JACQUELINE BETANCOURT, Plaintiff/Respondent, vs. TRINITAS HOSPITAL, Defendant/Appellant.	SUPERIOR COURT OF NEW JERSEY APPELLATE DIVISION DOCKET NO. A-003849-08 T2 Chancery Action On Appeal from a Final Decision of the Superior Court of New Jersey, Chancery Division Docket No. UNN-C-12-09 Sat Below: Hon. John Malone, J.S.C.

BRIEF AND APPENDIX ON BEHALF OF APPELLANT, TRINITAS HOSPITAL, IN SUPPORT OF THE APPEAL

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PRELIMINARY STATEMENT

This is a matter of first impression in the State of New Jersey. At issue is whether a hospital and its affiliated physicians can be compelled to provide inappropriate treatment when they have concluded, after consultation with medical experts and the hospital prognosis and ethics committees that the care sought by the family is contrary to recommended standards of care.

In the matter *sub judice*, the plaintiff's father, Ruben Betancourt, suffered an anoxic injury and is in a moribund, permanent vegetative state. Subsequent to the anoxic injury, Mr. Betancourt became ventilator dependent, feeding tube dependent and his renal function deteriorated into renal failure, requiring dialysis several times weekly. Notwithstanding all appropriate care, because of his poor nutritional status, Mr. Betancourt developed severe decubitis ulcers around his body, resulting in deep infections extending into the bone that are not likely to heal. While the treatments being rendered support respiration and, therefore, continue biologic life, the patient continues to essentially deteriorate and move closer to death. In short, Mr. Betancourt is dying and that dying is being prolonged by the treatment rendered. The hospital and physicians seek a ruling which preserves the respect for life over its length and which would comport with

the standard of care in these extraordinary situations. This is a matter which requires the guidance of the Court to determine when it is proper to withhold inappropriate medical treatments in situations where the care to be rendered is futile and below the standard of care.

The Trial Court concluded that because the family desired all heroic measures to be implemented, there were no circumstances which would justify withholding inappropriate treatments. While family desire should certainly be a component of any analysis, it should not be the talisman which controls. Physicians must be able to exercise their judgment, in consultation with medical experts and appropriate hospital committees, to determine when care is appropriate and the respect for life warrants cessation of treatment. The questions presented here implicate multiple ethical, moral and medical dilemmas. This is an issue that will likely be repeated with advances in medical treatment that can maintain biologic life long beyond historical expectations. The defendant seeks a ruling which balances the family's interest with the need for the medical providers to maintain their independence and exercise their judgment in a manner which comports with all applicable standards of care.

For the reasons that will follow, defendant respectfully requests that this Court enter an Order reversing

the decision of the Trial Court and authorizing the hospital and its affiliated physicians to withhold inappropriate treatments when they are below the standard of care.

PROCEDURAL HISTORY

This matter was initiated by the filing of a Verified Complaint seeking to appoint Jacqueline Betancourt as guardian and to restrain the defendant, Trinitas Hospital, from discontinuing allegedly life-sustaining medical treatment. (1a). The application was supported by an Affidavit of Carl S. Goldstein, M.D. (6a). A Brief in support of the application was also filed. (Brief omitted pursuant to Rule 2:6-1(a)(2)).

In response to the Verified Complaint, the defendant filed a Brief with attached Certifications of Arthur Millman, M.D.; Bernard Schanzer, M.D.; Maria Khazaei, M.D.; and William McHugh, M.D. (Brief omitted pursuant to Rule 2:6-1(a)(2); (11a; 17a; 22a; 27a;)). Defendant also submitted several policy statements regarding the cessation of life-sustaining treatment when a patient is terminal. (31a, 32a, 35a). On January 23, 2009, the Court entered an Order temporarily restraining the hospital from discontinuing or suspending medical treatment. (9a). Hearings were conducted before the Honorable John F. Malone, J.S.C., on January 22, February 17 and February 23, 2009. (T1, T2 and T3).

On February 10, 2009, the Court entered an Order again restraining the suspension of treatments and setting this matter down for further hearings. (42a).

After taking testimony, the Court entered a written decision on March 4, 2009, appointing Jacqueline Betancourt as guardian and ordering Trinitas to continue to provide all previously supplied services. (44a). The Court entered an Order memorializing this decision on March 20, 2009. (52a).

Thereafter this appeal ensued. Defendant filed a timely application to accelerate the appeal which was granted.

STATEMENT OF FACTS

In or around November 2007, Ruben Betancourt was diagnosed with a malignant thymoma, a cancerous condition of the thymus gland, with pericardial metastasis. On January 22, 2008, Mr. Betancourt underwent a mediastinal sternotomy, resection of the malignant thymoma with resection of graft and reconstruction of the innominate artery. Post-operatively, the patient self extubated with subsequent respiratory/cardiac arrest. While the patient was resuscitated, he suffered anoxic injury. (44a).

On or about March 4, 2008, the patient was discharged to the Kindred Ventilator Facility for weaning from the ventilator. He was, thereafter, discharged from Kindred to the JFK Head Injury Rehabilitation Program and then to an Elizabeth nursing home. On June 10, 2008, the patient was readmitted to Trinitas with a diagnosis of hypoglycemia. He again needed continued ventilator support. On June 25, 2008, the patient was discharged to Genesis for long-term ventilator care. He returned to Trinitas on July 3, 2008 with a diagnosis of renal failure, and dialysis was initiated. (44a).

The patient remains at Trinitas, despite attempts to transfer him to another facility which can provide comparable care, on artificial ventilator, dialysis and nutrition by feeding tube. (44a). Mr. Betancourt remained in a permanent vegetative state until his death. (44a).

During the hearings on the Order to Show Cause, defendant offered the testimony of Arthur Millman, M.D., the patient's attending physician. Dr. Millman described the patient's current diagnosis:

> Q. What is Mr. Betancourt's current diagnosis?
>
> A. Well he has multi-organ system failure. His kidneys have failed, his lungs have failed. He's intermittently septic.
>
> He has an underlying malignant thymoma which was brought into surgery in the first place, and he has hypertensive heart disease, intermittent congestive failure which is currently under control and the overwhelming problem is of course the permanent anoxic encephalopathy with total loss of cognizant function.
>
> Q. The last part of Mr. Betancourt's diagnosis, doctor, can you explain that in - -
>
> A. While he had anoxic episode in the hospital after his surgery. He lost all his cognizant brain function.
>
> And initially he was treated aggressively in the hope that perhaps that would come back which sometimes it does.
>
> But if you don't see any change for the better within a few days, the likelihood of return to cognizant function is virtually zero, particularly in the older adult. It's different in children.

(2T:9-23 to 10-19).

Dr. Millman also described the patient's prognosis:

> Q. Doctor, in your medical opinion, what is Mr. Betancourt's prognosis:

A. He's terminally ill. He has been dying slowing and painfully.

Q. Can you describe the mechanical measures that Trinitas Hospital is using to keep Mr. Betancourt alive currently?

A. He's on a ventilator that supports the breathing. He's being dialyzed at least three times a week, that supports the kidneys. He gets antibiotics for treatment of some truly horrific decubitus ulcers and continued antibiotics.

He's receiving nourishment via a PEG tube, it's a tube that goes into the stomach and provides access for food, medicines, things like that.

And he gets really aggressive nursing care. They're always turning him from one side or another, desperately trying to treat the decubiti with which he was unfortunately admitted on the current admission which is, must be something likely seven months old, something like that.

Q. Doctor, what, in your medical opinion, is Mr. Betancourt's neurological state?

A. He's in a non-cognitive state. That is, there's no higher mental function. None of the things that make us human are present. All that is left is brain stem function and the nervous system, nothing that is aware.

Q. Is - in your opinion is Mr. Betancourt permanently unconscious?

A. Yes.

(2T:11-4 to 12-9).

Finally, Dr. Millman testified that in his professional medical opinion it is inconsistent with accepted standards of medical practice to continue dialysis for Mr. Betancourt. (2T:23-13 to 17). He testified that

Mr. Betancourt's illness is irreversible and the risks and burdens of continued dialysis outweigh any benefits. (2T:25-4 to 10). He continued that dialysis will only prolong his dying in a painful fashion. (2T:25-11 to 15).

Defendant also presented the testimony of William G. McHugh, M.D., the Medical Director at Trinitas Hospital. (2T:62-8 to 16). Dr. McHugh became involved in this matter as a member of the Prognosis Committee at Trinitas Hospital. (2T:62T-17 to 63T-10).

