In the Matter of Westchester County Medical Center, on Behalf of Mary O'Connor, Appellant. Helen A. Hall et al., Respondents

[NO NUMBER IN ORIGINAL]

Court of Appeals of New York

72 N.Y.2d 517; 531 N.E.2d 607; 534 N.Y.S.2d 886; 1988 N.Y. LEXIS 2685

August 31, 1988, Argued October 14, 1988, Decided

SUBSEQUENT HISTORY:

As Amended April 11, 1989.

PRIOR HISTORY:

Appeal, by permission of the Appellate Division of the Supreme Court in the Second Judicial Department, from an order of that court, entered August 16, 1988, which affirmed a judgment of the Supreme Court (Nicholas Colabella, J.), entered in Westchester County, (1) denying an application by Westchester County Medical Center for authorization to insert a nasogastric feeding tube in Mary O'Connor, a hospital patient who is mentally incompetent and unable to obtain food or drink without medical assistance, in order to provide her with sustenance, and (2) granting a counterclaim by respondents to discontinue intravenous feeding of Mary O'Connor.

Matter of Westchester County Med. Center (O'Connor), 139 AD2d 344.

DISPOSITION:

Order reversed, etc.

LexisNexis(R) Headnotes

Healthcare Law > Treatment > Withdrawal of Life Support

[HN1] A person has the right to decline medical treatment, even lifesaving treatment, absent an overriding state interest. A hospital or medical facility must respect this right even when a patient becomes incompetent, if while competent, the patient stated that he or she did not want certain procedures to be employed under specified circumstances.

Healthcare Law > Treatment > Withdrawal of Life Support

[HN2] The right to decline medical treatment is personal and, under existing law in New York, could not be exercised by a third party when the patient is unable to do so.

Healthcare Law > Treatment > Withdrawal of Life Support

[HN3] Where a patient was competent and capable of expressing his will before he was silenced by illness, it would be appropriate for the court to intervene and direct the termination of artificial life supports, in accordance with the patient's wishes, because it was established by clear and convincing evidence that the patient would have so directed if he were competent and able to communicate.

Civil Procedure > Appeals > Standards of Review > Standards Generally

[HN4] Whether there is sufficient evidence in the record to satisfy the clear and convincing standard presents a question of law reviewable by the appellate court.

Civil Procedure > Appeals > Standards of Review > Standards Generally

[HN5] Since the inquiry in New York is limited to ascertaining and then effectuating the patient's expressed wishes, the court's focus must always be on what the patient would say if asked today whether the treatment in issue should be terminated. However, it can never be completely certain of the answer to the question, since the inquiry assumes that the patient is no longer able to express his or her wishes. Most often, therefore, the inquiry turns on interpretation of statements on the subject made by the patient in the past.

Healthcare Law > Treatment > Withdrawal of Life Support

[HN6] The substituted judgment approach remains unacceptable because it is inconsistent with the fundamental commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another. Consequently, the courts adhere to the view that, despite its pitfalls and inevitable

uncertainties, the inquiry must always be narrowed to the patient's expressed intent, with every effort made to minimize the opportunity for error. Every person has a right to life, and no one should be denied essential medical care unless the evidence clearly and convincingly shows that the patient intended to decline the treatment under some particular circumstances This is a demanding standard, the most rigorous burden of proof in civil cases. It is appropriate because if an error occurs it should be made on the side of life.

Civil Procedure > Appeals > Standards of Review > Standards Generally

[HN7] The "clear and convincing" evidence standard requires proof sufficient to persuade the trier of fact that the patient held a firm and settled commitment to the termination of life supports under the circumstances like those presented. As a threshold matter, the trier of fact must be convinced, as far as is humanly possible, that the strength of the individual's beliefs and the durability of the individual's commitment to those beliefs makes a recent change of heart unlikely. The persistence of the individual's statements, the seriousness with which those statements were made and the inferences, if any, that may be drawn from the surrounding circumstances are among the factors which should be considered.

Healthcare Law > Treatment > Incompetent, Minor & Mentally Disabled Patients

[HN8] Commitment to a mental institution does not necessarily show that a person lacks the mental capacity to make any mental health choices. Thus a mental patient's refusal to consent to a particular treatment should generally be honored unless it is proven that the person's mental disability does in fact impair the ability to make such a choice.

COUNSEL:

Marilyn J. Slaaten, County Attorney (Carol L. Van Scoyoc, Kenneth E. Powell and *Cataldo F. Fazio* of counsel), for appellant. I. Specificity must be required with respect to expressions of a patient made when competent as to the type of medical treatment to be withheld and under what circumstances such treatment shall be withheld. *(Schloendorff v Society of N. Y. Hosp*., 211 NY 125; *Matter of Eichner v Dillon*, 52 NY2d 363; *Matter of Delio v Westchester County Med. Center*, 129 AD2d 1.) II. The order of the court below affirming the lower court's decision is an adoption of the substituted judgment doctrine which this court has expressly rejected. *(Matter of Eichner [Fox]*, 73 AD2d 431, *mod sub nom. Matter of Eichner v Dillon*, 52 NY2d 363.) III. The lower courts' orders to withhold a nasogastric feeding tube and to withdraw intravenous feeding from a conscious Mary O'Connor is not sustained by clear and convincing evidence. *(Blum v Fresh Grown Preserve Corp*., 292 NY 241; *Matter of Storar*, 52 NY2d 363.) IV. The case at bar is not controlled by prior precedent. *(Matter of Storar*, 52 NY2d 363; *Matter of Delio v Westchester County Med. Center*, 129 AD2d 1; *Rivers v Katz*, 67 NY2d 485; *Schloendorff v Society of N. Y. Hosp*., 211 NY 125.)

Julius W. Cohn, Carl Stahl and *Wayne H. Spector* for respondents. I. Mary O'Connor's wishes were expressed with a sufficient degree of specificity and were proven by clear and convincing evidence. *(Matter of Eichner [Fox]*, 73 AD2d 431, *mod sub nom. Matter of Eichner v Dillon*, 52 NY2d 363, 454 U.S. 858.) II. An incompetent person, though not comatose or in a persistent vegetative state, has the right to refuse life-prolonging medical treatment. *(Rivers v Katz*, 67 NY2d 485; *Matter of Storar*, 52 NY2d 363, 454 U.S. 858; *Matter of Hall Hosp. [Cinque]*, 116 Misc 2d 477.)

Barry Birbrower, Law Guardian.

Fenella Rouse, Elena N. Cohen, M. Rose Gasner and *Richard Wasserman* for Society for the Right to Die, Inc., *amicus curiae*. I. There was clear and convincing evidence of Mary O'Connor's wishes to forego medical treatment in her current condition. *(Matter of Storar*, 52 NY2d 363, 454 U.S. 858; *Matter of Hofbauer*, 47 NY2d 648; *Addington v Texas*, 441 U.S. 418; *Matter of Delio v Westchester County Med. Center*, 129 AD2d 1.) II. The clear and convincing standard should be reconsidered. *(Matter of Storar*, 52 NY2d 363; *People v Eulo*, 63 NY2d 341; *Matter of Delio v Westchester County Med. Center*, 129 AD2d 1; *Matter of Beth Israel Med. Center [Weinstein]*, 136 Misc 2d 931.) III. Artificial feeding is medical treatment that people have a right to reject. IV. A person's right to refuse treatment is not limited to certain medical conditions. *(Matter of Delio v Westchester County Med. Center*, 129 AD2d 1; *Matter of Storar*, 52 NY2d 363; *Randolph v City of New York*, 117 AD2d 44, 69 NY2d 844; *Rivers v Katz*, 67 NY2d 485.) V. No State interest outweighs Mary O'Connor's right of self-determination. *(Matter of Storar*, 52 NY2d 363; *Matter of Jamaica Hosp*., 128 Misc 2d 1006; *Matter of Von Holden v Chapman*, 87 AD2d 66; *Matter of Beth Israel Med. Center [Weinstein]*, 136 Misc 2d 931; *Randolph v City of New York*, 117 AD2d 44, 69 NY2d 844; *Matter of Melideo*, 88 Misc 2d 974.)

Richard J. Concannon and *Mary Ellen Gunnison* for New York Medical College, *amicus curiae*. Petitioner-appellant's application should be granted in all respects.

David Zwiebel for Agudath Israel of America, *amicus curiae*. I. Personal autonomy is not absolute. *(Matter of Delio v Westchester County Med. Center*, 129 AD2d 1.) II. The evidence is insufficient to show the patient's wishes. *(Matter of Storar*, 52 NY2d 363.)

Anne M. Perone for New Jersey Right To Life Committee, Inc., *amicus curiae*. I. The court should heed the lesson of recent history in determining whether anyone has the right to terminate the life of a handicapped person by denying them food and water. II. Legal safeguards are required to protect the interests of incompetent patients.

Elliot B. Pasik for Greater New York Health Care Facilities Association, Inc., *amicus curiae*. The request to withhold or withdraw tube-delivered food and water should be rejected on public policy grounds. *(Matter of Delio v Westchester County Med. Center*, 129 AD2d 1; *Matter of Von Holden v Chapman*, 87 AD2d 66; *Matter of Storar*, 52 NY2d 363; *Byrn v New York City Health & Hosps. Corp*., 31 NY2d 194.)

