specifically am going to refer to are since his care.

I would believe that if he is making a statement of an opinion based on her records and on his experience with this patient, he would be aware of what these notes say specifically pertaining to her laughter. Mr. Felos is the one who provided me with these records.

MR. FELOS: Your Honor, number one, we can't cross-examine a line in the medical records. If counsel wanted to present evidence that a social service worker perhaps interpreted Theresa's Schiavo's sounds as laughter, she had the opportunity to find the social service worker and subpoena her as a witness. List her as a witness and subject her to cross-examination.

Number one, the records are hearsay.

But number two, even beyond that point, because they were not going to be introduced and used, we did not take the step of going through the balance of the thousands of pages of records to have an opportunity to rebut that.

THE COURT: Well, clearly they are hearsay, but there are exceptions to the hearsay rule. One of them is business records. You know, the way Mr. Erhardt drafted the statute, contemporaneously by business documents. I don't know what the record is because it's not in evidence.

Were this a trial over simply dollars, I would probably hold you to a little higher standard than what you put on your pretrial statement. For the very limited purpose, although I'm not sure it matters what happened three years ago, I think what really matters is what the condition is today, but for the limited purpose of impeachment, I'll permit you to allow the doctor to read the note.

MS. CAMPBELL: Thank you.

THE COURT: The evidence is such, because it has not been listed, but for

impeachment purposes see if that alters --

MS. CAMPBELL: As one note of correction, we didn't have a pretrial order in this case which required the exchange of evidence. Both parties did give each other a list, but there was not a specific pretrial order that was provided in this case.

THE COURT: We will stand corrected then, although with the caliber of attorneys, I am not sure I need an order. So you may show the notes. You will, for the record, tell us what date those notes are and who is the author.

MR. FELOS: May I see the notes you are going to show?

MS. CAMPBELL: May I approach the witness?

THE COURT: Yes.

Q (By Ms. Campbell) Doctor, I am showing you a page out of the activities progress notes dated 2-11-98. Were you treating Theresa in February of '98 to your knowledge?

A Yes. The date of my first visit was February the 5th. This is dated February 11th.

Q If you can go halfway down in the middle of the note where it begins "staff residents are

familiar". If you could please read that sentence.

A Before I read that sentence --

Q Um-hmm.

A -- could I just ask -- I see that this is signed by a CTR. Could you explain to me what a CTR is?

Q I'm not too sure. Looks like her name is Marie. I'm not sure what the last name is.

A I'm not familiar with the term CTR, as to what that signifies.

Q I'm not familiar, other than what the note refers to. If you would like to take a minute and read the whole note.

A Yeah. It would help me to know who this person is, and you know, are they a recreational therapist? Is this a medical person?

MR. FELOS: I believe, if it would assist the proceedings, this is a recreational therapist.

THE WITNESS: All right.

MS. CAMPBELL: If you would like to take a minute and read the full note.

A Okay. Resident's status is unchanged. She is minimally responsive, oriented times one.

Q (By Ms. Campbell) If you really -- I'd just like you to read that silently to yourself and then go down to the main part where it says residents are familiar.

A Oh. Okay. Would you like me to read where it says staff residents?

THE COURT: We don't need that into the record.

MS. CAMPBELL: Okay.

THE COURT: It almost does sound like that is true hearsay.

MS. CAMPBELL: Okay. If you can take a minute to read that note.

THE WITNESS: Yes. I have read it.

Q (By Ms. Campbell) Thank you. I will take it back. Do you see where it specifically refers to visitors stopping to tell her jokes?

A Yes. It also says that she occasionally laughs. It does not suggest a cause/effect relationship.

Q I'm now going to, I would like to now show you recreation notes dated July 23, 1999. If you can specifically read this first portion of it.

A This is signed on a different page. Do

you know who made this entry?

Q I do not. Would these typically be notes that you would have available to you to look at in the file?

A Yes. Those notes are available to me and I did not review those notes from the recreational therapist.

Q Excuse me. I do have the second page. It does not really have any notes on it, just the signature.

A Okay. Thank you.

MR. FELOS: May I see the signature?

Q (By Ms. Campbell) On these notes, do you see any comments about --

MR. FELOS: Your Honor, I object. I believe what the Court has allowed or instructed is the witness may read the notes and then be asked whether it changes his opinion, without having the substance of the note read or explained.

THE COURT: I believe that was what we are to do was to permit the doctor to read the notes to see if they altered his opinion.

Q (By Ms. Campbell) Have you ever witnessed Theresa Schiavo laughing?

A No.

Q Have you ever told her any jokes?

A No.

Q If you -- have you ever witnessed Theresa Schiavo with her mother, Mary Schindler?

A No.

Q If you were made aware of, on a regular basis, Mrs. Schindler going to the hospital or to the nursing home to visit with Terri and there being signs of laughter, tears, if she is having her menstrual period she may moan from apparent pain, would that information, in additional coupled with the additional note I have just shown you, would that alter your opinion any as far as Terri's cognitive ability?

A It would not change my assessment of her.

Q And why would that not?

A During my examination and the examination of many others that I have reviewed that are physicians that are familiar with individuals like Terri and how grimacing or movement are sometimes misinterpreted as being part of a cognitive or thought process. A reaction to something.

I will give you an example. When I examined her, Terri will look around. Her eyes will move right to left. And when you enter the room, if you enter the room when she is looking, she turns her eyes to that side. It appears that she is acknowledging you. It appears that way. You can walk up to Terri and take your hand and put it over her eye and she will not blink.