Dr. McHugh, based upon his evaluation, discussed the patient's current condition and his prognosis:

Q What - from your awareness, what is Mr. Betancourt's current diagnosis?

A He's in a persistent vegetative state, he's diabetic, he has chronic obstructive pulmonary disease, he has renal failure. He has hypertensive cardiovascular disease with past congestive heart failure. He has multiple major decubiti and osteomyelitis of the bone.

Q In your professional opinion, what is the outlook for Mr. Betancourt?

A There is no outlook. He cannot regain consciousness at this state.

Q Now besides the life support, if you will, to use a layman's term, the ventilator, the dialysis, feeding tube, is there any affirmative treatment that would improve Mr. Betancourt's condition?

A No. There's nothing possible.

Q In your 50 years of medical experience, have you seen a patient that's been in a persistent

vegetative state for as long as Mr. Betancourt has improved?

A No. This is probably a record. I mean we deal with persistent vegetative state often.

Usually treatment is withdrawn after several days or a week of no responsiveness. It's unusual to see - I've never seen anyone go quite this long.

Q And in your professional medical opinion, is continuation of the mechanical assistance, the ventilator, the feeding tube, the dialysis is that medically appropriate in Mr. Betancourt's case?

A Can I comment freely?

This is a state that did not exist when I started in medicine. These people were dead. He's neither alive nor dead at this point. We have him on lung support, kidney support, nutritional support, support for his recurrent infectious processes.

We couldn't do this when I started. It is kind of an artifact of modern medicine that this could be continued.

Q In your opinion, is Mr. Betancourt's condition terminal?

A Yes, but it may take some time. And he's been terminal for the last, frankly, for the last year.

Q What will happen between now and that time to Mr. Betancourt?

A It depends on how much we continue to intervene.

Q Well let's assume things stay the way they are today, you know, whatever the mechanical sustaining treatment is provided. What will happen to Mr. Betancourt otherwise?

A This could go on for quite a while. I think he'll continue to deteriorate, continue to breakdown, he will not wake up. He will not become conscious. He'll basically get no better and likely slowly get worse.

Q And what - doctor, what specifically will get worse?

A The skin will breakdown further. You have to realize that the only organ that is functioning really is his heart. Everything else is mechanically supported at this time.

His brain is irreparably damaged. His kidneys don't work. His lungs don't work. His skin is broken down. I guess his liver is working, but everything is irreparably damaged.

(2T:64-11 to 66-25).

Defendant also produced Bernard Schanzer, M.D., the Chief of Neurology at Trinitas Hospital and a treating physician of Mr. Betancourt. (2T:77-6 to 25). Dr. Schanzer also served on the Prognosis Committee. (2T:78-12 to 19).

Dr. Schanzer described that Mr. Betancourt is in a permanent vegetative state:

Q Okay, and can you describe for the Court what that is?

A. I felt that he was in a vegetative state, and I think that as was mentioned before, he's been in a persistent vegetative state.

And at this point, looking at a year after, we can say that he is in a permanent vegetative state.

And you know what is the difference?

A vegetative state is somebody who is unaware of self and of his environment.

It become [sic] persistent by definition if it lasts for more than a month.

And then the question comes in as to in terms of prognosis so that when we talk about a permanent vegetative state, then we're making a statement of prognosis beyond the descriptive term of the patient's condition.

So that at this point, he is in a permanent vegetative state having continued to be in this for over a year.

(2T:81 to 25).

Defendant also produced Paul Veiana, M.D., another member on the Prognosis Committee. (2T:113-9 to 25). Dr. Veiana testified that maintaining dialysis would not meet the standard of care for the patients at Trinitas Hospital.

Q Doctor, in your experience at Trinitas and otherwise, are you trained or required by your profession to maintain a certain standard of care for your patients?

A Yes, we are.

Q And does the continued mechanical support of Mr. Betancourt meet or is consistent with the professional standard of care?

A No it's not because there is no - at least from my opinion, there is no chance that he's going to recover. We are just in a sense doing something that we should not be doing.

(2T:119-17 to 120-3).

Finally, defendant produced Maria Silva Khazaei, M.D., the patient's treating nephrologist. (3T:66-8 to 12).

Dr. Khazaei described that continuing dialysis in light of Mr. Betancourt's situation as merely prolonging an imminent dying process and as against the standard of care. (3T:68-1 to 70-13).

In addition to the family members, plaintiff produced the testimony of Carl Goldstein, M.D., a doctor consulted by the family with respect to the patient's renal status. (3T:43-15 to 24). Dr. Goldstein did not testify about the patient's neurological status or his prognosis. His only testimony was that dialysis was appropriate based upon the family's request.

Mr. Betancourt, pursuant to Court Order, remained at Trinitas Hospital receiving ventilator support, dialysis, and nutritional support until his death on May 29, 2009.

For the reasons that will follow in the annexed Legal Argument section of this brief, defendant respectfully requests that the Trial Court's Order compelling these treatments be reversed.

LEGAL ARGUMENT

POINT I

THE TRIAL COURT ERRED IN COMPELLING A HOSPITAL AND ITS INDEPENDENT PHYSICIANS TO PROVIDE MEDICAL SERVICES THAT ARE CONTRARY TO RECOGNIZED STANDARDS OF CARE TO A MORIBUND PERMANENTLY VEGETATIVE PERSON WHICH WILL DO NOTHING MORE THAN PROLONG AN INHUMANE, PAINFUL DEATH.

Medicine historically has intentionally endeavored to extend life. With advances in medical care and technology, life expectancy has been extended. The challenge is to know when advances in medical care and technology are beneficial to a person and when they are not. Prolonging inhumane, painful dying clearly is an abuse. It violates one of the basic facts of the Hippocratic Oath of a physician to "first do no harm."

The present case presents an issue of first impression concerning life-prolonging treatments in a terminal patient. The patient, Ruben Betancourt, has been in a permanent vegetative state for nearly a year-and-a-half. He is unresponsive, and his physicians maintain that there is no chance for improvement or recovery; rather, he will continue to deteriorate while his bodily functions are maintained by mechanical means. Mr. Betancourt is dying.

New Jersey Courts have previously addressed the related issue of a family's desire to terminate support when the

patient is in a persistent vegetative state. This case presents the converse, where the hospital, after an appropriate review by its Prognosis Committee, has determined that continuing mechanical services is inhumane, below the prevailing standard of care, and will only serve to extend the length of biologic life rather than promote its dignity. Citing to prior precedent, the Trial Court concluded that family desire controls in these situations. However, it remains the hospital's and its independent physicians' position that while a family's input is important, medical decision making in these circumstances must be taken into account with uniform standards set for the withdrawal of inappropriate treatment when it is below the standard of care and would only serve to prolong eventual and certain death.

New Jersey Courts first addressed the standards for discontinuance of extraordinary procedures for life-sustaining treatment in In re Quinlan, 76 N.J. 10 (1976). Quinlan involved a father's quest for guardianship in an effort to withhold life-sustaining treatment for his incompetent daughter. 70 N.J. at 29-30. In this seminal and oft-cited decision, the New Jersey Supreme Court conferred the right of termination to a surrogate in the circumstances presented. Id. at 55.

Approximately ten years later, the Court confronted a similar situation involving a nursing home patient. See In re

Conroy, 98 N.J. 321 (1985). Different from Quinlan, the incompetent patient in Conroy was not in a persistent vegetative state but had severely limited mental and physical functioning. The Conroy Court was particularly concerned with the special vulnerability of mentally and physically impaired individuals in nursing homes, as well as the potential for abuse by unsupervised institutional decision making. Again, the Court authorized surrogate decision making in accordance with certain rules. The Court enunciated three tests that a guardian must utilize to implement a patient's wishes: the subjective test, a limited-objective test, or a pure-objective test. 98 N.J. at 384, 360, 365-66.

Three more cases followed. In re Peter, 108 N.J. 335 (1987), In re Farrell, 108 N.J. 365 (1987), and In re Jobes, 108 N.J. 394 (1987). Farrell involved an application for appointment as guardian by a husband for purposes of removing his competent wife from a respirator. Peter involved the application for an appointment of a guardian of a close friend who was designated to make surrogate medical decisions for the incompetent patient. Neither case involved the issues presented in this matter.