Mary B. Spaulding, James Bopp, Jr., Thomas J. Marzen, Mary M. Nimz, Daniel Avila and *Teresa Kealy* for the Ethics and Advocacy Task Force of the Nursing Home Action Group, *amicus curiae*. I. The State's compelling interest in the preservation of the life of Mrs. O'Connor and others similarly situated requires that she be fed and hydrated. *(Matter of Fox [Eichner]*, 102 Misc 2d 184; *Matter of Storar*, 52 NY2d 363.) II. Absent sufficient evidence that Mrs. O'Connor would refuse nutrition and hydration and pursuant to her best interests, intravenous tube feeding and hydration should be provided. *(Matter of Eichner [Fox]*, 73 AD2d 431, *mod sub nom. Matter of Storar*, 52 NY2d 363, 454 U.S. 858; *Matter of Delio v Westchester County Med. Center*, 129 AD2d 1; *People v Eulo*, 63 NY2d 341.) III. Mental or physical disability is irrelevant to any standard under which treatment, nutrition or hydration might be foregone for patients unable to make medical decisions. *(Cleburne v Cleburne Living Center*, 473 U.S. 432; *Shelly v Kraemer*, 334 U.S. 1; *Palmore v Sidoti*, 466 U.S. 429.)

Michael Vaccari, Edward R. Grant, James Michael Thunder and *Clarke D. Forsythe* for New York State Nurses for Life, Inc., *amicus curiae*. I. The evidence is clear that Mary O'Connor is not terminally ill nor imminently dying and that she is in neither a persistent vegetative state nor a coma. II. The decision and analysis of the court below directly conflicts with this court's controlling decision in *Matter of Storar*. *(Matter of Delio v Westchester County Med. Center*, 129 AD2d 1; *Matter of Eichner [Fox]*, 73 AD2d 431, *mod sub nom. Matter of Eichner v Dillon*, 52 NY2d 363; *Matter of O'Brien*, 135 Misc 2d 1076.) III. The common-law right to refuse medical treatment does not permit the withdrawal of food and water with the specific intent to proximately cause the death of the patient when the patient is neither terminally ill nor imminently dying. *(Matter of Von Holden v Chapman*, 87 AD2d 66; *People v Stubbs*, 122 AD2d 91.)

Giles R. Scofield, III, for Concern for Dying, *amicus curiae*. I. The right to forego treatment is protected under the State Constitution and under the common law. *(Schloendorff v Society of N. Y. Hosp*., 211 NY 125; *Matter of Storar*, 52 NY2d 363, 454 U.S. 858; *Rivers v Katz*, 67 NY2d 485; *People v P. J. Video*, 68 NY2d 296; *Matter of Delio v Westchester County Med. Center*, 129 AD2d 1; *Matter of Beth Israel Med. Center [Weinstein]*, 136 Misc 2d 931.) II. The right to forego treatment includes the right to forego artificially provided nutrition and hydration. III. The lower courts' conclusion that the evidence of Mary O'Connor's wishes was clear and convincing comports with this court's ruling in *Storar*. IV. Should this court conclude that the evidence of Mary O'Connor's wishes is not clear and convincing, it is not precluded from and should complete its articulation of the substituted judgment standard expressed in *Storar* and *Rivers*. *(People v Eulo*, 63 NY2d 341; *Addington v Texas*, 441 U.S. 418.)

Thomas J. Ford, Robert F. Van Der Waag, Paul Callahan, Eugene Ferencik and *J. Randolph Hundertmark* for the Catholic Lawyers Guild of the Diocese of Rockville Centre, *amicus curiae*. I. The facts relied upon by the majority below fall short of establishing clearly and convincingly that Mrs. Mary O'Connor, when competent, determined to have life-sustaining medical treatment, including the withdrawal or withholding of all sustenance, terminated. *(Matter of Eichner v Dillon*, 52 NY2d 363.) II. In the case at bar there are State interests in preserving the life of Mary O'Connor that compel reversal. *(Matter of Vogel*, 134 Misc 2d 395; *Matter of O'Brien*, 135 Misc 2d 1076.)

JUDGES:

Judges Kaye, Titone and Bellacosa concur with Chief Judge Wachtler; Judge Hancock, Jr., concurs in result in a separate opinion; Judge Simons dissents and votes to affirm in another opinion in which Judge Alexander concurs.

OPINIONBY:

WACHTLER

OPINION:

[*522] [***887] [**608] **OPINION OF THE COURT**

Mary O'Connor is an elderly hospital patient who, as a result of several strokes, is mentally incompetent and unable to obtain food or drink without medical assistance. In this dispute between her daughters and the hospital the question is whether the hospital should be permitted to insert a nasogastric tube to provide her with sustenance or whether, instead, such medical interven-

tion should be precluded and she should be allowed to die because, prior to becoming incompetent, she made several statements to the effect that she did not want to be a burden to anyone and would not want to live or be kept alive by artificial means if she were unable to care for herself.

The hospital has applied for court authorization to insert the nasogastric tube. The patient's daughters object claiming that it is contrary to her "expressed wishes", although they conceded at the hearing that they do not know whether their mother would want to decline this procedure under these circumstances, particularly if it would produce a painful death. The trial court denied the hospital's application, concluding that it was contrary to the patient's wishes. The Appellate Division affirmed, with two Justices dissenting. The hospital has appealed by leave of the Appellate Division which also granted a stay permitting the patient to be fed intravenously while this appeal is pending.

We have concluded that the order of the Appellate Division should be reversed and the hospital's petition granted. On this record there is not clear and convincing proof that the patient had made a firm and settled commitment, while competent, to decline this type of medical assistance under circumstances such as these. n1

n1 On this analysis it is unnecessary to reach the many other issues presented on this appeal including the question as to State interest in prolonging life particularly in view of the fact that that issue is not asserted by the parties.

[*523] I.

The patient is a 77-year-old widow with two children, Helen and Joan, both of whom are practical nurses. After her husband's death in 1967 she lived alone in her apartment in the New York City area where she was employed in hospital administration. In 1983 she retired from her job after 20 years service.

Over the years a number of her close relatives died of cancer. Her husband died of brain cancer. The last two of her nine brothers died of cancer, one in 1975 and the other in 1977. During their final years she regularly visited them in the hospital and cared for them when they were home. In November 1984, after being informed that her stepmother had died of cancer in Florida, Mrs. O'Connor had an attack of congestive heart failure and was hospitalized. She was released from the hospital in December 1984.

In July of the following year she suffered the first of a series of strokes causing brain damage and related disabilities which rendered her unable to care for herself. [***888] [**609] She became passive, could only carry on limited conversations, and could not walk, eat, dress or care for her bodily needs without assistance from others. Upon her release from the hospital in August 1985, Mrs. O'Connor resided with her daughter Helen who, together with Joan and another woman, provided her with full-time care.

In December 1987, Mrs. O'Connor had a second major stroke causing additional physical and mental disabilities. She became unresponsive and unable to stand or feed herself. She had to be spoon-fed by others. Her gag reflex was also impaired, as a result of which she experienced difficulty swallowing and thus could eat only pureed foods. In this condition her daughters found that they could no longer care for her at home and, when she left the hospital in February 1988, she was transferred to the Ruth Taylor Institute (the Institute), a long-term geriatric care facility associated with the Westchester County Medical Center (the hospital). In conjunction with this transfer, her daughters submitted a document signed by both of them, to be included in her medical file, stating that their mother had expressed the wish in many conversations that "no artificial life support be started or maintained in order to continue to sustain her life", and that they wanted this request to be honored.

During the initial part of her stay at the Institute the staff [*524] found Mrs. O'Connor was cooperative, capable of sitting in a chair and interacting with her surroundings. However, in June her condition deteriorated. She became "stuperous, virtually not responsive" and developed a fever. On June 20, 1988, she was transferred from the Institute to the hospital.

At the hospital it was determined that she was suffering from dehydration, sepsis and probably pneumonia. The hospital staff also found that she had lost her gag reflex, making it impossible for her to swallow food or liquids without medical assistance. She showed marked improvement after receiving fluids, limited nourishment and antibiotics intravenously. Within a few days she became alert, able to follow simple commands and respond verbally to simple questions. However her inability to swallow persisted and her physician, Dr. Sivak, determined that a nasogastric tube should be used to provide more substantial nourishment. When Mrs. O'Connor's daughters objected to this procedure, the matter was brought before the hospital's ethics committee which found that it would be inappropriate to withhold this treatment under the circumstances.

On July 15, the hospital commenced this proceeding by order to show cause seeking court authorization to use the nasogastric tube, claiming that without this relief Mrs. O'Connor would die of thirst and starvation within a

few weeks. In an opposing affidavit her daughters stated that this was against their mother's expressed wishes because before becoming incompetent, she had repeatedly stated that she did not want her life prolonged by artificial means if she was unable to care for herself. They noted the number of relatives she had comforted during prolonged final illnesses and urged that the effect of her statements should be evaluated against that background.

The hearing on the petition began on July 19 and concluded on July 21. Two medical experts testified regarding Mrs. O'Connor's condition: Dr. Sivak for the hospital and Dr. Wasserman for the respondents. With respect to the patient's statements concerning life-sustaining measures the respondents themselves both testified and called one additional witness, James Lampasso.