You can take anyone who has the least bit of consciousness and put their hand anywhere near their eye, from the side, and they will blink. And she will continue to look, but will not blink. It is hard for me to appreciate that she knows that something else is there if she can't even appreciate a threat, which is a very basic instinct.

Q Are you aware or does Terri currently receive any physical or occupational therapy?

A She has from time to time. I think at this point therapy is provided on, they use the term on a restorative basis. It is not done by a licensed therapist. It is done by nursing staff who have been trained in therapy.

Q How often does she receive that kind of restorative therapy?

A She should receive this restorative therapy every day as part of the nursing care.

Q Would that assist in any stimulation to be provided to Theresa?

A You know, I would -- I'm not sure what you are getting at, but I would assume that any type of stimulation would be something, even just in the daily care, which is something that could provoke some response if it was present.

Q Is Theresa currently being treated for any infections in the two years you have been treating her?

A I recall an upper respiratory infection during that period of time.

Q And she was treated?

A Yes.

Q Have you at any time since you have been taking care of her had Mr. Schiavo ask you not to treat an infection?

A No. There were never any occasions where he withheld any treatment that I recall. He was very cooperative.

Q Are you aware of any discussions that took place between the nursing home and Mr. Schiavo concerning the treatment of infections for

Theresa?

A No. Not that I recall.

Q Not in the two years you have been treating her?

A No.

MS. CAMPBELL: I have no further questions.

THE COURT: Redirect?

MR. FELOS: Thank you, Your Honor.

REDIRECT EXAMINATION

BY MR. FELOS:

Q You were asked about the treatment of infections, whether under your care Terri has been treated for any infections, and you mentioned a respiratory infection. In fact, hasn't Terri had a bladder infection that was treated?

A Yes. Now that you mention it, she also has had a bladder infection.

Q How was that bladder infection treated?

A With an antibiotic.

Q How were the antibiotics administered?

A Through the feeding tube.

Q Were there any IVs?

A I don't recall. But, you know, I really was not prepared to give this detail on her two

year history.

Q Um-hmm.

A Whether we used an IV at some point in time.

Q In your testimony, I believe in the cross-examination you centered on the word "occasional" when Ms. Campbell did read a portion of the notes. I think you made the comment that because the word occasional was used, that would tend to suggest that these are not cognitive responses on Terri's part. Can you explain a little bit more why that is so?

A Well, the way it was written, I guess you would have to read the statement, but the way it was written, it is just that passersby are making jokes and occasionally she laughed. Now, okay, does that mean that from that information I should conclude that she was laughing at their jokes? This was a, you know, she received some information which she processed and then decided to laugh in response to it?

Q You were on cross-examination and opposing counsel mentioned that Theresa's mother believes that Terri laughs and responds. Theresa's mother testified in her deposition that

one of the actions that she takes to be a cognitive response of Terri is that when she speaks on one side of Terri, Terri will move her head. However, in her deposition, Mrs. Schindler said sometimes she will turn her head and look right at me.

The fact that Theresa does not turn her head every time to look at her mother, would that support or detract from your opinion?

A I think a consistency would be helpful to me. If you said nine out of ten times she turned to me, that would have some meaning. But if it was occasional, a random act --

Q Sometimes?

A -- suggests a more random act rather than a purposeful act. That is what I can glean from the information that you have provided and from the notes of the recreational therapist.

Q You were also asked about, I think menstrual pain or pain or moaning. Do you agree with the opinion of Dr. Barnhill that moans that Terri has in response to certain stimuli that we would consider painful is a brain stem response?

A Yes. I would. I think that, if I can just give you an example, that if you were to

touch a hot stove with your finger, you would pull it away very rapidly or before you really perceived what had happened because that is a higher function. I think this is a brain stem response.

Q Okay. How often do you go to nursing homes?

A Every day.

Q You are familiar with -- you are board certified in making sure people get quality care?

A Yes, sir.

Q Is it fair to say you are somewhat familiar with how nursing homes work?

A Yes, sir.

Q Do you have any idea as to what training a person who is in the activity program of a nursing home might have? Do they go to medical school?

A No. They do not.

Q Do they go to nursing school?

A No. They do not.

Q Do you know whether they have any clinical training or skills to be hired to sit with the residents and play cards with them or watch TV with them as engaged in activities with

them?

A I'm not aware of the specific qualifications of the individuals that had made notes in the record.

Q Would you disagree that -- would you disagree with the statement that no specific training is required for those positions?

A Perhaps that is true. I really could not say for sure.

Q As a physician, would you give much weight to a medical diagnosis given by someone hired by a nursing home to play cards or watch television with a resident?

A Would you repeat that question again?

Q Would you give, as a physician, would you give much weight to a medical opinion given by an individual hired by a nursing home to play cards and have activities with a patient?

A I certainly would respect their opinion and would review the situation myself and try to recreate what they have described. You know, in my experience and from my discussions with others who are more knowledgeable of medical issues, this was not apparent to my observation or the observation of those whose judgment I feel, you

know, is worthy of note.

Q Thank you. Dr. Gambone, you are a caring physician; you are interested in Theresa's welfare; is that correct?

A Yes. I am.

Q Is there any reason whatsoever that you would not say you believe Theresa was responsive or had cognition if you felt that was so?

A No. There is no reason for me not to only give you the information that I have and make an opinion based upon my knowledge and expertise in the area.

MR. FELOS: Okay. Thank you.

THE COURT: Any recross?

MS. CAMPBELL: No.

THE COURT: Is Dr. Gambone under subpoena?

THE WITNESS: Yes.

THE COURT: Is there any reason for him to be retained further?

MR. FELOS: No.

MS. CAMPBELL: No, Your Honor.