Jobes involved a husband seeking to remove life-sustaining nutrition from his comatose wife. 108 N.J. at 402. Again, the New Jersey Supreme Court authorized a surrogate

decision maker to refuse life-sustaining treatment. The Court required, however, that this surrogate require statements from at least two independent physicians that the patient is in a persistent vegetative state and there was no possibility that the patient will recover. Id. at 424-428.

While these cases are certainly instructive and provide guidance applicable to the individual circumstances presented, they are not applicable to the present matter now before this Court. The matter before this Court is not whether treatment should be withheld or withdrawn from a patient. Rather, the issue is whether physicians are compelled to provide futile medical care to a patient when they believe such treatment is not only against the standard of care, but is inhumane when death is imminent. This is a topic which has received considerable debate within the medical community.

By way of example, the New Jersey Department of Health and Senior Services has issued a policy statement for the withholding or withdrawal of life-sustaining medical treatment. (31a). Likewise, the Renal Physicians Association and American Society of Nephrology have issued a clinical practice guideline suggesting that in "Patients who have irreversible, profound neurological impairment such that they lack signs of thought, sensation, purposeful behavior, and awareness of self

environment" it may be appropriate to withhold or withdraw dialysis. (32a at 33).

Further, evolving legal theory supports physician choice with respect to abiding by the standard of care. In Causey v. St. Francis Medical Center, 719 So.2d 1072 (La. App. 2d. Cir. 1998), a patient's family brought an intentional battery-based tort action against the hospital and the physician who withdrew life-sustaining care to a 31-year-old comatose quadriplegic with end-stage renal failure, over the strong objections of the patient's family. In that case, the patient's treating physician believed that continuing dialysis would have no benefit. Despite this, the patient's family demanded aggressive, life-sustaining care. Id. at 1073. Dialysis was discontinued, the ventilator was removed, and, subsequently, the patient died of respiratory and cardiac failure. Id. at 1074.

The Causey Court, citing In re Quinlan, 70 N.J. 10 (1976), emphasized that a patient's participation in medical decision making is a well-established right. Thus, where a patient is incompetent, decision making typically falls on the guardian or on the next of kin. Nevertheless, "The Court, as the protector of incompetents, however, can override an intolerable choice by a surrogate decision maker." Id.

In Causey, as in the present case, the family desired certain medical treatment rendered, and the physicians believed

that such treatment was futile and below the standard of care. The Court recognized that where a medical professional and a patient, through a surrogate, disagree on the worth of pursuing life, there is inherent conflict over values. Id. at 1074-5. The Court recognized that "futility is a subjective and nebulous concept which, except in the strictest physiological sense, incorporates value judgments." Id. at 1075. Thus, the Court instead emphasized the importance of acknowledging the standard of medical care in a particular case. Id. In doing so, the Court recognized that:

> Physicians are professionals and occupy a special place in our community. They are licensed by society to perform this special role. No one else is permitted to use life-prolonging technology which is considered by many as 'fundamental' healthcare. The physician has an obligation to present all medically acceptable treatment options for the patient or her surrogate to consider and either chose or reject; **however, this does not compel a physician to provide interventions that in his view would be harmful, without effect, or 'medically inappropriate.'**

Id. at 1075 (emphasis supplied).

The Causey Court ultimately concluded that "a finding that the treatment is medically inappropriate by a consensus of physicians practicing in that specialty translates into a standard of care." Therefore, the Court found in favor of the defendant hospital and physician.

Here, the unambiguous and un-rebutted testimony is that the patient remained in a permanent vegetative state with no chance of recovery. He was terminal. The various physicians, many of whom were on the Prognosis Committee and who treat the patient, all agree that continuing dialysis on the patient is not only against the standard of care but is medically and ethically inappropriate. As set forth by the Causey Court, physicians should not be compelled to provide medical treatment which they believe is medically inappropriate or futile.

The American Medical Association Counsel on Ethical and Judicial Affairs (the "Counsel") agrees that the definition of "futility" inherently involves a value judgment. The Council's Report on Medical Futility and End-of-Life Care (the "Report") expresses the Council's preference for the due process approach for determining whether to withhold or withdraw what is felt to be futile care. The Report recommends that earnest attempts to have joint decision making between the patient or proxy and the hospital be made. Where this does not resolve a dispute, an institutional committee, such as an ethics committee, should meet to attempt to resolve these issues. Where the patient (or the surrogate decision maker) continues to disagree, transfer of the patient to another facility should be

Here, there were multiple meetings between the physicians and the patient's family to attempt to resolve the disagreements related to the patient's care. The family has refused to allow a DNR order to be placed, requiring the hospital to utilize useless resuscitative efforts. There was a Prognosis Committee meeting that determined that continued care would be futile. Attempts to transfer the patient have been unsuccessful as no other facility has been willing or able to accept the transfer.

There is no dispute that this is a thorny issue that requires judicial guidance. However, this Court has held that a Court may not order health care professionals to pursue a course which they believe is inappropriate or unsafe or against their own professional practices and ethics. See Couch v. Visiting Home Care Services, 329 N.J. Super. 47, 53 (App. Div. 2000). That is precisely what the Trial Court did in this circumstance. It compelled Trinitas Hospital and its affiliated physicians to provide dialysis, ventilator and nutritional support to a patient who is dying. This support, while it may prolong the dying process, will not result in improvement. Further, the patient's quality of life will only continue to deteriorate. Mr. Betancourt is covered in decubitus ulcers, many of which extend to the bone and are infected. His nutritional status cannot improve to the point where the infections can be fought

off. In the end, the family will bear witness to continuing deterioration and decompensation if these services are continued.

Accordingly, it is respectfully requested that this Court enter an Order reversing the decision of the Trial Court and removing the Order compelling continued interventional services.

POINT II

THE TRIAL COURT IMPROPERLY APPOINTED JACQUELINE BETANCOURT AS GUARDIAN FOR HER FATHER, RUBEN BETANCOURT.

The Court's Order in this matter appointed Jacqueline Betancourt as the guardian for her father, Ruben Betancourt. This appointment was unsupported and presents an inherent conflict. First, the rules governing the appointment of a guardian, set forth in Rule 4:86-1, *et seq.* were not followed in this appointment. Secondly, and more importantly, upon information and belief, Ms. Betancourt intends to file a lawsuit against Trinitas Hospital for the event which caused the anoxic injury. Accordingly, she has a personal stake, premised upon secondary gain, to maintain her father alive. In such circumstances, an independent person, without financial motivation, should have been appointed as guardian.

The standards for a complaint seeking the appointment of a guardian are set forth in Rule 4:86-1. That Rule requires specificity of pleadings with respect to the guardian sought to be appointed and facts concerning the incompetent or incapacitated person. Even a cursory review of the Verified Complaint in this matter (1a) reflects a failure to comply with the governing rule. Paragraph 12 of the Complaint (3a) merely

asks the Court to appoint a guardian and does not specify Jacqueline Betancourt as the individual seeking guardianship.

Rule 4:86-2 requires that the Complaint have annexed thereto affidavits of two physicians. While there is no dispute that Mr. Betancourt remained in a permanent vegetative state, plaintiff did not come forward with two affidavits. Rather, plaintiff relied exclusively on the affidavit of Dr. Goldstein, a nephrologist, who during his testimony, could not comment upon the competency of the patient. His only opinion was that family wishes control with respect to the continuation of dialysis. Again, plaintiff failed to comply with the rules governing the appointment of a guardian.

These rules are designed to foster appropriate hearings concerning the appointment of a guardian for an incapacitated individual. While there is no doubt that Mr. Betancourt fits that definition, compliance with these rules must be strict in order to ensure the best interests of the incompetent. Here, it cannot be disputed that these rules were not complied with.

More importantly, the appointment of Jacqueline Betancourt as the guardian for her father presents an inherent and compelling conflict.

During her testimony, Jacqueline Betancourt testified:

The Witness: Yeah, basically my father is in the situation that he's in because of a hospital error, okay.

(3T:35-23 to 25). Upon information and belief, Ms. Betancourt, as well as other family members intend to file a lawsuit against the hospital for the incident which led to the anoxic injury. Plaintiff's current counsel, Mr. Martin, is a well known and experienced medical malpractice plaintiff's attorney.