The treating physician, Dr. Sivak, testified that Mrs. O'Connor was suffering from multi-infarct dementia as a result of the strokes. This condition substantially impaired her cognitive ability but she was not in a coma or vegetative state. She [*525] was conscious, and capable of responding to simple questions or requests sometimes by squeezing the questioner's hand and sometimes verbally. She was also able to respond to noxious stimuli, such as a needle prick, and in fact was sensitive to "even minimal discomfort", although she was not experiencing pain in her present condition. When asked how she felt she [***889] [**610] usually responded "fine", "all right" or "ok". The treating physician also testified that her mental awareness had improved at the hospital and that she might become more alert in the future. In fact during the latest examination conducted that morning, in response to the doctor's request she had attempted to sit up and had been able to roll over on her side so that he could examine her lungs. However, Dr. Sivak stated that she is unable to comprehend complex questions, such as those dealing with her medical treatment, and doubted that she would ever regain significant mental capacity because the brain damage was substantial and irreparable.

The doctor stated that Mrs. O'Connor was presently receiving nourishment exclusively through intravenous feeding. However, this procedure was inadequate for long-term use because it does not provide sufficient nutrients and the veins tend to deteriorate. He testified that intravenous feeding is used as a temporary measure which generally must be discontinued within several weeks. He noted that these difficulties could be overcome with a gastric tube connected to the patient's digestive tract through her nose or abdomen. This procedure would provide adequate nutrients and could cause only transient discomfort at the time of insertion. Since the patient's condition is otherwise fairly stable, this procedure would preserve her life for several months, perhaps several years. If the procedure were not employed and the intravenous methods could no longer be used or were otherwise discontinued, she would die of thirst and starvation within 7 to 10 days. The doctor stated that death from starvation and especially thirst, was a painful way to die and that Mrs. O'Connor would, therefore, experience extreme, intense discomfort since she is conscious, alert, capable of feeling pain, and sensitive to even mild discomfort.

The respondents' expert Dr. Wasserman, a neurologist, agreed essentially with Dr. Sivak's evaluation and prognosis. In his opinion, however, Mrs. O'Connor would not experience pain if permitted to die of thirst and starvation. Because of the extensive brain damage she had suffered, the doctor did not "think she would react as you or I would under the [*526] circumstances" but would simply become more lethargic, unresponsive and would ultimately die. If she experienced pain he believed she could be given pain killers to alleviate it. He conceded, however, that he could not be "medically certain" that she would not suffer because he had never had a patient, or heard of one, dying after being deprived of food and water. Thus he candidly admitted: "I guess we don't know".

Interestingly, Dr. Wasserman also admitted that during his examination, which occurred just before the close of the hearing, the patient exhibited further improvement in her condition. He found that she was generally able to respond to simple commands, such as a request to move her arm or foot. He also noted that she was able to state her name, seemed to be aware of where she was, and responded to questions about 50 or 60% of the time, although her speech was slow and halting and her responses were not always appropriate. Most significantly, she was able to converse in short sentences of two or three words which, he noted, she had not been able to do since her admission to the hospital. He also observed that she had a gag reflex. Although he did not know whether Mrs. O'Connor would be able to use it to eat, he recognized the possibility that she might.

Neither of the doctors had known Mrs. O'Connor before she became incompetent and thus knew nothing of her attitudes toward the use of life-sustaining measures. The respondents' first witness on this point was James Lampasso, a former co-worker and longtime friend of Mrs. O'Connor. He was also acquainted with other members of the family and presently worked with the patient's daughter Helen at a local hospital. He testified that his first discussion with Mrs. O'Connor concerning artificial means of prolonging life occurred about 1969. At that time his father, who was dying of cancer, informed him that he would not want to continue life by any artificial method if he had lost his dignity because he could no longer control his normal bodily [***890]

[**611] functions. The witness said that when he told Mrs. O'Connor of this she agreed wholeheartedly and said: "I would never want to be a burden on anyone and I would never want to lose my dignity before I passed away." He noted that she was a "very religious woman" who "felt that nature should take its course and not use further artificial means." They had similar conversations on two or three occasions between 1969 and 1973. During these discussions Mrs. O'Connor variously stated that it is "monstrous" to keep someone alive by using "machinery, [*527] things like that" when they are "not going to get better"; that she would never want to be in the same situation as her husband and Mr. Lampasso's father and that people who are "suffering very badly" should be allowed to die.

Mrs. O'Connor's daughter Helen testified that her mother informed her on several occasions that if she became ill and was unable to care for herself she would not want her life to be sustained artificially. The first discussion occurred after her husband was hospitalized with cancer in 1967. At that time Mrs. O'Connor said that she never wanted to be in a similar situation and that she would not want to go on living if she could not "take care of herself and make her own decisions." The last discussion occurred after Mrs. O'Connor's stepmother died of cancer and Mrs. O'Connor was hospitalized for a heart attack: "My mother said that she was very glad to be home, very glad to be out of the hospital and [hoped] she would never have to be back in one again and would never want any sort of intervention any sort of life support systems to maintain or prolong her life." Mrs. O'Connor's other daughter, Joan, essentially adopted her sister's testimony. She described her mother's statements on this subject as less solemn pronouncements: "it was brought up when we were together, at times when in conversations you start something, you know, maybe the news was on and maybe that was the topic that was brought up and that's how it came about."

However, all three of these witnesses also agreed that Mrs. O'Connor had never discussed providing food or water with medical assistance, nor had she ever said that she would adhere to her view and decline medical treatment "by artificial means" if that would produce a painful death. When Helen was asked what choice her mother would make under those circumstances she admitted that she did not know. Her sister Joan agreed, noting that this had never been discussed, "unfortunately, no".

At the conclusion of the hearing the daughters submitted a counterclaim seeking an order directing the hospital to also discontinue the intravenous feeding.

As noted the trial court denied the hospital's petition and granted the counterclaim concluding that Mrs. O'Connor's "past expressions plainly covered any form of life-prolonging treatment". The Appellate Division affirmed noting that requiring greater specificity would impose an undue burden on those seeking to avoid life-prolonging treatment.

[*528] II.

It has long been the common-law rule in this State that [HN1] a person has the right to decline medical treatment, even lifesaving treatment, absent an overriding State interest *(Schloendorff v Society of N. Y Hosp., 211 NY 125, 129-130).* In 1981, we held, in two companion cases, that a hospital or medical facility must respect this right even when a patient becomes incompetent, if while competent, the patient stated that he or she did not want certain procedures to be employed under specified circumstances *(Matter of Storar* and *Matter of Eichner v Dillon, 52 NY2d 363).* In *Storar,* involving a retarded adult suffering from terminal cancer, who needed blood transfusions to keep him from bleeding to death, we declined to direct termination of the treatment because it was impossible to determine what his wish would have been were he competent and it would be improper for a court to substitute its judgment for the unascertainable wish of the patient. Commenting on this latter [***891] [**612] principle in a subsequent case we noted that [HN2] the right to decline treatment is personal and, under existing law in this State, could not be exercised by a third party when the patient is unable to do so *(People v Eulo, 63 NY2d 341).* n2

n2 The status of the law on this point has since been changed to some extent by legislation. The Legislature has now authorized third parties to issue do not resuscitate orders for incompetent patients under certain circumstances (Public Health Law art 29-b). More recently the Legislature enacted a statute permitting individuals to create "springing powers of attorney", which come into effect when another designated person determines that the maker has become incompetent (*General Obligations Law § 5-1602*). This broadens the "durable power of attorney" which simply survives incompetency (*General Obligations Law § 5-1601*). Although powers of attorney have traditionally been limited to delegation of financial powers as opposed to personal decisions *(see, e.g., Camardella v Schwartz, 126 App Div 334, 337; Restatement [Second] of Agency § 17*), this limitation has been eroded by court recognition of the ability of third parties to express the wishes of incompetent patients without written authority *(see, 1984 Opns Atty Gen 58,* No. 84-F16). There is therefore no longer any reason

> in principle why those wishing to appoint another to express their specific or general desires with respect to medical treatment, in the event they become incompetent, may not do so formally through a power of attorney. The question raised by the dissent with respect to pure substituted judgment exercised by a third party not designated by the patient is not at issue in this case since Mrs. O'Connor's daughters made it very clear at the hearing that they were simply conveying their mother's wishes, and were not attempting to decide for her. There has been no change in the law which would confer such a power on the courts or others.

In contrast to the patient in *Storar*, the patient in *Eichner* [*529] had been [HN3] competent and capable of expressing his will before he was silenced by illness. In those circumstances, we concluded that it would be appropriate for the court to intervene and direct the termination of artificial life supports, in accordance with the patient's wishes, because it was established by "clear and convincing evidence" that the patient would have so directed if he were competent and able to communicate *(52 NY2d, at 379, supra; see also, Matter of Delio v Westchester County Med. Center, 129 AD2d 1; Addington v Texas, 441 U.S. 418, 424).* We selected the "clear and convincing evidence" standard in *Eichner* because it "'[impresses] the factfinder with the importance of the decision' * * * and it 'forbids relief whenever the evidence is loose, equivocal or contradictory'" *(Matter of Storar, supra, at 379).* Nothing less than unequivocal proof will suffice when the decision to terminate life supports is at issue. n3

> n3 [HN4] Whether there is sufficient evidence in the record to satisfy the clear and convincing standard presents a question of law reviewable by this court. Reviewing the entire record in this manner does not involve making new factual findings, as the dissent suggests.