THE COURT: Thank you. Doctor, you are released from your subpoena.

THE WITNESS: Thank you.

MR. FELOS: Call Beverly Tyler.

THE BAILIFF: Stop and stand here. Face the judge. Raise your right hand to receive the oath.

(THEREUPON, THE WITNESS WAS SWORN ON OATH BY THE COURT.)

THE COURT: Be seated in that chair, please.

DIRECT EXAMINATION

BY MR. FELOS:

Q Good morning.

A Good morning.

Q State your full name and address, please.

A My name is Beverly Tyler. 158 Adair Street in Decatur, Georgia.

Q How are you employed at this time, Ms. Tyler?

A Executive director of an organization called Georgia Health Decisions.

Q Can you tell us what is Georgia Health Decisions?

A Sure. We are a nonprofit organization in Georgia. Federally tax exempt. Our mission is threefold. Educate Georgians about health care

issues, understand their attitudes and values around health care decisions, and report those to people who make health policy in our state.

Q Tell us a little bit about the structure of your organization. How many employees?

A There are eight employees at Georgia Health Decisions. Three of them live in Atlanta. Others are community based. We do a lot of community based work around the state. There is a volunteer Board of Directors of about 40 people and many volunteers who work on projects throughout the state.

Q Why was Georgia Health Decisions formed?

A We began our organization in 1991. It was sort of at the height of, at the time, talking about health care reform in the state. We had not had much managed care. Twenty-two percent were uninsured. There were a lot of rising costs in insurance. A lot of those issues everybody in the country faced. A lot of plans about health care reform. We were the public voice. We formed to be the public voice in health care issues.

Q Have you been executive director since the organization was formed?

A I have. Since 1991.

Q What is the source of funding?

A It's a charitable foundation primarily. We get some founding on a project basis from state government. Not a regular funding from the state government.

Q Ms. Tyler, please tell us your educational background. Also your employment background prior to being executive director of Georgia Health Decisions.

A Masters. Bachelors. Masters in Geography from the Univsity of Georgia. My first employment was from '71 to '73, environmental planner, Georgia Department of Transportation. My second employment was at an architectural firm, Stevens Wilkinson Marketing Directors. There was thirteen years prior to coming to Georgia Health Decisions.

Q Why is it that a health care related organization selected somebody whose educational employment background was outside of health care for that position?

A Because the whole premise of Georgia Health Decisions was to bring the public voice into the health care system without any preconceived ideas about what that should be or

what the solutions for health care were. The people, the Board that was forming Georgia Health Decisions at that time, was afraid if they hired somebody with a health care background that they would come with a lot of baggage. A lot of preconceived ideas with the solutions. They specifically looked for someone outside of health care.

Q Refreshing approach. Ms. Tyler, are you familiar with a report by American Health Decisions titled "The Quest to Die with Dignity"? An analysis of American values, opinions, and attitudes concerning end of life care?

A I was the primary author of that report. It is a focus group study. I conducted at least half, maybe more, of the focus groups related to that study.

Q What was the overall purpose of this report?

A Well, the overall purpose was to really try to understand how Americans feel about health care issues at the end of life. To sort of identify their values, opinions, and attitudes. It was funded by the Robert Wood Johnson Foundation because they were interested in

beginning two initiatives. One, to educate physicians about health care at end of life. The other, to create a sort of statewide public awareness campaign around health care issues around the end of life. They wanted to know the public starting point on those issues as they funded those two other projects.

Q Was this report issued by American Health Decisions rather than Georgia Health Decisions, which was your organization?

A Sure. American Health Decisions is sort of a loose affiliation of a number of state associations who do similar things to what we do. The Robert Wood Johnson Foundation was familiar with those and called several of us to a meeting together to talk about how to do this approach. What expertise that American Health Decisions had to do this.

It became clear that Georgia Health Decisions was sort of the organization with the most experience in this. Because it was a national study, it seemed appropriate that American Health Decisions be the grantee for the grant, although Georgia Health Decisions sort of led the effort. Wisconsin also had a small role

in the development of the study.

Q How much did the Robert Wood Johnson Foundation pay to fund this research and report?

A About $250,000.

Q You mentioned a little bit about how the report was conducted. I would like to go into that in more specifics. What you mentioned is something about a focus group research. Can you explain a little more what that is? How the methodology of the research was conducted?

A This is qualitative as opposed to quantitative. Qualitative is often done when you want to find out why people feel the way they do. How do they come to the values they have. To explore more the attitudes and opinions that you can't get in a simple yes or no answer where you can count answers.

So focus groups are small conversations led by a trained facilitator with a predetermined set of questions asked in every group so you are having the same conversation with the same people. The participants are randomly selected to represent the cross section of people you are trying to get the opinions and attitudes of.

The conversations are recorded, and

transcribed, and later analyzed in different ways to figure out what are the recurring feelings. What are the recurring attitudes and opinions of people that participated.

Q How is it determined how many focus groups you had and how many people are in them?

A It depends on what you are trying to reach. We were trying to reach a cross section of Americans. We did a certain number of groups. Twelve throughout the country. Sort of randomly selected cross demographics. Different ages, incomes, racial backgrounds, religious backgrounds.

We wanted to know if there were differences of opinion on end of life care because of age, religious background, ethnic background. So we did a number of specific groups with people of a certain religious background, age background, or ethnic background.

Q How many focus groups and actual participants were there in this study?

A Thirty-six in this study across the country. About 385 participants.

Q Thirty-six groups with 385 participants?

A Yes.

Q Were there any other professionals assisting you in the focus group research and data collection analysis?

A Sure.

Q Who were those people?