No one disputes Jacqueline Betancourt's sincerity or love for her father. However, the potential for monetary gain in a situation like that presented here presents a conflict that requires disqualification of her serving as the guardian. Mr. Betancourt left no living will and identified no health care proxy. His wishes cannot be determined conclusively. Accordingly, under prior precedent, a surrogate decision maker has to be appointed from whom compelling testimony can be discerned with respect to Mr. Betancourt's wishes. Certainly, that testimony can be colored when there is secondary gain or monetary gain to be had by maintaining the patient alive for as long as possible. In situations like those presented here, the motives must be clear and unambiguous. Unfortunately, in this instance, they are not.

This Court is now confronted with a legal, moral, ethical and medical dilemma that requires careful thought and guidance. A decision from this Court will redound for decades

with respect to the procedures to be utilized in circumstances like those presented here, where maintenance of mechanical means can prolong dying but, according to physicians, is below the prevailing standard of care. In such circumstances, scrutiny of anyone seeking to be a guardian must be careful, close and unbiased. In view of the circumstances, there can be no confidence in this appointment.

Accordingly, it is respectfully requested that this Court enter an Order reversing the Trial Court's decision to appoint Jacqueline Betancourt as the guardian of her father.

CONCLUSION

For the foregoing reasons, it is respectfully requested that this Court enter an Order reversing the decision of the Trial Court, removing Jacqueline Betancourt as guardian, and removing any prohibition from terminating inappropriate mechanical means of support for Ruben Betancourt.

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JACQUELINE BETANCOURT, on behalf of RUBEN BETANCOURT, Plaintiffs, vs. TRINITAS HOSPITAL, Defendants.	SUPERIOR COURT OF NEW JERSEY CHANCERY DIVISION - UNION COUNTY Docket No. *Civil Action* VERIFIED COMPLAINT

Plaintiff, Jacqueline Betancourt, on behalf of her father, Ruben Betancourt, residing at 313 Christine Court, Elizabeth, New Jersey, complaining of the defendant, Trinitas Hospital, alleges and says:

1. Plaintiff's father, Ruben Betancourt is currently hospitalized at Trinitas Hospital in Elizabeth, New Jersey.

2. Ruben Betancourt has been a patient in the care of the defendant institution, its agents, servants and/or employees for an extended period of time.

3. At all relevant times herein, Ruben Betancourt has been and remains in an unconscious state unable to communicate with his physicians or family.

4. As a result of an incident that occurred following surgery, Ruben Betancourt was deprived of oxygen as a result of an extubation of a breathing tube .

5. As a consequence of the above described incident, Ruben Betancourt lapsed into

a unconsciousness and has not regained consciousness since the event. Ruben Betancourt remains unable to communicate with physicians, medical providers, or family.

6. Among other modalities of treatment, dialysis, ventilation and/or respiration have been provided via mechanical means.

7. Representatives of the defendant, Trinitas Hospital, have recently advised that plaintiff and other members of the Betancourt family, including Ruben Betancourt's spouse, Maria Betancourt, of its intention to discontinue manual/mechanical life support treatment. The defendant, through its representatives, have advised the Betancourt family that they believe that once the aforesaid treatment is discontinued, Ruben Betancourt will succumb and expire as a result of his overall medical condition.

8. Representatives of the defendant have advised the undersigned and the Betancourt family that they believe that Ruben Betancourt's condition is such that he is in an unresponsive irreversible vegetative state and that further treatment would be futile.

9. The undersigned and other members of the Betancourt family have been in constant contact with Ruben Betancourt and visit him daily. The undersigned and other members of the Betancourt family as set out in Affidavits that will be attached to the Verified Complaint, can and will testify that Ruben Betancourt is responsive to certain stimulus. His physical reactions have been described by his medical providers as autonomic movement. Based upon the undersigned observation and the observations of other members of the Betancourt family, it is my position that my father does in fact respond to the sound of certain voices, to certain other stimuli from family and others. My father does respond and recoil when approached from certain medical providers and in anticipation of certain medical treatments. His responses are clearly not uncontrolled or reflex. They are a direct response to certain

stimulus.

10. As of this writing, the undersigned has been unable to retain the services of another physician, outside the Trinitas Hospital system, to exam my father. I am actively seeking such a physician and when and if possible, I will supply his certification or affidavit.

11. It is my belief and the belief of my mother and brother that my father, given a choice, would resist termination of life support and chose to live.

12. I would ask that the court appoint a guardian or guardians to attempt to determine what my father's wishes would be and make a recommendation of a course of action to the court, so as to base the ultimate decision or an objective recommendation as opposed to the unilateral determination of the hospital

13. This Verified Complaint is being filed in an effort to obtain an Order of the Court restraining the defendant from discontinuing the aforesaid treatment and/or modalities and should continue to administer such care and treatment as is necessary to sustain my father, Ruben Betancourt.

WHEREFORE, plaintiff demands that the defendant, Trinitas Hospital, be required to continue all available treatment and/or care necessary to sustain its patient, plaintiff's father Ruben Betancourt.

MARTIN KANE & KUPER, LLC
Attorneys for Plaintiffs,
Jacqueline Betancourt, on behalf of Ruben Betancourt

By: _____
JAMES D. MARTIN, ESQ.

DATED: January 21, 2009

DESIGNATION OF TRIAL COUNSEL

Pursuant to the provisions of *Rule* 4:25-4 the Court is advised that JAMES D. MARTIN, ESQ. is designated as trial counsel.

RULE 4:5-1 CERTIFICATION

Pursuant to *Rule* 4:5-1, I hereby certify to the best of my knowledge, that the above-captioned action is not the subject of any other action pending in any court or the subject of a pending arbitration proceeding. No other action or arbitration proceeding is contemplated at this time.

MARTIN KANE & KUPER, LLC
Attorneys for Plaintiff
Jacqueline Betancourt, on behalf of Ruben Betancourt

By: _____
JAMES D. MARTIN, ESQ.

Dated: January 21, 2009

VERIFICATION

1. I am the Plaintiff named in the foregoing Verified Complaint.

2. The allegations in the Complaint are true to the best of my knowledge and belief and with respect to those matters that are alleged upon information and belief, I believe them to be true.

3. I certify that the above statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false I am subject to punishment.

Dated: January _____, 2009

JACQUELINE BETANCOURT

MARTIN KANE & KUPER
180 Tices Lane
Building B, Suite 200
East Brunswick, NJ 08816
(732) 214-1800
(732) 214-0307 (FAX)
Attorney for Plaintiffs

JACQUELINE BETANCOURT, on behalf of RUBEN BETANCOURT,

Plaintiffs,

vs.

TRINITAS HOSPITAL,

Defendants.

SUPERIOR COURT OF NEW JERSEY
CHANCERY DIVISION - UNION COUNTY
Docket No. UNN-C-12-09

Civil Action

CERTIFICATION OF FACSIMILE SIGNATURE

I, James D. Martin, Esq. Of full age, certify as follows:

The attached Affidavit of Carl S. Goldstein, M.D. contains a facsimile of the original signature of Dr. Goldstein. I acknowledge the genuineness of the signature, and that the Affidavit with the original signature affixed will be filed if requested by the Court or a party.

JAMES D. MARTIN, ESQ.

January 30, 2009

MARTIN KANE & KUPER
180 Tices Lane
Building B, Suite 200
East Brunswick, NJ 08816
(732) 214-1810
(732) 214-0317 (FAX)
Attorney for Plaintiffs

JACQUELINE BETANCOURT, on behalf of **RUBEN BETANCOURT**, Plaintiffs, vs. **TRINITAS HOSPITAL**, Defendants.	**SUPERIOR COURT OF NEW JERSEY** **CHANCERY DIVISION - UNION COUNTY** **Docket No. UNN-C-12-09** *Civil Action* **AFFIDAVIT OF** **CARL S. GOLDSTEIN, M.D.**

The undersigned, Carl S. Goldstein, M.D., of full age, being duly sworn according to law,

upon my oath, deposes and says:

1. I am a medical doctor; licensed in the State of New Jersey, since October 1, 1980.

2. I am Board Certified in the field of Nephrology, and have particular expertise in the area of renal disease, renal failure and dialysis.

3. I have no financial interest in the outcome of this action.

4. I do not know the parties nor have I treated Mr. Ruben Betancourt.

5. I have had no prior dealings with the firm of Martin, Kane & Kuper or attorneys James D. Martin or Todd Drayton.

6. I was contacted by Mr. Martin and asked to review a hospital chart for a patient, Ruben Betancourt.

7. I reviewed a Trinitas Hospital chart, with an admission date of July 2008 continuing through January 2009.

8. Based upon my review of the medical chart, I can state, within medical probability, the following:

Patient Ruben Betancourt suffers from end stage renal disease.