In *Eichner*, we had no difficulty finding "clear and convincing" evidence of the patient's wishes. Brother Fox, the patient in *Eichner*, was a member of a religious order who had conscientiously discussed his moral and personal views concerning the use of a respirator on persons in a vegetative state. The conclusion that "he carefully reflected on the subject * * * [was] supported by his religious beliefs and [was] not inconsistent with his life of unselfish religious devotion." *(Id., at 379-380.)* Further, his expressions were "solemn pronouncements and not casual remarks made at some social gathering, nor [could] it be said that he was too young to realize or feel the consequences of his statements" *(id., at 380).* Indeed, because the facts in Brother Fox's case were so clear, we had no need to elaborate upon the kind of showing necessary to satisfy the "clear and convincing" standard.

The facts in this case present a much closer question and require us to explore in more detail the application of that standard in this context. It would, of course, be unrealistic for us to attempt to establish a rigid set of guidelines to be used in all cases requiring an evaluation of a now-incompetent patient's previously expressed wishes. The number and variety of situations [***892] [**613] in which the problem of terminating artificial life supports arises preclude any attempt to anticipate all of the [*530] possible permutations. However, this case, as well as our prior decisions, suggest some basic principles which may be used in determining whether the proof "clearly and convincingly" evinces an intention by the patient to reject life prolonged artificially by medical means.

III.

At the outset, [HN5] since the inquiry in New York is limited to ascertaining and then effectuating the patient's expressed wishes, our focus must always be on what the patient would say if asked today whether the treatment in issue should be terminated. However, we can never be completely certain of the answer to our question, since the inquiry assumes that the patient is no longer able to express his or her wishes. Most often, therefore, the inquiry turns on interpretation of statements on the subject made by the patient in the past. This exercise presents inherent problems.

For example, there always exists the possibility that, despite his or her clear expressions in the past, the patient has since changed his or her mind. And, as Judge Simons in his dissenting opinion correctly points out, human beings are incapable of perfect foresight. Thus, almost inevitably, the medical circumstances in the mind of the patient at the time the statements were made will not coincide perfectly with those which give rise to the need for the inquiry. In addition, there exists the danger that the statements were made without the reflection and resolve that would be brought to bear on the issue if the patient were presently capable of making the decision.

But the existence of these problems does not lead inevitably to the conclusion that we should abandon the inquiry entirely and adopt as guideposts the objective factors used in the so-called "substituted judgment" approach *(see, Brophy v New England Sinai Hosp., 398 Mass 417, 429-440, 497 NE2d 626).* [HN6] That approach remains unacceptable because it is inconsistent with our fundamental commitment to the notion that no

person or court should substitute its judgment as to what would be an acceptable quality of life for another *(People v Eulo, supra, at 357).* Consequently, we adhere to the view that, despite its pitfalls and inevitable uncertainties, the inquiry must always be narrowed to the patient's expressed intent, with every effort made to minimize the opportunity for error.

Every person has a right to life, and no one should be [*531] denied essential medical care unless the evidence clearly and convincingly shows that the patient intended to decline the treatment under some particular circumstances *(Matter of Storar, supra, at 379).* This is a demanding standard, the most rigorous burden of proof in civil cases *(id.).* It is appropriate here because if an error occurs it should be made on the side of life.

Viewed in that light, [HN7] the "clear and convincing" evidence standard requires proof sufficient to persuade the trier of fact that the patient held a firm and settled commitment to the termination of life supports under the circumstances like those presented. As a threshold matter, the trier of fact must be convinced, as far as is humanly possible, that the strength of the individual's beliefs and the durability of the individual's commitment to those beliefs *(see, Matter of Eichner, supra, at 380)* makes a recent change of heart unlikely. The persistence of the individual's statements, the seriousness with which those statements were made and the inferences, if any, that may be drawn from the surrounding circumstances are among the factors which should be considered.

The ideal situation is one in which the patient's wishes were expressed in some form of a writing, perhaps a "living will," while he or she was still competent. The existence of a writing suggests the author's seriousness of purpose and ensures that the court is not being asked to make a life-or-death decision based upon casual remarks. Further, a person who has troubled [***893] [**614] to set forth his or her wishes in a writing is more likely than one who has not to make sure that any subsequent changes of heart are adequately expressed, either in a new writing or through clear statements to relatives and friends. In contrast, a person whose expressions of intention were limited to oral statements may not as fully appreciate the need to "rescind" those statements after a change of heart. n4

> n4 There are numerous instances in which the law refuses to recognize the exercise or waiver of an important right unless the intent to do so is clearly manifested. Waivers of constitutional rights are always carefully scrutinized by the courts and, indeed, waivers of some constitutional rights will be given no effect unless, in addition, the individual has been advised of the right and consequences of waiver, or has made the waiver in open court or has had the assistance of counsel actually present. It is also familiar law, even to most laymen, that the right to dispose of real property will not be legally effective unless the intent to do so is made in writing with a high degree of specificity. Indeed, no one's request to have real or personal property pass to a specified person upon death can be enforced in court, no matter how clear and unequivocal the intent may be, unless it is also expressly stated in a signed will, witnessed by others. Although one may argue whether such demanding, and sometimes formal requirements, should come initially from the Legislature, it cannot be seriously urged that it would be "unrealistic" for the law to accord the same protections to the individual's life and right to survive, as have long been accorded to the individual's land and pocketbook.

Of course, a requirement of a written expression in every [*532] case would be unrealistic. Further, it would unfairly penalize those who lack the skills to place their feelings in writing. For that reason, we must always remain open to applications such as this, which are based upon the repeated oral expressions of the patient. In this case, however, the application must ultimately fail, because it does not meet the foregoing criteria.

Although Mrs. O'Connor's statements about her desire to decline life-saving treatments were repeated over a number of years, there is nothing, other than speculation, to persuade the fact finder that her expressions were more than immediate reactions to the unsettling experience of seeing or hearing of another's unnecessarily prolonged death. Her comments -- that she would never want to lose her dignity before she passed away, that nature should be permitted to take its course, that it is "monstrous" to use life-support machinery -- are, in fact, no different than those that many of us might make after witnessing an agonizing death. Similarly, her statements to the effect that she would not want to be a burden to anyone are the type of statements that older people frequently, almost invariably make. If such statements were routinely held to be clear and convincing proof of a general intent to decline all medical treatment once incompetency sets in, few nursing home patients would ever receive life-sustaining medical treatment in the future. The aged and infirm would be placed at grave risk if the law uniformly but unrealistically treated the expression of such sentiments as a calm and deliberate resolve to decline all life-sustaining medical assistance once the speaker is silenced by mental disability. That Mrs. O'Connor made similar statements over a long pe-

riod of time, does not, by itself, transform them from the type of comments that are often made casually into the type of statements that demonstrate a seriousness of purpose necessary to satisfy the "clear and convincing evidence" standard.

We do not mean to suggest that, to be effective, a patient's expressed desire to decline treatment must specify a precise condition and a particular treatment. We recognize that human beings are not capable of foreseeing either their own [*533] medical condition or advances in medical technology. Nevertheless, it is relevant to the fundamental question -- the patient's desires -- to consider whether the infirmities she was concerned with and the procedures she eschewed are qualitatively different than those now presented. Not that the exact nature of her condition would be dispositive in this analysis -- it is but another element to be considered in the context of determining whether her pronouncement made on some previous occasion bears relevance to her present condition.

Thus, it is appropriate for us to consider the circumstances in which Mrs. O'Connor [***894] [**615] made the statements and to compare them with those which presently prevail.

Her statements with respect to declining artificial means of life support were generally prompted by her experience with persons suffering terminal illnesses, particularly cancer. However, Mrs. O'Connor does not have a terminal illness, except in the sense that she is aged and infirm. Neither is she in a coma nor vegetative state. She is awake and conscious; she can feel pain, responds to simple commands, can carry on limited conversations, and is not experiencing any pain. She is simply an elderly person who as a result of several strokes suffers certain disabilities, including an inability to feed herself or eat in a normal manner. She is in a stable condition and if properly nourished will remain in that condition unless some other medical problem arises. Because of her age and general physical condition, her life expectancy is not great. But that is true of many nursing home patients. The key thing that sets her apart -- though there are likely thousands like her -- is her inability to eat or obtain nourishment without medical assistance.

It is true, of course, that in her present condition she cannot care for herself or survive without medical assistance and that she has stated that she never wanted to be a burden and would not want to live, or be kept alive "artificially" if she could not care for herself. But no one contends, and it should not be assumed, that she contemplated declining medical assistance when her prognosis was uncertain. Here both medical experts agreed that she will never regain sufficient mental ability to care for herself, but it is not clear from the record that the loss of her gag reflex is permanent and that she will never be able to obtain food and drink without medical assistance.

The record also shows that throughout her life Mrs. O'Connor [*534] was an independent woman who found it distasteful to be dependent on others. Unfortunately, she has been unable to care for herself for several years. As a result of her first stroke in July 1985, she has required full-time care, and following her latest stroke in December of 1987, she had to be spoon-fed until her gag reflex completely failed in June of this year. No one contends that the assistance she received up to that point violated her wishes, although there is little question that she would not have survived without this constant attention from others, including some medical professionals. The only change in her condition is the loss of her gag reflex, and the consequent need for medical assistance in eating, which is said to be contrary to her desires.

In sum, on this record it cannot be said that Mrs. O'Connor elected to die under circumstances such as these. Even her daughters, who undoubtedly know her wishes better than anyone, are earnestly trying to carry them out, and whose motives we believe to be of the highest and most loving kind, candidly admit that they do not know what she would do, or what she would want done under these circumstances. n5

n5 The suggestion in Judge Simon's dissent (dissenting opn, at 549) that our decision today presents an ironic contrast to our holding in *Rivers v Katz (67 NY2d 485)* misconstrues the rule announced in that case as well as the basis for our decision in the case now before us.