A The primary team was a woman name Terri Lofton (phonetic), a medical anthropologist, who is trained to look at conversations and draw out what the values or underlying conversations are. A public policy analyst, Michael Perry, was involved. I did part of the analysis. A statistician name Frank Miller did part and an ethosist from Wisconsin, Dr. Jack Stanley.

Q Ms. Tyler, when was that report issued?

A In September of 1997.

Q Have you participated in any further research and study in this area since the publication of your report?

A I have. Based on some of the findings we had from this study, we went back to Georgia and wanted to explore some of the issues a little deeper in Georgia. We held twelve focus groups randomly in Georgia with Georgia citizens. Nine with health care professionals. We most recently have done eleven focus groups with family members

of patients tied in to hospitals in Georgia in the last year. Also done similar work in North Carolina. We continue to do some work on this issue.

Q Have you presented the findings in your report to any professional organization?

A Quite a number.

Q Tell us a few.

A The national meeting of the American Society on Aging. National Hospice Organization. At John Hopkins Institute, I've been a guest lecturer on this issue.

Q Have you lectured on end of life issues before any organizations?

A Sure.

Q To your knowledge, Ms. Tyler, has there ever been undertaken or published a study or report in this area as extensive as "The Quest to Die with Dignity"?

A No. No. The reason being, it's pretty expensive an undertaking to do this nationwide. You have to have a funder be interested in getting the information, like Robert Wood Johnson was, to be able to do this work.

Q At this time, I offer the witness as an

expert on the subject of American's values, opinions, and attitudes concerning end of life care.

THE COURT: Do you wish to voir dire?

MS. CAMPBELL: No, Your Honor. I accept those as expert in that area.

THE COURT: Excuse me?

MS. CAMPBELL: I accept her as an expert in that particular area.

THE COURT: Thank you.

Q (By Mr. Pelos) Ms. Tyler, what materials have you reviewed in preparation for your testimony?

A I reviewed paragraph ten from the suggestion of bias on the part of the guardian ad litem. I reread the deposition of Robert Schindler, deposition of Mary Schindler, the deposition of Robert Schindler, Jr. and the deposition of Susan Carr.

Q In your research and report, did you take note of the ways in which persons express their desires and feelings regarding the application of artificial life support and other end of life medical treatment issues?

A Yes. I think one of the key things we

found is how difficult the conversation is about death and dying. How much people avoid the conversation. Generally, it's stimulated by outside stimulus. It is a very short conversation, unless people have had sort of a family experience that leads them to have a more indepth conversation on this issue, or if they are in the middle of a terminal illness themselves. For the most part, avoidance and very short conversations.

Q Let's backtrack from the fact that oral statements tend to be categorized by an event and look at written directives.

A Okay.

Q What percentage of adult Americans have living wills, if you know?

A That is -- there are no strong statistics on that because of the issues, issues of language or those kinds of things, but the best estimates from people in the field are about 13 to 15 percent of people actually have a written document. Generally those are people older -- over 50, over 55 -- who have had some catalyst in wanting to complete a document of that nature.

Q Would it be fair to say that a person in

their twenties would be much less likely than the national average to have a written living will or directive?

A Absolutely. It's not a conversation that people in their twenties have. It's certainly not something they feel compelled to do, because they are young, healthy. It's not going to happen to them for years to come. Like I said, there are no statistics. My personal opinion is that I would be surprised if 2 percent of the population in their twenties actually had a written document.

Q Of the population in their twenties?

A Um-hmm.

Q The fact that Theresa Schiavo did not have a written advanced directive specifying her medical treatment wishes, because of that fact, do you think it is fair to say because she did not have an advanced directive that she wanted to be kept alive artificially?

A No. Not at all. Most people who do not have advanced directives would tell us when their time came they would like to die naturally. The main issues why people don't have them is because they don't like the document. They don't

understand. They have a whole problem with the legal business of putting it in writing, but they trust their family members to do what they want done for them.

Q Let's go back to the method in which oral statements are made. Was that addressed anywhere in your report? The issue of how conversations come about?

A Yeah. Like I said, a lot of them are started by some kind of external stimulus. I marked a passage in the report that might help clarify that for you. If you need to know, it is on Page 18 of the report.

Some of those in focus groups who had conversations with a local --

THE COURT: Stop. You read much quicker than you talk. Our court reporter is super, but the machine has a limitation, so slow done, please.

A I will. Thank you. Some of those of the focus groups who had coversations with the loved one appeared to have not really had a conversation at all, but rather to have made a spontaneous observation about something they do not want to happen to them. They told of vague

references to being hooked up to machines or seeing a television program and having said don't let that happen to me. Many of the focus groups believed that is good enough.

When talking about loved ones, many participants made comments like "they just know how I feel" and "I trust them to make the right decisions" suggesting they do not feel compelled to write these wishes down as advanced directives.

So for most people, some kind of external stimulus. Some short conversation where you say that I don't want that to ever happen to me.

Q So I gather, based upon your research, that the average American does not sit down one day and go to their spouse and say, "Well, gee. If I happen to be in a totally impaired condition with minimal degree of consciousness, then under those circumstances, this is what I'd like you to do for me."?

A No. Not at all. First of all, you know, I told you we avoid having that conversation altogether anyway. We actually avoid even associating with people going through death and dying, unless we have to. For most people, it's

not sort of in the realm of consciousness the kind of decisions that may need to be made one day. The kind of decisions that should they be in that place in their life, without that consent or awareness. You don't have a detailed conversation about specific treatments that you would or would not want.

So they use these metaphors or euphemisms like "being hooked up", "pull the plug". Those kinds of things.