Regular hemodialysis treatments are the standard of care for that condition.

The hemodialysis treatments that have been provided at Trinitas Hospital to date have been provided within the standard of care.

The hemodialysis treatments that have been and are being administered are neither harmful nor dangerous to the patient.

My review of the patient's medical record demonstrates that he has tolerated the hemodialysis treatments without comp ication.

My review of the plan of care outlined by the patient's nephrologist demonstrates that the plan is within the standard of care.

The foregoing conclusions and/or assertions are supported by the medical record.

I hereby certify that the foregoing statements made by me are true. I am aware that if any

of the foregoing statements are willfully false, I am subject to punishment.

CARL S. GOLDSTEIN, M.D.

Sworn and subscribed to before me

this 30TH day of JANUARY, 2009

NOTARY

THERESA G. DYER
NOTARY PUBLIC OF NEW JERSEY
My Commission Expires Nov. 13, 2013

MARTIN KANE & KUPER
180 Tices Lane
Building B, Suite 200
East Brunswick, NJ 08816
(732) 214-1800
(732) 214-0307 (FAX)
Attorney for Plaintiffs

FILED
JAN 23 2009
JOHN F. MALONE
J.S.C.

JACQUELINE BETANCOURT, on behalf of RUBEN BETANCOURT,

Plaintiffs,

vs.

TRINITAS HOSPITAL,

Defendants.

SUPERIOR COURT OF NEW JERSEY
CHANCERY DIVISION - UNION COUNTY
Docket No. UNN-C-12-09

Civil Action

ORDER

THIS MATTER being brought before the Court by James D. Martin, Esq., attorney for plaintiffs, Jacqueline Betancourt, on behalf of Ruben Betancourt, seeking relief by way of temporary restraints pursuant to R. 4:52, based upon the facts set forth in the Verified Complaint; and it appearing that immediate and irreparable damage will probably result before notice can be given and a hearing held and for good cause shown.

It is on this 22 day of JAN, 2009,

ORDERED that plaintiffs' application is hereby granted; and that

1. Defendant, Trinitas Hospital and/or its agents, servants and/or employees shall be temporarily restrained from discontinuing or suspending any treatment, including dialyses heretofore administered to the patient, Ruben Betancourt; and that

2. Defendant, Trinitas Hospital and/or its agents, servants and/or employees shall immediately re-establish and/or resume treatment, including dialysis, to patient Ruben Betancourt; and that

3. Defendant, Trinitas Hospital and/or its agents, servants and/or employees shall

remove a Do Not Resuscitate (DNR) order from the plaintiff's chart; and that

4. Defendant, Trinitas Hospital and/or its agents, servants and/or employees shall immediately make copies of the patient, Ruben Betancourt's records available to plaintiffs' counsel; and that

5. On or before Friday, January 30, 2009 plaintiffs shall provide the Court and defense counsel with a medical certification stating that:

   A. Treatment, including dialyses treatment, to the patient, Ruben Betancourt is appropriate;
   B. That said treatment is not harmful;
   C. That the administration of said treatment is within the standard of care; and that

6. A hearing in this matter shall be conducted before the Honorable John F. Malone, J.S.C. on January 30, 2009 at 2:00 p.m.; and that

7. A true and complete copy of this Order be served upon all counsel within seven (7) days of the date hereof.

J.S.C.

JOHN F. MALONE, J.S.C.

☒ Opposed

☐ Unopposed

GARFUNKEL, WILD & TRAVIS, P.C.
Continental Plaza II
411 Hackensack Avenue, 5th Floor
Hackensack, New Jersey 07601
(201) 883-1030
Attorneys for Defendant Trinitas Regional Medical Center

JACQUELINE BETANCOURT, on behalf of RUBEN BETANCOURT Plaintiff, vs. TRINITAS REGIONAL MEDICAL CENTER Defendant.	SUPERIOR COURT OF NEW JERSEY CHANCERY DIVISION UNION COUNTY Docket No. C-12-09 **CERTIFICATION OF ARTHUR MILLMAN, M.D.**

I, Arthur Millman, M.D., of full age, certify as follows:

1. This certification is made by me in support of Trinitas Regional Medical Center's ("Trinitas") opposition to Plaintiff's request for a temporary injunction, by which she seeks to force Trinitas to provide Ruben Betancourt (the "Patient") with inhumane and futile medical treatment that, at this time, would be medically inappropriate and against the standards of medical care and professional judgment.

2. I am a permanent resident in the State of New Jersey. I am a physician licensed to practice medicine in the State of New Jersey. I currently maintain an office at 240 Williamson Street, Elizabeth, New Jersey, 07207. I was first licensed to practice medicine in 1969 and received my New Jersey State license in 1976.

3. I hold the Doctor of Medicine degree from the Albert Einstein College of Medicine of Yeshiva University, located in Bronx, New York. I received my degree in 1969.

4. I completed two residencies. I did my first residency at Mount Sinai Medical Center from 1969 to 1972, specializing in internal medicine. I did my second residency at Mount Sinai Medical Center from 1974 to 1976, specializing cardiovascular disease.

5. I have been practicing medicine for nearly forty (40) years and specialize in internal medicine and cardiovascular disease.

6. As the attending physician assigned to the Patient's case, I am familiar with the Patient, his prognosis, his diagnoses, and with the details of and circumstances surrounding his care.

7. I make this certification in lieu of affidavit pursuant to R. 1:4-4 in regard to the above captioned matter.

Patient's Medical History

8. The Patient is a 73 year old male. Subsequent to surgery for a malignant thymoma on January 22, 2008, the Patient developed anoxic encephaplopathy. The lack of oxygen to the Patient's brain left him unresponsive.

9. Since that time, the Patient has been admitted to various treatment facilities, including the JFK Medical Center's Brain Trauma Unit, in Edison, New Jersey; the Genesis Health Care's Ventilation Unit, in Westfield, New Jersey; and the Elizabeth Nursing Home, in Elizabeth, New Jersey.

10. The Patient's condition is terminal.

11. On July 3, 2008, the Patient was readmitted to Trinitas, with a diagnosis of renal failure. Since this readmission, the Patient has remained at Trinitas. At the time of his readmission, the Patient was unresponsive and he has remained in a persistent vegetative state since his readmission.

Patient's Current Medical State

12. Currently, the Patient is on an artificial ventilator.

13. The Patient is entirely unresponsive. Any eye movements made are reflexive. The Patient has no ability to communicate and does respond to pain.

Diagnosis and Prognosis

14. The Patient is in a persistent vegetative state.

15. The Patient body is currently decomposing, and the Patient is actively dying.

16. The Patient is often septic and has ulcers on his bones due to osteomyelitis (a serious and chronic bone infection).

17. Based upon my nearly forty years (40) experience as a medical doctor, specializing in internal medicine and cardiovascular disease, the Patient will never recover from this persistent vegetative state.

18. Even with dialysis, I would not expect the Patient to live more than a few months due to his condition.

Informing the Patient's Family

19. Beginning several months ago, the Patient's family was informed by Trinitas's medical staff that the Patient remained in a persistent vegetative state and that no clinical probability existed that the Patient would ever return to a cognizant state.

20. It is my medical opinion that to continue dialysis treatments of the Patient is futile, inhumane and contrary to generally accepted standards of medical care, as well as my own professional judgment.

[Remainder of Page Intentionally Left Blank]

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Arthur Millman, M.D.

Dated: 1/22, 2009

GARFUNKEL, WILD & TRAVIS, P.C.
Continental Plaza II
411 Hackensack Avenue, 5th Floor
Hackensack, New Jersey 07601
(201) 883-1030
Attorneys for Defendant Trinitas Regional Medical Center

JACQUELINE BETANCOURT, on behalf of RUBEN BETANCOURT Plaintiff, vs. TRINITAS REGIONAL MEDICAL CENTER Defendant.	SUPERIOR COURT OF NEW JERSEY CHANCERY DIVISION UNION COUNTY Docket No. **CERTIFICATION OF FACSIMILE SIGNATURE**

I, Rebecca Edelman Levy, Esq., of full age, certify as follows:

The attached Certification of Arthur Millman, M.D. in Support of Trinitas Regional Medical Center's Opposition to Plaintiff's request for temporary injunctive relief contains a facsimile of the original signature of Dr. Millman. I acknowledge the genuineness of the signature, and that the Certification with the original signature affixed will be filed if requested by the Court or a party.