In *Katz* we simply held [HN8] that commitment to a mental institution does not necessarily show that a person lacks the mental capacity to make any mental health choices. Thus a mental patient's refusal to consent to a particular treatment should generally be honored unless it is proven that the person's mental disability does in fact impair the ability to make such a choice. There was no question in that case as to what treatments the patients intended to decline; the only question was whether they had sufficient mental capacity to make the choice.

The converse is true here. There is no question that Mrs. O'Connor was competent when she made the statements in issue and the only question is whether she intended by those statements to choose death by starvation and thirst in her present circumstances. Thus we are not holding that "an incompetent patient cannot forego the use of artificial life-sustaining machines offering

> no hope of improvement or cure." (Dissenting opn, at 549.) Indeed such a holding would be inconsistent with our decision in *Matter of Eichner (52 NY2d 363)* where as noted, the wishes of such a patient were upheld by this court upon clear and convincing evidence that the patient intended to decline the treatment under the circumstances. Our present decision simply demonstrates that the *Eichner* standard is a meaningful one, and that no one should be denied life-sustaining treatment when there is not clear and convincing evidence that this was in fact the patient's choice. In short it is unfair and inaccurate to suggest that mental patients have greater rights of "self-determination" than other patients. In fact, we noted in *Katz* that their wishes to decline a particular treatment for mental illness should not be honored if that would endanger their lives or the lives of others *(Rivers v Katz, supra, at 495).*

[***895] [**616] Accordingly the order of the Appellate Division should be [*535] reversed, the petition granted and counterclaim dismissed, without costs.

CONCURBY:

HANCOCK, JR.

CONCUR:

Hancock, Jr., J. (concurring). I concur in the result reached by the majority and with its application of the *Storar* rule *(Matter of Storar, 52 NY2d 363)* to the facts of this case. In my view, however, there are serious deficiencies in *Storar*, making it particularly unrealistic and unsatisfactory for deciding cases involving circumstances more extreme than those presented here. I believe that a critical need exists for a change in the present New York rule -- either through legislative action or judicial decision.

This case -- while certainly involving grievous difficulties for the family and the physicians -- does not, as I see it, entail an especially difficult application of our specific-subjective-intent rule, if that rule is applied strictly. The statements of the patient, while competent, are too general and imprecise to constitute the requisite clear expression of a present intention to forego artificially administered feeding in the existing circumstances. Moreover, I am quite confident that I would reach the same decision in this case under whatever reasonable standards might be adopted to replace our present rule, whether they constituted the "substituted judgment rule", "best interests analysis", "balancing of competing interests", or some combination thereof *(see*, Note, *In Re Quinlan Revisited, 15 Hastings Const LQ 479, 482-491; see generally*, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Biochemical Research, Deciding to Forego Life-Sustaining Treatment; Comment, *In Re Storar: The Right to Die and Incompetent Patients, 43 U Pitt L Rev 1087;* Moore, "*Two Steps Forward, One Step Back": An Analysis of New Jersey's Latest "Right-to-Die" Decisions, 19 Rutgers LJ 955).* The particular circumstances here -- e.g., the patient is neither terminal, comatose nor vegetative; she is awake, responsive and experiencing no pain; and the prescribed procedure is relatively simple and routine -- would weigh heavily in favor of continuing the medically assisted feeding under any of the approaches adopted by other state courts or recommended in the pertinent literature.

But there are, I believe, several reasons why the present [*536] New York rule -- requiring a factual finding of the patient's actual intent and precluding the exercise of judgment, in her best interests and on her behalf, by her physician and family, a court or guardian -- is unrealistic, often unfair or inhumane and, if applied literally, totally unworkable.

The rule posits, as the only basis for judicial relief, the court's finding by clear and convincing proof of a fact which is inherently unknowable: what the incompetent patient would actually have intended at the time of the impending life-support decision. What is required here is not a finding of intent as the term is used in its fictional sense as, for example, to express the legal conclusion of what the Legislature intended when it enacted a statute or what parties intended when they signed a contract. What the rule literally demands is an impossibility: a factual determination of the incompetent patient's actual desire at the time of the decision *(see, e.g.*, majority opn, at 530 ["what the patient would say if asked today"]; dissenting opn, at 540 [Simons, J.] ["what does the patient desire done"]).

At best, the finding of "actual intent" required by the rule must be based on [***896] [**617] nothing more than a calculated guess as to what the incompetent patient would have thought if she were competent. But even if a wise and well-founded guess were assumed to be enough to constitute proof that is clear and convincing, the fact finder could still never satisfy the rule because it insists upon a finding of actual present intent. There is simply no way of excluding the possibility that the patient has had a change of mind so that her past statements do not indicate her present wishes *(cf.*, Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law, 28 Ariz L Rev 373, 379* ["people experiencing various life events, including set-backs in their physical and mental functioning, may revise their goals, values, and definitions of personal well-being"]).

No matter how much the *Storar* rule is stretched, or the clear and convincing proof requirement relaxed, so that *Storar* may be made to fit some particularly compelling situation, the rule's fundamental flaws remain. Relief depends exclusively upon a showing of a present subjective intent, based upon the patient's past oral or written statements unequivocally expressing her desire not to have artificial life support continued under specific circumstances. Where the patient has never expressed such thoughts or has not done so clearly, artificial [*537] life support may simply not be withheld or withdrawn under *Storar*. Thus, even where the incompetent patient is completely and irreversibly comatose and vegetative *(see, e.g., Matter of Quinlan, 70 NJ 10, 355 A2d 647)* or, although not comatose or vegetative, in a terminal condition where further treatment would not only be futile but painful *(see, e.g., Matter of Conroy, 98 NJ 321, 486 A2d 1209)*, life-sustaining procedures must, apparently, be undertaken and continued. *(See*, majority opn, at 530-531 ["the inquiry *must always* be narrowed to the patient's expressed intent * * * no one should be denied essential medical care unless" the *Storar* evidentiary requirement is met (emphasis added)]; dissenting opn, at 540 [Simons, J.] ["his or her wishes must be ascertained"].)

Also, because the *Storar* rule ties the patient's rights of self-determination and privacy solely to past expressions of subjective intent, thereby precluding any consideration of the circumstances, a dilemma of another sort can arise: whether an incompetent patient's unequivocally expressed intent to decline life support must be honored, even when clearly contraindicated by the relatively good health of the patient or other existing circumstances *(see*, majority opn, at 528 ["a hospital or medical facility *must* respect this right" (emphasis added)]; dissenting opn, at 540 [Simons, J.] ["courts are bound to recognize and enforce" the patient's express wishes; a court "may not intrude into this area of personal autonomy and impose its paternalistic view of the patient's best interests"]).

A court should be permitted, and indeed required, to consider a wide range of medical and personal factors before making a life-support decision in a particular case. Certainly among the most significant of these are: (1) the intention of the patient under the existing circumstances, *to whatever extent it can be ascertained* from past expressions; (2) any moral, ethical, religious or other deeply held belief, insofar as it might bear on the patient's probable inclinations in the matter; (3) the medical condition of the patient, including the level of mental and physical functioning and the degree of pain and discomfort; (4) the nature of the prescribed medical assistance, including its benefits, risks, invasiveness, painfulness, and side effects; (5) the prognoses with and without the medical assistance, including life expectancy, suffering and possibility of recovery; (6) the sentiments of the family or intimate friends; and (7) the professional judgment of the involved physicians.

[*538] Obviously, no exhaustive list can be set forth here. Suffice it to say that any realistic and workable decision-making procedure -- to safeguard both a patient's right [***897] [**618] to refuse treatment and the State's interest in preserving life -- must recognize at least these crucial considerations. Indeed, while the *Storar* rule purportedly excludes any consideration but a patient's past expressions of intent, the majority and dissenting opinions today -- as well as this court's opinion in *Storar* itself -- clearly treat the surrounding medical and personal circumstances as highly relevant. Our extensive discussions and disagreements about these circumstances attest to that very fact *(see*, majority opn, at 523-527, 532-534; dissenting opn, at 543-546 [Simons, J.]).

I do not agree with the dissent that the majority opinion rests on its own substituted judgment. In my view, the *Storar* rule, strictly applied, leads by itself to the result reached today. I do agree with Judge Simons, however, that the better approach to life-support decisions entails a careful consideration of all the circumstances *(see*, dissenting opn, at 541-542 [Simons, J.]) -- especially the above-mentioned factors which are typically applied under the various rules of other jurisdictions *(see, e.g., Brophy v New England Sinai Hosp., 398 Mass 417, 429-440, 497 NE2d 626; see also*, President's Commission, *op. cit.*, at 132-136; The Hastings Center, Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying, at 27-28). I have little doubt that in many cases decision makers, whether consciously or not, are considering the circumstances, including the best interests of the patient, while ostensibly making the required determinations under *Storar*. The reality is that in some cases only a thorough consideration of all the relevant circumstances can lead to a proper result. Our rule should reflect this reality. It should also make relief possible where there are no unequivocal expressions on which a finding of specific-subjective-intent can be based.