Q Now in this case, Ms. Tyler, there has been evidence that Theresa Schiavo, in response to her grandmother's impending death and the dependency issue of her uncle, said to her husband that if I had to be cared for by others, please don't let me live like that. And in response to a television program where somebody was severely impaired or on machines, either said to a sister-in-law or her husband, "Not for me. I don't want to be kept alive artificially."

Assuming that occurred, do you have an opinion whether such declarations of Theresa Schiavo were made in a manner consistent with the way you found declarations to be made in your report?

A Yes. I mean, they really reflect many of the underlying values people bring to this discussion. Sort of the value of freedom and independence and self-reliance of not wanting to be cared for by something else. Not wanting to be a burden to family. Wanting death with dignity. Wanting a quality of life that provides them some level of independence. Again, I have passages that I could read to you regarding those values.

Q Let me backtrack a little bit first.

A Okay.

Q I think you already mentioned in your report that people use phrases like "hooked up on machines". As you got into your focus groups and probed that deeper, what did people mean when they said "I don't want to be hooked up to machines"?

A They basically meant they don't want their life artificially extended. If they can't live on their own, they don't want a machine or some other kind of life sustaining treatments to keep them alive beyond their natural death. Like again, a euphemism to all the kinds of things that could be done to a person to extend their life beyond their natural death.

Q Including artificial hydration and

nutrition?

A Yes.

Q In your focus group research, were people familiar with the nature of the medical devices used to sustain people? I mean, did they know how a respirator worked? What has to be done to intubate a patient? How artificial provision of sustenance and hydration is made? Did people understand the technicalities of how that was done?

A Only those who had been through the experience with a loved one or someone close to them. But the normal person, lay person who has never been through that, they really don't. They don't have any clue and they don't want to think about it or talk about it and certainly not find out about it on their own.

They use the terms "don't put me on machines". "Don't hook me up". "If it is my time, pull the plug". Do you want me to sort of read the report?

Q A euphemism which means what to them?

A Which means let me die a natural death. When it's my time, it's my time. Sort of let me go.

Q I think we touched on this. On some of the factors that were included in that expression. Not being a burden. Being self-reliant. Let me ask it this way. What factors did you find most concerned people regarding end of life medical treatment and application of artificial life support?

A Quality of life is probably the primary concern. Quality of life also deals with self-reliance, independence, being able to take care of themselves. Not being a burden on their family. Having some kind of dignity at the end of their lives. Quality of life really was a key factor. People define that in different ways.

Q Did you cite in your report -- do you have any examples in your report that demonstrate that concern that most people felt when using these metaphors?

A About quality of life?

Q Yes.

A Um-hmm. While some individuals maintain they could gain satisfaction from life if they were aware and could only minimally communicate, others contend that quality of life would be conditional upon their being independent and

having some degree of mental comprehension and physical ability. Being dependent on others for every need envoked images of indignity and humiliation.

Q I think you mentioned values of being self-reliant or freedom and personal control. Were there any examples of this?

A Given the uncertainty about the proper usage and benefits of medical technology, many participants feared they or a loved one may remain on life support without the possibility of regaining a semblance of normal life, being in a vegetative state or unconsciously aware kept on life support artificially. Being hooked in a trap which they are ensnared by dependency to the wires that plug them into an exterior power source and food tubes that deliver food and oxygen.

This entrapment occurs because they no longer have control of choices as individuals, but are subordinate to the rules and procedures of medical and legal institutions. So a lot of conversation about that.

Q Were these prevalent or consistent themes that you found among individuals?

A Very consistent. I would say that it

surprised me, the consistency with which the people talk about that. When it is their time, they would like to have a natural death. They don't want to be hooked up to machines. They want to sort of go naturally.

This issue of self-reliance and independence and being a burden is really quite prevalent.

Q Was there any themes, or did the fact of the probability of recovering, factor into a person's feelings as to whether they would want artificial life support?

A Certainly. I mean, people don't say that they never want any kind of life support if it can give them a normal quality of life. If it can return them to some quality of life, they certainly will do what they call try it for a while.

What they really don't want, when people say I don't want to be on machines, they don't necessarily mean I don't want to be on a machine ever, but they don't want to live on machines is what they mean. To be on them to prolong death when death is, would be the natural extension of what happens to them.

Q Or when there is no hope of improvement?

A When there is no hope of improvement.

Q Did you come across any themes in your report about how a patient felt or person felt about their personal appearance about not wanting to be seen by others if they were in an impaired or unconscious state?

A There was sort of an under theme of that that came out. We did not pursue it a lot because it did not become obvious until we had read a lot of the transcripts, but there were a number of people, because of a control issue, who did not want to die in front of somebody because they don't like to be seen as vulnerable and weak. So, yes. It was not as prevalent a theme as many of the other themes that came out of the study.

Q In your opinion, Ms. Tyler, were the oral declarations as relayed to you of Theresa Schiavo consistent or inconsistent of the predominant values of the persons found in your report?

A Exactly what we expected, particularly for someone her age. That she would not have had an intense conversation about this issue, that her conversation would have been the result of a

personal illness, an uncle, a grandmother's illness, a television show. Somebody that they know.

That it would have been short conversations like I would not want to live that way. I would not want people to take care of me. I would not want to be hooked up. If that happens to me, pull the plug. Those are typical kinds of conversations. Yes, it would be a typical way that people would convey their wishes on this issue.