R Edelman Levy

Rebecca Edelman Levy, Esq.

Dated: January 22, 2009

1121750v.1

GARFUNKEL, WILD & TRAVIS, P.C.
Continental Plaza II
411 Hackensack Avenue, 5th Floor
Hackensack, New Jersey 07601
(201) 883-1030
Attorneys for Defendant Trinitas Regional Medical Center

JACQUELINE BETANCOURT, on behalf of RUBEN BETANCOURT Plaintiff, vs. TRINITAS REGIONAL MEDICAL CENTER Defendant.	SUPERIOR COURT OF NEW JERSEY CHANCERY DIVISION UNION COUNTY Docket No. **CERTIFICATION OF BERNARD SCHANZER, M.D.**

I, Bernard Schanzer, M.D., of full age, certify as follows:

1. This certification is made by me in support of Trinitas Regional Medical Center's ("Trinitas") opposition to Plaintiff's request for a temporary injunction, by which she seeks to force Trinitas to provide Ruben Betancourt (the "patient") with inhumane and futile medical treatment that, at this time, would be medically inappropriate and against the standards of medical care and professional judgment.

2. I am a permanent resident in the State of New Jersey. I am a physician licensed to practice medicine in the State of New Jersey. I currently maintain an office at 700 N. Broad St. Elizabeth, NJ 07208. I was first licensed to practice medicine in 1962 and received my New Jersey State license in 1969.

3. I hold the Doctor of Medicine degree from the University Libre De Bruxelles, Fac De Med Et De Pharm, located in Brussels, Belgium. I received my degree in 1962.

4. I completed two residencies. I completed my first residency at Maimonides Medical Center, Brooklyn, New York, in 1965, specializing in internal medicine. I began my second residency at the Bronx Municipal Hospital Center in 1966, specializing in neurology. I completed this second residency in 1969, after a two year hiatus in the United States Air Force.

5. I have been practicing medicine for forty (40) years and specialize in neurology.

6. As a consulting neurologist assigned to the patient's case, I am familiar with the patient, his prognosis, his diagnoses, and with the details of and circumstances surrounding his care.

7. I make this certification in lieu of affidavit pursuant to R. 1:4-4 in regard to the above captioned matter.

Patient's Current Medical State

8. Currently, the patient is on an artificial ventilator.

9. Although the patient will open his eyes at times and spontaneous eye movement exists, no eye contact is present.

10. Occasionally, the patient demonstrates sucking mouth movements. However, no spontaneous movements of the extremities exist. Likewise, deep tendon reflexes are absent.

11. The patient does not respond to pain.

Diagnosis and Prognosis

12. The patient is in a chronic and persistent vegetative state.

13. Based upon my forty years (40) experience as a neurologist, it is my professional medical opinion that the patient will never recover from this chronic and persistent vegetative state.

Informing the Patient's Family

14. Beginning several months ago, the patient's family was informed that the patient remained in a persistent vegetative state and that no clinical probability existed that the patient would ever return to a cognizant state.

[Remainder of Page Intentionally Left Blank]

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Bernard Schanzer, M.D.

Date: Jan 22, 2009

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593v.1

GARFUNKEL, WILD & TRAVIS, P.C.
Continental Plaza II
411 Hackensack Avenue, 5th Floor
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(201) 883-1030
Attorneys for Defendant Trinitas Regional Medical Center

JACQUELINE BETANCOURT, on behalf of RUBEN BETANCOURT Plaintiff, vs. TRINITAS REGIONAL MEDICAL CENTER Defendant.	SUPERIOR COURT OF NEW JERSEY CHANCERY DIVISION UNION COUNTY Docket No. **CERTIFICATION OF FACSIMILE SIGNATURE**

I, Rebecca Edelman Levy, Esq., of full age, certify as follows:

The attached Certification of Bernard Schanzer, M.D. in Support of Trinitas Regional Medical Center's Opposition to Plaintiff's request for temporary injunctive relief contains a facsimile of the original signature of Dr. Schnazer. I acknowledge the genuineness of the signature, and that the Certification with the original signature affixed will be filed if requested by the Court or a party.

RYLevy

Rebecca Edelman Levy, Esq.

Dated: January 22, 2009

1121744v.1

GARFUNKEL, WILD & TRAVIS, P.C.
Continental Plaza II
411 Hackensack Avenue, 5th Floor
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(201) 883-1030
Attorneys for Defendant Trinitas Regional Medical Center

JACQUELINE BETANCOURT, on behalf of RUBEN BETANCOURT, Plaintiff, vs. TRINITAS REGIONAL MEDICAL CENTER Defendants.	SUPERIOR COURT OF NEW JERSEY CHANCERY DIVISION UNION COUNTY Docket No. **CERTIFICATION OF MARIA KHAZAEI, M.D.**

I, , Maria Khazaei, M.D., of full age, certify as follows:

1. This certification is made by me in support of Trinitas Regional Medical Center's ("Trinitas") opposition to Plaintiff's request for temporary injunction, by which she seeks to force Trinitas to provide Ruben Betancourt (the "patient") with inhumane and futile medical treat that, at this time, would be medically inappropriate and against the standards of medical care and professional judgment.

2. I am a permanent resident in the State of New Jersey. I am a physician licensed to practice medicine in the State of New Jersey. I currently maintain an office at 240 Williamson

Street, Elizabeth, New Jersey, 07207. I was first licensed to practice medicine in _____ and received my New Jersey State license in 1996.

3. I hold the Doctor of Medicine degree from the University of Central Del Este, Esc De Med, San Pedro De Macoris, located in the Dominican Republic. I received my degree in 1986.

4. I completed two residencies. I completed my first residency at St. Barnabas Medical Center in 1996, specializing in internal medicine. I completed my second residency at the University of Medicine and Dentistry, New Jersey in 1998, specializing in nephrology.

5. I have been practicing medicine for over ten (10) years and specialize in nephrology.

6. As the patient's treating nephrologist, I am familiar with the patient, his prognosis, his diagnoses, with the details of and circumstances surrounding his care.

7. I make this certification in lieu of affidavit pursuant to R. 1:4-4 in regard to the above captioned matter.

Informing the Patient's Family

8. Beginning several months ago, the patient's family was informed by Trinitas's medical staff that the patient remained in a persistent vegetative state and that no clinical probability existed that the patient would ever return to a cognizant state.

9. When the patient was initially started on dialysis, I advised the family that the dialysis regimen was only a temporary measure as it may be futile.

10. It is my medical opinion that to continue dialysis treatments is futile, inhumane, and contrary to generally accepted standards of medical care, as well as my own professional judgment.

[Remainder of Page Intentionally Left Blank]

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Maria Khazaei, M.D.

Dated: 1/22/09, 2009

1121569v.3

GARFUNKEL, WILD & TRAVIS, P.C.
Continental Plaza II
411 Hackensack Avenue, 5th Floor
Hackensack, New Jersey 07601
(201) 883-1030
Attorneys for Defendant Trinitas Regional Medical Center

JACQUELINE BETANCOURT, on behalf of RUBEN BETANCOURT Plaintiff, vs. TRINITAS REGIONAL MEDICAL CENTER Defendant.	SUPERIOR COURT OF NEW JERSEY CHANCERY DIVISION UNION COUNTY Docket No. C-12-09 **CERTIFICATION OF FACSIMILE SIGNATURE**

I, Rebecca Edelman Levy, Esq., of full age, certify as follows:

The attached Certification of Maria Khazaei, M.D. in Support of Trinitas Regional Medical Center's Opposition to Plaintiff's request for temporary injunctive relief contains a facsimile of the original signature of Dr. Khazaei. I acknowledge the genuineness of the signature, and that the Certification with the original signature affixed will be filed if requested by the Court or a party.

R Levy
Rebecca Edelman Levy, Esq.

Dated: January 22, 2009

1121748v.1

GARFUNKEL, WILD & TRAVIS, P.C.
Continental Plaza II
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(201) 883-1030
Attorneys for Defendant Trinitas Regional Medical Center

JACQUELINE BETANCOURT, on behalf of RUBEN BETANCOURT Plaintiff, vs. TRINITAS REGIONAL MEDICAL CENTER Defendant.	SUPERIOR COURT OF NEW JERSEY CHANCERY DIVISION UNION COUNTY Docket No. **CERTIFICATION OF WILLIAM J. MCHUGH, M.D.**

I, William McHugh, M.D., of full age, certify as follows:

1. This certification is made by me in support of Trinitas Regional Medical Center's ("Trinitas") opposition to Plaintiff's request for a temporary injunction, by which she seeks to force Trinitas to provide Ruben Betancourt (the "Patient") with inhumane and futile medical treatment that, at this time, would be medically inappropriate and against the standards of medical care and professional judgment.