As I perceive the majority decision, it adheres strictly to the *Storar* rule and, if anything, reinforces its rigid limitations. While I am fully in accord with the majority's recognition of the State's interest in preserving life as one of overriding importance, I believe that a more flexible rule, and one which does not circumscribe so narrowly the limits of legal conduct, is required. Only such a rule, in my opinion, can be applied satisfactorily -- and with wisdom and sensitivity -- by decision makers in legal proceedings, and by hospitals and physicians [*539] who must daily face the exigencies of making

life-support determinations in cases involving the terminally ill. *

> * One unfortunate practical consequence of the *Storar* rule on decision-making by physicians and the families of terminally ill patients is discussed in a recent commentary: "[The *Storar* rule] could lead to an interference with the policies that the hospitals and physicians have used in dealing with these situations in the past. Since serious illness often renders a patient incompetent, the effect of requiring past expressions as to wishes concerning life-sustaining treatment could be far-reaching. The standard of proof was defined as 'clear and convincing' and this may not be an easy standard to meet. Many individuals, especially younger people, do not tend to think about themselves in the stage of a terminal illness, or make their wishes known in a manner that will be seen as reliable evidence later. Certainly family and friends who have known an individual throughout his or her life can have some idea of what that individual would want. *Physicians make life and death decisions as a part of their everyday job and it is their duty to keep the best interests of the patient at heart. Between the patient's loved one, and the ethical standards physicians follow, with a decision reviewable by a hospital committee formed for that purpose in the event of conflict, it would seem as if a proper decision could be made* [emphasis added]" (Comment, *In Re Storar: The Right to Die and Incompetent Patients*, *43 U Pitt L Rev 1087, 1105; see also*, Moore, *"Two Steps Forward, One Step Back": An Analysis of New Jersey's Latest "Right-To-Die" Decisions*, *19 Rutgers LJ 955, 992;* dissenting opn, at 541-542 [Simons, J.]).

47

DISSENTBY:

SIMONS

DISSENT:

Simons, J. (dissenting). Respondents have established that Mary O'Connor did not wish any "artificial or mechanical support systems" used to sustain her life; if she were unable to function on her own, she wanted "nature to take its course". That being so, and inasmuch as no countervailing State interest has been [***898] [**619] asserted, she is entitled to have the court respect and implement her choice. The majority refuses to do so because it holds her statements were too indefinite. Its holding substantially rewrites the law of self-determination, at least for cases such as this, and has for all practical purposes foreclosed any realistic possibility that a patient, once rendered incompetent, will have his or her wishes to forego life-sustaining treatment enforced. Moreover, these new requirements will undoubtedly increase litigation in this area because medical and hospital personnel, fearful of civil and criminal liability, will hesitate to honor patients' wishes without judicial approval. Accordingly, I dissent.

I

Courts have resolved the question of when medical treatment of the gravely ill may be terminated by using two legal theories. The first is based on the common-law right of self-determination, [*540] which gives an individual essentially unrestricted authority to limit others' contact with his or her body *(see, Rivers v Katz, 67 NY2d 485, 492-493; Schloendorff v Society of N. Y. Hosp., 211 NY 125, 129).* This fundamental right, similar to other privacy rights recognized at common law and by the Constitution, guarantees individuals the freedom to behave as they deem fit so long as their wishes do not conflict with the precepts of society. It encompasses a patient's freedom to refuse medical treatment even when such refusal is life threatening *(see, e.g., Randolph v City of New York, 117 AD2d 44, 49, mod 69 NY2d 844; Matter of Erickson v Dilgard, 44 Misc 2d 27* [Meyer, J.]), and it particularly includes the right of a dying patient to refuse medical care or treatment that cannot restore health *(Matter of Storar*; and *Matter of Eichner v Dillon, 52 NY2d 363, 376-379).* Before a patient's right of self-determination can be enforced, however, his or her wishes must be ascertained. If the patient is incompetent and cannot presently express those wishes, they will be enforced if established by clear and convincing evidence. The right to reject treatment is not absolute but, absent some overriding State interest, the courts are bound to recognize and enforce it. The test for granting relief is entirely subjective: what does the patient desire done. The court's role is limited to ensuring that effectuating the patient's wishes does not violate the State's interest; it may not intrude into this area of personal autonomy and impose its paternalistic view of the patient's best interests *(see, Matter of Storar, supra).*

The second theory is the substituted judgment approach. Although courts apply this theory differently, generally the obligation of the court when implementing substituted judgment is to ensure that a surrogate of the patient, usually a family member or a guardian, effectuates as nearly as possible the decision the incompetent would make if he or she were able to state it *(see, Matter of Jobes, 108 NJ 394, 529 A2d 434).* The subjective views of the patient remain important, but the absence of a clearly expressed intent is not determinative; objective

factors are also considered in deciding what is best for the patient in the circumstances presented. Thus, the surrogate's decision should take into account the patient's personal values and religious beliefs, prior statements on the subject, attitudes about the impact his or her condition will have on others, and any other factors bearing on the issue. Inasmuch as the patient's wishes cannot be known with certainty, objective factors indicating that the burdens of [*541] continued life outweigh the benefits of that life for the patient are significant.

Both these theories were presented to us in *Matter of Storar* and its companion case, *Matter of Eichner (52 NY2d 363, supra). Matter of Eichner* involved Brother Fox, a member of a religious order, who, having expressed his views on the situation of Karen Quinlan *(see, Matter of Quinlan, 70 NJ 10, 355 A2d 647, cert denied sub nom. Garger v New Jersey, 429 U.S. 922),* subsequently [***899] [**620] suffered from precisely the same condition. We had little difficulty in discovering Brother Fox's subjective wishes under those unusual circumstances, and we recognized his right of self-determination. *Matter of Storar* presented the case of a terminally ill cancer patient who had never been able to express his wishes because he had been profoundly mentally retarded from birth. His mother requested the termination of painful, life-sustaining treatment, but this court refused to accept her "substituted judgment". I participated in *Storar* in the Appellate Division and voted otherwise *(see, Matter of Storar, 78 AD2d 1013, revd 52 NY2d 363, supra).*

I find this court's decision in *Storar* unfortunate. Like Judge Hancock, I believe there should be some recognized legal process to address the use of life-sustaining measures for patients who, because of age or mental condition, are unable to express their wishes or who, through oversight, have failed to do so. A broadening of the *Eichner* rule is necessary because under it relief would be denied even to a person in a vegetative state, like Karen Quinlan, who had never expressed her wishes on the subject. Moreover, the absence of such a rule actually may cause physical and emotional pain to be inflicted on the patient and the patient's family for the sake of "treatment". One need look no further than the case of Charles Storar, the 52-year-old patient with a mental age of 18 months, who was terminally ill with bladder cancer. He was required to undergo regular blood transfusions to maintain his life. As a result, he was subjected to continuous pain and the frightful experience, for one of his mental age, of observing blood and blood clots in his urine. His 77-year-old mother experienced the emotional trauma of her son's last days, spent in pain from compelled medical treatment.

The absence of relief in New York under such circumstances undoubtedly inflicts needless suffering on many of our citizens, and simple decency requires that a remedy be found. I would prefer that we provide relief by broadening our limited rule and joining the majority of American jurisdictions [*542] that recognize some form of substituted judgment n1 *(see, e.g., Matter of Jobes, 108 NJ 394, 529 A2d 434, supra; Matter of Conroy, 98 NJ 321, 486 A2d 1209; Brophy v New England Sinai Hosp., 398 Mass 417, 497 NE2d 626; Kennedy Mem. Hosp. v Bludworth, 452 So 2d 921* [Fla]; *Rasmussen v Fleming, 154 Ariz 207, 741 P2d 674; Conservatorship of Drabick, 200 Cal App 3d 185, 245 Cal Rptr 840, review denied* Cal [July 28, 1988]; *and see,* President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavior Research, Deciding to Forego Life-Sustaining Treatment, at 126-136; Report of New York State Task Force on Life and the Law, Life Sustaining Treatment [July 1987], at 14-16, 26-27, 73 [recognizing the need, because of this court's decision in *Storar*, for legislation to permit some form of substituted judgment]).

n1 Judge Alexander takes no position on the desirability of the theory of substituted judgment or similar rules.

Nevertheless, the *Storar* and *Eichner* cases established the New York law on the subject: the only available avenue for relief is to establish the patient's subjective wishes and the only relevant proof is evidence of the patient's statements on the subject made before he or she became incompetent. n2 The patient's mental and physical condition is not relevant except as it may implicate the State's interests.

n2 The *Storar* decision has been widely criticized for its overly restrictive consequences *(see, e.g., Matter of Hier, 18 Mass App 200, 464 NE2d 959, review denied 392 Mass 1102, 465 NE2d 261; Conservatorship of Drabick, 200 Cal App 3d 185, 245 Cal Rptr 840;* Note, *A Patient's Last Rights -- Termination of Medical Care -- an Analysis of New York's In re Storar, 46 Albany L Rev 1380;* Comment, *In Re Storar: The Right to Die and Incompetent Patients, 43 U Pitt L Rev 1087).*

Applying that rule, Mary O'Connor clearly expressed her wishes in the only realistic way she could and, inasmuch as none of the litigants claims the State has any interest in prolonging her life, her wishes should be recognized and the order of the Appellate Division should be affirmed. [***900] [**621] The order will

not be affirmed, however, because the majority, by its decision today, narrowly restricts the only available avenue of relief. Mary O'Connor's wishes will not be recognized because her daughters cannot prove she anticipated her present condition and specifically stated that under such circumstances she chose to die rather than be nourished by artificial means. The court has confined the *Eichner* holding to the singular facts of that case and inasmuch as few persons will be able to satisfy [*543] the new test, the right of self-determination is reduced to a hollow promise.