Q You may recall in the depositions of Mr. and Mrs. Schindler and their daughter, Susan, and son, Robert, statements to the effect that if they were in a permanent or vegetative state with no hope of recovery that they would want all medical treatments whatsoever to keep them alive. I think three out of the four said if they developed gangerine and needed to have limbs amputated to maintain life in that condition, they would do so rather than choose to die. Do you recall those statements?

A I do.

Q In your research and interviews and focus groups of hundreds of people, have you ever

come across a belief or expression that extreme?

A I have not. We certainly had people that say, yes, I want to be kept alive, but not to the extreme that they want amputation or surgery or anything like that if they were in a vegetative state.

Q In the deposition of Mrs. Schindler, she mentioned that if she was in that condition, a permanent vegetative state, even if the medical treatment impoverished her family, she would still want it. Do you recall that statement?

A I do.

Q Was the cost of care and burden on a family, financial burden on a family, something that was a theme that came up in your research?

A Very much so. As a matter of fact, when they talked about being a burden, the first thing they talk about is a financial burden and not wanting to exhaust family resources to take care of me if there is no hope of recovery. I would not want my family to be left financially strapped. I would not want to use up all our resources.

So being a burden sort of starts with being a financial burden and working its way

through to be a physical and emotional burden.

Q I would like to read to you from Mary Schindler's deposition of August 12, 1999. Page 39, Line 16.

Question. Well, in your mind, does there come a point in time where the experience of discomfort or pain on the part of the patient becomes a factor in deciding whether to remove life support?

Answer. No.

Were the persons in your focus groups at all concerned about suffering pain in end of life care and how that issue of pain related to continued artificial treatment?

A Certainly. Pain is -- we talked to people about how far they would go to pursue care and what should be done as far as treatment of people with terminal illness. One of the first things is do whatever you can to manage pain. That is everyone's primary concern. Both as a patient and as a family member, that is a primary concern.

The compassion of not wanting someone to be in pain, they would say, "I don't care. Give them as much pain relief as they need, even if it

hastens death, even if it makes them sort of unconscious, because I don't want to see my loved one suffer." So pain is really a key issue with people who are talking about how far to pursue care and how much pain medication to administer.

Q In determining in your study, for the average person in determining if a person determined they did not want to be kept alive artificially, they wanted to go when their time came, they did not want to be taken care of by others, they did not want to be a burden, did you see much distinction in that belief for a patient who might be in a vegetative state as opposed to a patient who might be significantly and permanently impaired?

A Certainly. Because when you talk about quality of life, cognizance seems to be a key there. You know, if people can be cognizant and can be aware and communicate in some way with their loved ones, many people define that as quality of live to continue as opposed to when you sort of lose that level of cognizance, that ability to communicate in any way to have meaningful exchanges.

Q What did they mean by communicate and

have meaningful exchanges?

A Let me see if I can find some examples that might help that. The importance of self-reliance was most evident in participants' discussion concerning quality of life. This feeling was dramatically expressed by a guy in New Orleans who confided "I really, truly would rather be dead than to sit down and have somebody do just about everything for me."

Ed Leeman (phonetic) from West Virginia defined quality of life as being able to care for your basic needs. Feed yourself. Go to the bathroom. Get up and move about. Do things for yourself. As long as you don't consider yourself a burden on people. A man from Maine admitted he would not want anyone to take care of him, and an Indiana woman felt strongly that she did not want to depend on someone else. Those are the kinds of ways people talked about this quality of life.

Q Well, when people said, gee, I would want to stay alive if I could communicate, what did they mean? Did they mean talking? Conversation?

A No. They did not necessarily have to have conversations. What they had to have is some

cue of I'm sending you a signal; I'm sending you one back. We understand what is going on with each other. I'm conveying to you my wishes. A lot of times you can still do that even if you can't talk. You can write it down or it's a conveying of wishes. Conveying an exchange of thought processes.

MR. FELOS: I have no further questions. Thank you.

THE COURT: Ms. Campbell, cross-examination?

CROSS-EXAMINATION

BY MS. CAMPBELL:

Q Thank you. Good morning, Ms. Tyler. My name is Pam Campbell. I am the attorney for Mr. and Mrs. Schindler, the parents of Theresa Schiavo.

A Certainly.

Q Is there an organization similar to yours in Florida?

A There is not a Florida Health Decisions. There is an organization called Aging with Dignity that does some of the similar kinds of work around health care at end of life helping people prepare and have conversations.

Q Did they participate in this national study?

A They did not.

Q Out of your study, there were 385 participants?

A Um-hmm.

Q So your comments and readings this morning from the different parts of the study are based on these 385 participants?

A They are.

Q What was the average age of the participant?

A I can't tell you. What we did was, for twelve of the groups, we did a cross section of the American population and recruited individuals to represent the different age groups of the population. Then we did some groups specifically with participants that were 18 to 34; 35 to 55; 55 to 65 and over 65. That way we did not ever alienate the average age of all groups together.

Q Did you notice a distinction in people of the age group of 25 to 35 versus older people 70 and up?

A There was some very, very small distinctions. What we really came away from this

report feeling was the magnitude of which most of the major themes out of the report were prevalent throughout the society, throughout age groups, throughout the religious groups, throughout the ethnic groups.

The differences we saw were on specific issues like physician assisted suicide and very specific things like that. The broad feelings, values, were pretty widely held throughout the population.

Q Were any of these participants from Florida?

A Yes. They were.

Q Do you know how many?

A We did two focus groups in Florida. So there must have been about 24 to 28. Something like that.

Q How did you become a participant in the study?

A Because of the prior work that we have done at Georgia Health Decisions, we have been doing this work in Georgia since 1991 and trying to understand citizen's values around health care, we have held probably 700 to 800 focus groups in Georgia. We held thousands of community forums.