2. I am a permanent resident in the State of New Jersey. I am a physician licensed to practice medicine in the State of New Jersey. I currently maintain an office at 240 Williamson Street, Elizabeth, New Jersey, 07207. I was first licensed to practice medicine in 1970 and received my New Jersey State license in 1970.

3. I hold the Doctor of Medicine degree from the State University of New York – Health Science Center at Brooklyn College of Medicine, Brooklyn, New York. I received my degree in 1961.

4. I have been practicing medicine for nearly forty (40) years.

5. I am the medical director at Trinitas.

6. I make this certification in lieu of affidavit pursuant to R. 1:4-4 in regard to the above captioned matter.

7. I have met with the Patient and have also discussed his treatment with all of his treating physicians.

8. The physicians strongly believe that dialysis is futile for this patient. The family has been told that such treatment is futile for months and have made no efforts to transfer the Patient to another facility.

9. It is my opinion that the family is dictating the medical care in this case and, in doing so, is ignoring the professional medical judgment of the treating physicians.

10. It is my medical opinion that to continue dialysis treatments for the Patient is futile, inhumane and contrary to generally accepted standards of medical care, as well as my own professional judgment.

11. It is also my opinion that to continue dialysis treatments for the Patient violates the American Medical Association, Council on Ethical and Judicial Affairs Report on Medical Futility in End-of Life Care. *Attached hereto.*

[Remainder of Page Intentionally Left Blank]

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

William McHugh, M.D.

Dated: 1-22, 2009

GARFUNKEL, WILD & TRAVIS, P.C.
Continental Plaza II
411 Hackensack Avenue, 5th Floor
Hackensack, New Jersey 07601
(201) 883-1030
Attorneys for Defendant Trinitas Regional Medical Center

JACQUELINE BETANCOURT, on behalf of RUBEN BETANCOURT Plaintiff, vs. TRINITAS REGIONAL MEDICAL CENTER Defendant.	SUPERIOR COURT OF NEW JERSEY CHANCERY DIVISION UNION COUNTY Docket No. **CERTIFICATION OF FACSIMILE SIGNATURE**

I, Rebecca Edelman Levy, Esq., of full age, certify as follows:

The attached Certification of William McHugh, M.D. in Support of Trinitas Regional Medical Center's Opposition to Plaintiff's request for temporary injunctive relief contains a facsimile of the original signature of Dr. McHugh. I acknowledge the genuineness of the signature, and that the Certification with the original signature affixed will be filed if requested by the Court or a party.

RYLevy

Rebecca Edelman Levy, Esq.

Dated: January 22, 2009

1121949v.1

New Jersey Department of Health and Senior Services
Division of Aging and Community Services
Office of the Ombudsman for the Institutionalized Elderly
PO Box 807
Trenton, NJ 08625-0807
TOLL FREE HOTLINE: 1-877-582-6995

POLICY STATEMENT FOR THE WITHHOLDING OR WITHDRAWING OF LIFE-SUSTAINING MEDICAL TREATMENT (LSMT)

The right to decline medical treatment is not absolute. In promulgating the NJ Advance Directive for Health Care Act (NJADHCA), the legislature listed seven specific circumstances where LSMT could be withheld or withdrawn. Although specifically applicable only when decision-making is affected pursuant to the terms of an advance directive, we suggest that the list appropriately details the universe of situations where forgoing LSMT would ordinarily be acceptable. Accordingly, the Board would anticipate that decisions to forgo LSMT could appropriately be effected in the following circumstances:

1. The proposed LSMT is likely to be ineffective or futile in prolonging life.
2. The proposed LSMT is likely to merely prolong an imminent dying process.
3. The patient is permanently unconscious, as determined by the attending physician and confirmed by a second qualified physician.
4. The patient is in a terminal condition, as determined by the attending physician and confirmed by a second qualified physician.
5. The patient has a serious irreversible illness or condition, and the likely risks and burdens associated with the medical intervention to be withheld or withdrawn may reasonably be judged to outweigh the likely benefits to the patient from such intervention.
6. The patient has a serious irreversible illness or condition, and imposition of the medical intervention on an unwilling patient would prove inhumane.
7. The proposed LSMT is experimental, unproven therapy.

A decision to forgo LSMT for an incompetent individual, pursuant to a living will, may only be made if one of the seven situations listed is determined to exist. Theoretically, decisions to forgo LSMT in other situations may be made by competent patients, or even by surrogate decision-makers acting on behalf of an incompetent patient without a living will. We urge that physicians approach any such situations with extreme caution, and seek judicial intervention if any question concerning the reasonableness of appropriateness of the proposed actions exists.

Excerpted from the revised Policy Statement of the New Jersey Board of Medical Examiners, Division of Consumer Affairs, NJ Department of Law and Public Safety, promulgated by Fred M. Jacobs, M.D., J.D., President.

Shared Decision-Making in the Appropriate Initiation of and Withdrawal from Dialysis

RPA
RENAL PHYSICIANS ASSOCIATION

ASN

Renal Physicians Association and
American Society of Nephrology

Clinical Practice Guideline

Number 2 • Washington, DC • February 2000

home patients found that while most life-sustaining therapy was provided in a manner consistent with patient's or surrogate decision maker's expressed preferences, there was no relationship between the written advance directive and the care provided.[222] (Level C Observational Evidence) The study also found that care in the nursing home was more likely to conflict with patients' wishes than care in the hospital, emphasizing the importance of transferring advance care planning between health care venues. Taken together these studies show that many aspects of end-of-life care, especially including advance care planning, need to be improved. Several recent studies suggest that nephrologists may be able to enhance communication of patients' preferences for end-of-life care by facilitating patient-family discussions of patients' specific treatment preferences and values regarding suffering.[223-225]

RECOMMENDATION NO. 6
WITHHOLDING OR WITHDRAWING DIALYSIS

It is appropriate to withhold or withdraw dialysis from patients with either ARF or ESRD in the following situations:

- Patients with decision-making capacity, being fully informed and making voluntary choices, who refuse dialysis or request dialysis be discontinued
- Patients who no longer possess decision-making capacity who have previously indicated refusal of dialysis in an oral or written advance directive
- Patients who no longer possess decision-making capacity and whose properly appointed legal agents refuse dialysis or request that it be discontinued
- Patients who have irreversible, profound neurological impairment such that they lack signs of thought, sensation, purposeful behavior, and awareness of self and environment.

Rationale

The legal and ethical principles supporting this recommendation include informed refusal, respect for patient autonomy, beneficence, nonmaleficence, justice, and professional integrity. In both state and federal case law and by federal statute (PSDA), competent patients have an absolute right to accept or refuse medically indicated treatment. Conversely, physicians are not ethically obligated to offer or deliver treatment that is not medically indicated. Relevant observational evidence is limited but suggests that withdrawal is common, with rates ranging from 17-50% of deaths in different dialysis populations.[226-229] (Level C Observational Evidence) Most patients on chronic dialysis appear to know that withdrawal is an option. However, few have thought about it or other end-of-life issues, communicated and discussed their preferences with family or renal care team members, or completed written advance directives.[38,38-40,42,56-60] (Level B Observational Evidence) A few studies suggest that patients with decision-making capacity most often initiate the discussion of withdrawal of dialysis themselves, while physicians most often raise the issue for patients without decision-making capacity.[226-228,230] (Level C Observational Evidence) For patients who lack decision-making capacity, substituted judgment in the absence of documentation of the patient's feelings on life support may not be permitted in some states.