II

Preliminarily, it is important to clearly understand the facts of Mary O'Connor's condition.

Mrs. O'Connor is a 77-year-old widow who has suffered a series of progressively debilitating strokes that have left her bedridden, substantially paralyzed, and unable to care for herself. Dr. Sivak, an associate director of petitioner hospital who attended Mrs. O'Connor daily, described her as "severely demented" and Dr. Wasserman, the respondents' expert, described her as "profoundly incapacitated". She is neither comatose nor in a vegetative state, but she responds only sporadically to simple questions or commands, and then frequently inappropriately. The doctors agree that the neurological damage from the strokes is irreparable, and no hope exists for significant improvement in her mental or physical condition.

Mrs. O'Connor has two daughters, Helen Hall and Joan Fleming, who have attended her since her health began to deteriorate. They graphically described her condition. Mrs. O'Connor lived with Mrs. Hall after a stroke in 1985 and until she had another in December 1987. At that time she was transferred to a nursing home and, after her condition deteriorated, she was transferred to Westchester County Medical Center. Both daughters testified that since their mother was hospitalized at the Medical Center they have visited her daily, sometimes twice a day and, despite their efforts to detect some sign of consciousness, their mother has never spoken or responded to them in any way, even by facial expression or hand movement. Mrs. Fleming described her visit to the hospital the Friday before the trial of this proceeding started. She stood by her mother's bedside and tried to explain to her the procedure for feeding by nasogastric tube. She got no reaction. Mrs. O'Connor "did not even open her eyes".

As a result of her stroke in December 1987, Mrs. O'Connor lost her ability to swallow. She apparently has a gag reflex but she cannot control it neurologically. Accordingly, Mrs. O'Connor cannot be fed orally and artificial intervention is required to deliver nourishment to her body. She is presently fed intravenously, but that will soon be impossible. Thus, the hospital seeks to intubate her and pass food through her nose [*544] directly to her stomach. The doctors estimate that given her underlying condition, Mrs. O'Connor's life can be sustained in this fashion for a period of two months to two years. The nourishment will strengthen her generally, but will not improve her condition. She will continue to exist, as the trial court found, but will remain in an "irreversibly incapacitated condition".

This evidence was accepted by the trial court and the Appellate Division and, under rules of law too well known to require citation, it binds this court. Nevertheless, the majority characterizes Mrs. O'Connor's condition in quite different terms, stating: "She is awake and conscious; she can feel pain, responds to simple commands, can carry on limited conversations, and is not experiencing any pain. She is simply an elderly person who as a result of several strokes suffers certain disabilities, including an inability to feed herself or eat in a normal manner * * * Because of her age and general physical condition, her life expectancy is not great. But that is true of many nursing home patients." (Majority opn, at 533.)

Dr. Sivak described Mrs. O'Connor's ability to engage in "limited conversations" somewhat differently. In response to a [***901] [**622] question whether she could speak, he answered, "She will phonate, make a sound and sometimes answer yes. She will answer when asked what her name is, she'll say 'Mary' and phonate. That's about it really". He later testified the only other words she used were "'okay', 'alright', something like that". Neither of the doctors could testify with assurance, moreover, that she even understood the questions she "answered".

Dr. Sivak testified that Mrs. O'Connor sometimes responded to "simple commands" or questions by squeezing his hand, but when he asked her to take a deep breath so he could listen to her lungs, or asked whether she was in pain, where she was or similar questions, she did not respond. He assumed this was because "it is difficult for her to understand". Although the majority states she attempted to sit up and to roll over, none of the witnesses who testified saw Mrs. O'Connor do so. The statement was hearsay reported by a doctor who saw Mrs. O'Connor in the hospital one day.

As far as Mrs. O'Connor's ability to feed herself, she is not simply "an elderly person" unable to do so. Unlike a patient weakened by infirmity, or an infant who is capable of eating if only someone will put the food in their mouth, Mrs. O'Connor's [*545] ability to swallow, necessary to continued existence, is gone and cannot be restored. Unless its absence is replaced by artificial means, she will die. This breakdown is a substantial loss of a

bodily function, analogous to a patient's loss of kidney function requiring dialysis to sustain life or the inability to breathe without the aid of a respirator. Indeed, Mrs. O'Connor cannot even ask to be fed because, as Dr. Sivak said, "she could not comprehend that question". The majority contends the key factor setting Mrs. O'Connor apart from others "is her inability to eat or obtain nourishment without medical assistance." (Majority opn, at 533.) Of course, the only thing that set Karen Quinlan and Brother Fox apart from other patients was their inability to breathe without respirators.

Mrs. O'Connor's condition has improved from the stuporous condition she was in when she entered the hospital because the pneumonia and urinary infection she then had have been treated. No significant change in her underlying condition has been observed, however, and the debilities from which she suffers certainly cannot be described as "improved". While she may not be terminally ill in the sense that death is imminent, she is dying because she has suffered severe injuries to her brain and body which, if nature takes its course, will result in death. Full medical intervention will not cure or improve her, it will only maintain her in a rudimentary state of existence.

I could go on but this is sufficient to demonstrate why the trial court, the Appellate Division and I view Mrs. O'Connor's physical condition quite differently than the majority.

III

Both courts below, properly applying the clear and convincing standard of evidence, found that Mrs. O'Connor did not wish any artificial means used to prolong her life under these circumstances. This affirmed finding is abundantly supported by the evidence in the record, for Mrs. O'Connor clearly stated her wishes on many occasions, and it should be dispositive.

Specifically, Mr. Lampasso, her coemployee and the assistant director of pathology at the hospital where she worked, testified that he and Mrs. O'Connor had several discussions about prolonging life by artificial means, occasioned by deaths or illnesses in their families. She consistently expressed her view that artificial means should not be used to sustain life. He related in detail one discussion with her in which she [*546] stated that if ill, she would never want to be a burden or "lose her dignity", that "nature should take its course" without the use of "artificial means"; she thought it was "monstrous to keep someone alive" by artificial means, "by using machinery, things like that if they were not going to get better". Although this conversation occurred several [***902] [**623] years earlier, to Mr. Lampasso's knowledge, Mrs. O'Connor had not changed her views.

Mrs. O'Connor also discussed the use of artificial means to sustain her life with her daughter, Mrs. Hall, after Mrs. O'Connor's husband died and again after Mrs. O'Connor was hospitalized for congestive heart failure in 1984, telling her daughter she hoped she would never have to go to the hospital again and that "she would never want any sort of intervention, *any* sort of life support system" (emphasis added). Her other daughter, Mrs. Fleming, testified to similar statements by her mother. When the particularity of her mother's statements was questioned at trial, as the majority questions them now, she stated she had "no doubt" her mother would not wish artificial means used to prolong her life in the present situation.

Notwithstanding these statements of her intentions, which it accepts as accurate, the majority characterizes them as inadequate, for a variety of reasons, and refuses to recognize them. I disagree with the majority's characterizations of Mrs. O'Connor's conversations, as I do with its description of her physical condition, but I find even more troublesome the court's exercise of fact-finding powers on the subject. This court is a court of law (*NY Const, art VI, § 3)*. It cannot find facts, but must take them as found by the lower courts. Simply because the clear and convincing standard of proof is applicable, rather than the more common preponderance of the evidence standard, does not alter this fundamental principle. The trier of facts, whether Judge or a jury, makes findings and draws inferences from the evidence and if those findings are affirmed by the Appellate Division, our review is limited solely to determining whether there is any valid line of reasoning and permissible inferences which could lead a rational person, using the proper standard, to the conclusion reached by the trier of fact on the basis of the evidence at trial *(People v Bleakley, 69 NY2d 490; Humphrey v State of New York, 60 NY2d 742, 743-744; Le Roux v State of New York, 307 NY 397, 405; see generally*, Cohen and Karger, [*547] Powers of the New York Court of Appeals § 111, at 476-478 [rev ed]).

The majority does not, nor could it, claim that the courts below used the wrong legal standard. Neither does it hold that the facts and inferences drawn by the lower courts lack support in the record. Nevertheless, the majority makes its own findings and draws its own inferences to support its contrary decision. For example, the majority states "Although Mrs. O'Connor's statements about her desire to decline life-saving treatments were repeated over a number of years, there is nothing, other than speculation, to persuade the fact finder that her expressions were more than her immediate reactions to the unsettling experience of seeing or hearing of another's unnecessarily prolonged death." (Majority opn, at 532.) The trial court and the Appellate Division drew exactly the opposite conclusion from the evidence. The

trial court, after seeing and hearing the witnesses, inferred that the sophistication of Mrs. O'Connor's desire to withhold artificial life support "was evidenced by her background in hospital-services as well as her years of caring for ill relatives. The consistency in her stated wishes over the years also established the careful consideration she gave her choice" (trial court, slip opn, at 6). Nor is the majority correct that Mrs. O'Connor's reactions were always in response to seeing or hearing of another's death or prolonged illness (majority opn, at 532). The clearest statement of Mrs. O'Connor's wishes was made after her own hospitalization for congestive heart failure. She told her daughter that she "was very glad to be out of the hospital and [hoped] she would never have to be back in one again and would never want any sort of intervention, any sort of life support systems to maintain or prolong her life."

One more illustration will serve to prove the point. The majority states that the applicable rule is that "the trier of fact must be convinced, as far as is humanly [***903] [**624] possible, that the strength of the individual's beliefs and the durability of the individual's commitment to those beliefs * * * makes a recent change of heart unlikely." (Majority opn, at 531.) The majority relies on the absence of such proof in reaching its result. Manifestly, the courts with fact-finding powers concluded that Mrs. O'Connor did not have a change of heart. Had they found otherwise, they could not have granted her daughters relief.