Q My question is really more how would a person become a participant in this study?

A They were randomly recruited from a call list. When we go into the city, we contract with an independent contractor that does this kind of thing for a living. They randomly recruited people. They tell them what the conversation is going to be. We pay participants to come to get a cross section of people. If need be, we actually go out and provide transportation, if people have trouble getting there, to try to make sure we do get a good cross section of individuals.

Q Was there a type of average pay for participants to be involved?

A Yes. It was between 35 to $50. Generally, if you were in a rural area, you pay somebody $35. If you were in New York City, you had to pay a little more to try to get -- to entice them.

Q Would the focus groups be at one particular setting?

A Yes.

Q So they received anywhere from 35 to $55 for an afternoon of discussion?

A It was two-and-a-half hours. Everybody

in one focus group would get paid the same amount of money. So if it were in Indianapolis, you might have gotten $35. If you were in New York City, you might have gotten $50.

Q In your statistical configuration, was there any way to know or question these people as to their personal experience with end of life decisions?

A We did. In addition to the focus groups, we had 29 participants that were either terminally ill at the time or had a family member or someone who recently died that we did indepth telephone interviews with, one-on-one, to get that personal experience of, recent experience of people going through that situation.

But when you randomly recruit people, you will get the cross section of people who have had that experience; who have not had the experience. Going through it all, those experiences come to the table in this kind of research.

Q Do you know the statistics as far as how many people have gone through the experience of a loved one as opposed to -- personal experience as opposed to an ill person?

A I don't. Because this is quantatative research. You don't have the quantatative numbers that you are getting at. You can't say from focus group research, you can't say therefore 65 percent of the people in the country feel this way. It is not that kind of research. It is more when you are trying to get to what underlies people's values. What they say. Why they say it.

Q Where were the two focus groups in Florida held?

A I think one was in Miami. The other one was in Jacksonville.

Q Did you have a specific focus group on the Catholic faith?

A We did.

Q How many people participated in that group?

A We had two groups. So again, there would have been somewhere between 24 and 28.

Q Did you notice -- what other types of faiths did you have focus groups on?

A Protestant, Jewish and Muslim.

Q Did you notice any significant difference in the Catholics over --

A Not on the primary issues. Again, there

were only like seven very specific issues that we saw any differences among any of the categories. Let's see. The Catholic response for this group shows that they are more likely to trust physicians. They are somewhat more comfortable with discussions about death. More likely to agree that physicians should initiate end of life discussions and less likely to support mandatory living wills. They are split in support for physician assisted suicide.

So those are the only distinctions we could attach to someone being Catholic, as opposed to another religion.

Q Was part of that focus group or one of the questions for them to discuss the issue of artificial feeding? Nutrition and hydration?

A We did not discuss specific treatments about extension of life because we were getting more at general ideas of opinions and attitudes, and because most people are not that familiar with these specific kinds of treatments.

But when we ask -- when people would make these comments about pulling the plug, we would ask what does that mean to you. We would ask questions like would that also include

artificial feedings. Those kind of things.

Q Did you find in the different focus groups a difference between people's values and beliefs on life sustaining as to a ventilator versus food? Artificial sustenance?

A Not in general. No. No. If the -- sort of the determining factor is if anything is sort of keeping me alive and I can't get better, if I'm not going to regain a quality of life, then I would not generally, the prevailing attitude is I would not want that.

So the key, the key is is there a hope for me to get better. Would I regain a quality of life. If I'm not going to do that, don't do anything to prolong my death.

Q Was there a specific question for these groups to discuss the distinction between the differences of a ventilator versus artificial sustenance?

A No.

Q So your comments pertaining to that are from the comments that would have been asked voluntarily to pursue a further question?

A Right. When the topic would come to the table, the facilitator would ask the question what

does that mean to you.

Q These were groups of about twelve people each?

A Yeah. Twelve to fourteen.

Q Have you ever met Theresa Schiavo?

A I have not.

Q Have you met with her parents?

A I have not.

Q You stated that you had reviewed paragraph eleven of the suggestion of bias on the part of the guardian ad litem; is that correct?

A Um-hmm. Let me make sure that was the paragraph that I -- paragraph ten.

Q Ten.

A Um-hmm.

Q Did you read the report of the guardian ad litem?

A I did not.

Q Were you informed in any way about comments that Theresa would have made pertaining to maintaining life on a feeding tube or any kind of artificial sustenance?

A No. No. I read this and I read the depositions.

Q So you were not given any of the

information that the parents would have thought their daughter's wishes would be?

A No. Well, other than what is in the deposition. I did read the depositions.

Q Which were the depositions taken by Mr. Felos; correct?

A I assume.

Q Would the credibility of any of the statements contained in paragraph ten, would that change your opinion as to, one way or the other, as to whether or not Theresa fell within the norm of your study?

A Paragraph ten basically, to me, said this is how she had her conversation. That it was a response to a stimulus. It was reaction to a loved one that was ill. It was in reaction to an uncle or grandmother. So from reading those paragraphs, those pages, it was a typical way that people have conversations.

Q Would it also be typical if she made comments the other way?

A It would have been typical in the stimulus for the conversation, some external stimulus. There are people who do say I want to be kept alive no matter what, but it also would

probably be stimulated by some external stimulus like a TV show. Like a loved one who is ill. Particularly for somebody in that age group.

They do not normally sit down and inititate a conversation about, gee, one day I may be in a car wreck or terminally ill and if that happens, I want feeding tubes. I want blood products. It is just not what people, even in their fifties, normally do. So having a stimulus is a catalyst, really, for having these conversations.