IV

The majority refuses to recognize Mrs. O'Connor's expressed [*548] wishes because they were not solemn pronouncements made after reflection and because they were too indefinite.

Respondents have established the reliability of the statements under any standard. The hospital has acknowledged the truth and the accuracy of the evidence of their mother's wishes, and the majority accepts its truth and accuracy also and there can be no question Mrs. O'Connor's statements reflected her personal convictions. These were not "casual remarks", but rather expressions evidencing the long-held beliefs of a mature woman who had been exposed to sickness and death in her employment and her personal life. Mrs. O'Connor had spent 20 years working in the emergency room and pathology laboratory of Jacobi Hospital, confronting the problems of life and death daily. She suffered through long illnesses of her husband, stepmother, father and two brothers who had died before her. She herself has been hospitalized for congestive heart failure and she understood the consequences of serious illnesses.

Because of these experiences, Mrs. O'Connor expressed her wishes in conversations with her daughters, both trained nurses, and a coemployee from the hospital who shared her hospital experience. There can be no doubt she was aware of the gravity of the problem she was addressing and the significance of her statements, or that those hearing her understood her intentions. She clearly stated the values important to her, a life that does not burden others and its termination with dignity, and what she believed her best interests required in the case of severe, debilitating illness. She found "monstrous" the imposition of artificial means to maintain her under circumstances when natural conditions would end her life, and she objected to the use of "any" and "all" life-support systems on her behalf.

Notwithstanding this, the majority finds the statements entitled to little weight because Mrs. O'Connor's exposure was mostly to terminally ill cancer patients, or because her desire to remain independent and avoid burdening her children constituted little more than statements of self-pity by an elderly woman. There is no evidence to support those inferences and no justification for trivializing Mrs. O'Connor's statements. She is entitled to have them accepted without reservation. Particularly offensive is the majority's implication that the daughters' case is somehow weakened or prejudiced because they did not object to spoon-feeding their mother. [*549] Such a decision, whether resulting from indecision, hope for the patient's improvement or because the feeding did not involve artificial means, is irrelevant.

The majority asserts that this kind of decision would be more reliable if contained in a power of attorney or a living will. I fail to see how that would help this case. The problem is not in establishing Mrs. O'Connor's wishes. They were clearly stated and convincingly proven. The majority faults the proof because her statements were not sufficiently specific. Use of a power of attorney or written instructions will not solve the requirement of specificity. Indeed, the substantial burden of specificity the majority now imposes will be met in few cases, whether the instructions are memorialized in writings such as powers of attorney and living wills, or delivered with the utmost formality to family or trusted friends and advisors.

V

The requirement of specificity is to be found in the majority's statement that the [***904] [**625] patient's family must prove by clear and convincing evidence: that the patient held a firm and settled commitment to the termination of life-support systems under the circumstances presented (majority opn, at 531), and that she would consider the alternative of death without the life-support system in question, in this case lack of nourishment, preferable to being sustained by artificial means (majority opn, at 531, 533, 534). As the majority con-

cedes, it is a "demanding standard". Inasmuch as Mrs. O'Connor's daughters could not honestly testify that their mother, when competent, had anticipated her present condition and made the choice to forego nourishment by mechanical means, the majority holds the case for self-determination is not made out. I find it ironic that the court that held that a mentally ill patient has a constitutional right to decline medication which would improve his condition, absent overriding State interests *(see, Rivers v Katz, 67 NY2d 485, supra)* now holds an incompetent patient cannot forego the use of artificial life-sustaining machines offering no hope of improvement or cure. More to the point, I find the majority's rule unworkable and unwise.

The rule is unworkable because it requires humans to exercise foresight they do not possess. It requires that before life-sustaining treatment may be withdrawn, there must be proof that the patient anticipated his or her present condition, [*550] the means available to sustain life under the circumstances, and then decided that the alternative of death without mechanical assistance, by starvation in this case, is preferable to continued life (majority opn, at 531, 532-533). The majority states that Mrs. O'Connor's instructions are rejected because the "infirmities she was concerned with and the procedures she eschewed are qualitatively different than those now presented". The implication is that courts may exercise some flexibility in applying these rigorous standards if the condition and treatment referred to in the patient's instructions and those that presently exist are qualitatively similar. If that is so, the majority's statement fails to include any test for determining when conditions and procedures are "qualitatively" the same or different. Is physical and mental incapacity caused by accident qualitatively similar to the same condition caused by illness? Is incapacity caused by cancer qualitatively similar to the same condition caused by cerebral accident? Judging from the distinction the majority has drawn between Mary O'Connor's prior experience with cancer patients and her present condition, one would guess its answer would be "no". As to support systems, is feeding by nasogastric tube qualitatively different from the surgical implantation of a feeding tube in the patient's stomach or intestine? The two options involve different procedures and present different risks. Inasmuch as it is now no longer sufficient to provide that "all" life-support systems be withdrawn, the patient must anticipate these distinctions and resolve them. If he or she fails to do so, the instructions will not be recognized.

I also doubt that medical personnel are capable of implementing this standard of "qualitative" similarity. Whatever meaning or content the term may have for lawyers, it has none for doctors or laymen. Indeed, physicians do not even agree on what is "extraordinary" or "ordinary" care, "optional" or "obligatory" care, or "advanced" and "basic life support systems". Nor is there agreement on the definitions for words like "life support system", "artificial means" or "life-sustaining system" *(see*, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment, at 82-89 [1982]; New York Task Force on Life and the Law, Life-Sustaining Treatment, at 3 [1987]; Ruark, *Initiating and Withdrawing Life Support, 318 N Eng J Med 25* [1988]; US Congress, Office of Technology Assessment, Life-Sustaining Technologies and the Elderly, at 415 [1987]). The [*551] practical problem is illustrated in the Report of the President's [***905] [**626] Commission which noted the difficulty in achieving agreement among doctors even on whether respirators were "ordinary" or "extraordinary treatment" *(supra*, at 83). Given the uncertainty of these common terms, it is unrealistic that doctors or patients will be able to distinguish qualitatively similar or different treatment and effectively implement the patient's wishes.

Even if a patient possessed the remarkable foresight to anticipate some future illness or condition, however, it is unrealistic to expect or require a lay person to be familiar with the support systems available for treatment -- to say nothing of requiring a determination of which is preferable or the consequences that may result from using or foregoing them. Indeed, the conditions and consequences may change from day to day. Dr. Sivak testified that even he has not decided which method of nourishment he will use for Mrs. O'Connor if the hospital is successful in this proceeding.

In short, Mary O'Connor expressed her wishes in the only terms familiar to her, and she expressed them as clearly as a lay person should be asked to express them. To require more is unrealistic, and for all practical purposes, it precludes the right of patients to forego life-sustaining treatment.

The rule adopted is not only unworkable, it is unwise. Given the disparity of knowledge between lay persons and doctors, medical personnel will undoubtedly be reluctant to honor a patient's instructions if they are unclear or less than complete. Inevitably, the courts will be required to intervene, not because the State has any interest in prolonging the life of the particular patient, but because the family and the doctors are uncertain that the patient's wishes meet the majority's strict standard and are justifiably concerned about the consequences of an erroneous decision. The majority holds that the instructions must be specific, solemn pronouncements, but they need not be precise. Surely, no doctor is prepared to implement that ambiguous legal direction without judicial assistance. The patient's statements will have to be construed like statutes or contract terms -- and the courts

necessarily must be the ones to construe them, to make the findings and draw the inferences interpreting the patient's statements, using the imprecise considerations set forth in the majority opinion -- to determine if the strict, "demanding" standard of the majority has been met. Decisions under such circumstances will necessarily [*552] reflect the value choices of the Judge, rather than those of the patient, and are nothing short of arbitrary intrusions into the personal life of the patient.

In simpler times, decisions involving life and death were made by the family and its advisors based upon the patient's wishes or what the family thought best as justified by its knowledge of the patient's values and its sense of what the patient's best interests required. In today's world, the sick are removed to hospitals where a broad array of mechanical equipment awaits, capable of prolonging life even though no cure or repair is possible. Necessarily, others must be involved in the decision whether to use it. Until today, under New York law, decisions concerning medical treatment remained the right of the patient. Today's opinion narrowly circumscribes our rule to a degree that makes it all but useless. Few, if any, patients can meet the demanding standard the majority has adopted and the requirements of precision will necessarily be satisfied by pragmatic judicial decisions of what is "best" under the circumstances. If the court wishes to recognize the need for a substituted judgment rule in cases where the patient's wishes are not specific enough or cannot be clearly determined, then it should clearly announce the rule, define it, and give the parties an opportunity for a surrogate decision that can be reviewed by the court. Instead, the majority, disguising its action as an application of the rule on self-determination, has made its own substituted judgment by improperly finding facts and drawing inferences contrary to the facts found by the courts below. Judges, the persons least qualified by training, experience or affinity to reject the patient's instructions, have overridden Mrs. O'Connor's wishes, negated her long held values [***906] [**627] on life and death, and imposed on her and her family their ideas of what her best interests require.

Accordingly, I dissent and would affirm the order of the Appellate Division.

Send To: FEDERMAN, JONATHAN
HINMAN STRAUB PC
121 STATE ST
ALBANY, NY 12207-1633