Q So based on your experience and the study you have been involved in, the typical part is Theresa's making comments, one way or the other, related to a relative or a TV show?

A Yes. Stimulants. The prevalent attitude. Like I said, I do not know Theresa, so I can't testify about her comments, but prevalent attitudes throughout the population tend to go toward not wanting to prolong life through artificial means.

Q In your focus groups, did you make any distinction on end of life versus a parent versus the end of life of a child?

A We did not. That is because when I say

child, I mean somebody under 18.

Q Excuse me. I'll narrow it. A child being from the prospective of a parent, having your own parent die versus your own child die.

A I think that, you know, a loved one, having a loved one die or to be in that situation is a very emotional kind of thing. That people often, when they are having to struggle with these decisions, are struggling from the viewpoint of loss and emotional loss on their own part rather than what is the best care, what is the best thing for the loved one.

Anybody over age, you know -- it became clear that anybody over 18 has the right to make decisions for themselves. The laws in Georgia and I assume in Florida give people the right, over 18, to make decisions on how far they want to extend their life. The primary thing that came out is if those wishes are known, then family members, physicians, whoever else, should be obligated to follow those wishes, if there is some way to understand those wishes.

Q Are you familiar with the financial issues of this case?

A No. Not really. No.

Q Are you aware whether or not there is any financial burden or hardship on anyone for Theresa's care?

A No: I'm not aware of that.

MS. CAMPBELL: Thank you. No other questions.

THE COURT: Redirect?

REDIRECT EXAMINATION

BY MR. FELOS:

Q You were asked about your focus group of Catholics. The prevalent themes that you talked about on direct examination, I want to ask you if they pertain to Catholics. The prevalent theme of self-reliance, that people don't want to be maintained artificially if they are incontinent, can't eat, can't brush their hair, can't brush their teeth, if they are totally dependent, is that any different for Catholics?

A No.

Q The prevalent theme that artificial life support was not deemed to be considered beneficial if there was no hope of recovery, was that any different for Catholics?

A No.

Q The prevalent theme regarding quality of

life, that if you can't make your wishes known, if you can't communicate, if you can't have an interchange, if you can't have some enjoyment of life, that people don't want to be maintained artificially, is that any different for Catholics?

A No.

Q You were asked about the typicality of Theresa's expressions and that they were triggered by a catalyst and that's how people make them. Regarding the content of her expression as relayed to you, in your opinion, were they typical of the comments, the prevalent comments in your report?

A Very prevalent. I would say that, you know, of the 385 people that we talked to maybe a handful of them would say no matter what, I want to be kept alive. Put me on machines. You know.

So there were just -- the other attitude of when it's my time, it's my time, if there is no hope of recovery, quality of life was so prevalent in those conversations. It really was.

Q Talking about younger people, did you have any participants in their twenties?

A Yes. In two focus groups all participants were 18 to 34 and scattered throughout the other groups as well.

Q Was there any difference in terms of the prevelant attitudes among the younger people than the older people?

A One specific one that is not too relative to this case is that they were less fearful of talking about death, and that they were more skeptical of physicians. Just very odd things like that. Nothing on the prevalent themes or values and attitudes.

Q You were asked about the number of focus groups. How people were selected. You had social scientists working on this report?

A We did.

Q You had a statistician working on this report?

A We did.

Q Did those persons and yourself take any care to make sure that you had enough people, enough focus groups in enough areas, so this would be accepted as a social science work rather than an anecdotal reporting of what people said?

A Absolutely. There was a lot of thought in the preparation where we would go. Who the facilitators would like for each group and following through with each group to make sure

that we would -- we stay on top of it. Recruiting for every group and looking at demographics to make sure they were the cross section we need.

I have done this work for nine years. The first lesson I learned is that if people don't like what is in the report, they will question your methodology. So you better have that tight or you don't have much group to stand on. This report has been accepted very well across the country as a good social science report.

MR. FELOS: Thank you.

THE COURT: Any recross?

MS. CAMPBELL: No, Your Honor.

THE COURT: Thank you, ma'am. You may stand down. Further witnesses?

MR. FELOS: No further witnesses at this time. We do have on our subpoena and listed as a witness Mr. Pearse, but opposing counsel and I have agreed, rather than have Mr. Pearse come twice, once now and then called in respondent's case, that respondents will call Mr. Pearse and I can get my questions in during cross-examination. I wanted to inform the Court of that.

The only other thing I had at this time in the case, before we close, is the introduction

of the suggestion of bias. Your Honor, what number are we up to?

THE COURT: I believe that is Number Seven. Is there an objection?

MS. CAMPBELL: No, Your Honor.

THE COURT: Thank you. It will be received. With this having been received, Mr. Felos, does the petitioner rest?

MR. FELOS: One moment. Let me go through my list here. Yes. That is it at this time.

THE COURT: Thank you.

MS. CAMPBELL: Your Honor, since it's quarter of 11:00, my first witness is Mary Schindler and I think she will take quite a while. I would suggest an early lunch hour and then come back. I'll begin with her. Then that will give us appropriate time, rather than break her testimony up.

THE COURT: It is time for a break. The bailiff reminded me it is overdue. I have something to do over the noon hour, so we'll just be back at 1:00. It does make sense for us to break until then probably, rather than have her on for an hour, then you cannot talk to her over the

noon hour. So why don't we stand in recess until one o'clock.

MS. CAMPBELL: Thank you, Your Honor.

THE BAILIFF: All rise. Circuit court is in recess until one o'clock.

(THEREUPON, A RECESS WAS TAKEN AT 10:50 A.M. UNTIL 1:00 P.M.)