The evidence regarding patients' preferences for continuing or discontinuing dialysis in the event of certain health states is based on studies using hypothetical vignettes. This evidence demonstrates some variability in hypothetical preferences among patients, with approximately 50- 85% saying they would want to stop dialysis in conditions of severe permanent neurologic impairment such as severe dementia or permanent coma.[42,210,231,232] (Level C Observational Evidence) Evidence is lacking regarding agreement between what patients say they would prefer hypothetically and what they actually do. Surveys and observational studies show nephrologists may be inconsistent and variable in their withdrawal practices. Prominent factors that they have reported to affect their withdrawal decisions include a patient's neurological and physical functional status, comorbidities, family wishes, and age.[52-54,194,196,230,233] (Level C Observational Evidence) Other patient factors that have been associated with withdrawal have included diabetes, severe pain, lack of a significant partner, Caucasian race, female gender, nursing home residence, and terminal illness.[53,196,211,226-228,230,231,233-235] (Level C Observational Evidence) Data on withholding of dialysis is limited. Information on withholding can be inferred from studies of referral practices. Of six relevant studies on dialysis referral, one large prospective cohort study indicates that the withholding rate for ARF is substantial (29%) and that increasing age and dementia were independent predictors of withholding in multivariate analyses adjusting for confounders.[111] (Level B Observational Evidence) Two retrospective cohort studies and two studies using cross-sectional surveys suggest that withholding in ESRD increases with age (15-83% over age strata from 16 to >70 years old), and may be higher in women.[194,195,236,237] (Level C Observational and Prognostic Evidence) These studies also suggest that cultural or financial contexts may influence physicians' rates of initiating dialysis. A large Canadian survey study suggests that family practitioners and internists consider the following in their decisions on whom to refer for dialysis: age, serum creatinine level, mental and psychiatric status, distance from dialysis center, overcrowding of dialysis centers, and

comorbid illnesses.[238] (Level C Observational Evidence) Over half of the Canadian physicians felt rationing should be based on patient wishes, cognitive status, life expectancy, quality of life, age, and long-term institutionalization.

RECOMMENDATION NO. 7: SPECIAL PATIENT GROUPS

It is reasonable to consider not initiating or withdrawing dialysis for patients with ARF or ESRD who have a terminal illness from a nonrenal cause or whose medical condition precludes the technical process of dialysis.

Rationale

The ethical principles of beneficence and nonmaleficence allow and support a judgment that, in certain conditions, dialysis does not offer a reasonable expectation of benefit.[239,240] Further, the right of patients or their legal agents to request dialysis must be balanced against continuing treatment that violates the ethical principle of professional integrity and that is considered medically inappropriate.[239-243] The Working Group, however, felt that the renal team should be sensitive to patient goals and individual circumstances. For example, persons with a terminal illness may desire to have dialysis to help them live long enough for a special family event (e.g., the pending birth of a grandchild).

Dialysis may be considered medically inappropriate for a patient with terminal illness from a nonrenal disease. In this Guideline, terminal illness is defined as a life expectancy of 6 months from non-renal disease(s) in patients not deemed to be candidates for solid organ transplant. Conditions that may fall into this category are end-stage cirrhosis with hepato-renal syndrome, severe CHF, widely metastatic cancer unresponsive to chemotherapy, end-stage pulmonary disease, end-stage acquired immunodeficiency syndrome, bone marrow transplant recipients with multiorgan failure, and advanced neurodegenerative diseases. Such conditions affect the survival of patients requiring renal replacement therapy.[73,74,76-80,132] (Level A Prognostic Evidence) The survival for patients with intact renal function and such selected terminal comorbid conditions may be estimated. When the expected survival for patients with intact renal function and particular comorbid conditions is less than six months, it is logical to conclude that dialysis for patients with ARF or ESRD and one or more of the above conditions is unlikely to extend survival.

Another situation where dialysis may be considered medically inappropriate exists when a patient is permanently unable to purposefully relate to others. This is defined as being unable to recognize familiar persons, lacking orientation to self, place, and time, and the absence of higher cognitive functioning. All forms of severe irreversible dementia and persistent vegetative states fulfill this definition. Dialysis may also be inappropriate for patients with significant and ongoing problems with access for dialysis or failure to thrive. In addition, dialysis may be inappropriate for some patients who are unable to cooperate with the dialysis process. Such patients may be harmful to themselves, other patients, and personnel in the dialysis unit and may create an unsafe working environment.[244] Examples of patients who might be in this category include those who require physical or chemical restraints or a sitter during dialysis to prevent harm to self or others in the unit.

RECOMMENDATION NO. 8: TIME-LIMITED TRIALS

For patients requiring dialysis, but who have an uncertain prognosis, or for whom a consensus cannot be reached about providing dialysis, nephrologists should consider offering a time-limited trial of dialysis.

Rationale

Experts recommend time-limited trials of life-sustaining treatment such as dialysis in certain situations.[47,245-247] The ethical principles of beneficence, nonmaleficence, and respect for patient autonomy provide support for this recommendation. The patient's clinical course during the period of time-limited dialysis may provide patients and families with a better understanding of dialysis and its benefits and burdens and may provide the renal care team with a more informed assessment of the likelihood of the benefits of dialysis outweighing its burdens. For example, a patient who is uncertain about their quality of life on dialysis may benefit from a time-limited trial. In this way, a time-limited trial of dialysis may promote informed shared decision-making. No research data regarding outcomes of time-limited trials of dialysis were found. The exact time period for the trial may be made on a case-by-case basis. For patients with ARF, time periods of days to two weeks may be reasonable; for patients with ESRD, time periods of one to three months are reasonable. If there is uncertainty about the inability of a patient to cooperate with dialysis, the patient should be considered for a time-limited trial of dialysis before it is withdrawn to enable all parties to evaluate the appropriateness of continuing dialysis.

CEJA Report 2 – I-96
Medical Futility in End-of-Life Care

INTRODUCTION

In the course of clinical care of a critically ill patient it may become clear that the patient is inevitably dying, and that further intervention will do no more than prolong the active dying process. At this point, further intervention is often described as "futile." The Council has discussed related issues in previous reports, in particular affirming the ethical standing of withdrawing and withholding ineffective or inappropriate intervention and noting the constructive role that advance care planning can play in preempting difficult and conflicted situations.[1] However, the Council has thus far not directly defined "futility", a term whose meaning inherently involves a value judgment.[2] In this report, in response to a request from The Board of Trustees which notes the need for guidance on the matter, the difficulties of defining futility are balanced with the need to have an operational understanding of it.[3] The Council recommends defining futility on a case-by-case basis, taking full account of the context and individuals involved; it proposes a due process approach to achieving this case-by-case definition.

CIRCUMSTANCES WHERE FUTILITY JUDGMENTS ARE RELEVANT

Clinical paradigms of futile care have included life-sustaining intervention for patients in the persistent vegetative state, and resuscitation efforts for the terminally ill.[4,5,6,11] Other examples include the use of chemotherapy or surgery for advanced cancer and also less invasive treatments such as antibiotics or intravenous hydration for near moribund conditions. Futility can be relevant in non-life-threatening circumstances, for instance when a patient uses vitamins or popularized notions of meditation biofeedback to attempt cure of a chronic condition such as rheumatoid arthritis or macular degeneration. However, this report concerns itself with the use of interventions for life-threatening illness.

If the goals of one party differ from those of another, the question of futility is especially likely to arise.[7] In these situations one party, e.g. the proxy, often wants to pursue the goal of preserving life with or without much hope of future improvement while another party, e.g. the physician, sees that dying is inevitable and wishes to pursue the goal of comfort care. In such circumstances of disagreement it is likely that the physician, complying with proxy goals, intervenes with the sense that the only reasonable expectation for the intervention is to prolong the dying process. The parties may also hold reverse goals, for instance with the proxy believing that the physician is excessively pursuing life prolongation when death seems inevitable.

REASONS FOR DEFINING MEDICAL FUTILITY

There are many motivations for attaining clarity on what is meant by futility in end-of-life medical care, and how to manage relevant situations. First, advances in technological capacity have permitted intervention to sustain different biological systems even when cognizant human life is no longer possible, leading many to question the value of the intervention. Second, some of these dilemmas have not been resolvable within the systems of medical care, and they have resulted in widely publicized court cases, such as those of Wanglie and Gilgunn.[11,12] Patients, families, physicians and others would benefit if the medical system of care could handle such situations without need for recourse to the courts. Third, many have pointed out the expense of life-sustaining intervention. While life should not be lost for want of financial resources, nonetheless many have sought areas where costs can be saved in this time of concern over the large size of the health care budget. Fourth, people are living

A version of this Report was published as "Medical Futility in End-of-Life Care" (*JAMA*. 1999; 281: 937-941)

longer and conceptions of appropriate and inappropriate intervention for the increasingly large geriatric population are undergoing reexamination. Fifth, medical decision-making has moved from a more parentalistic mode to a patient-centered mode, consistent with the strong endorsement of autonomy as a value in society and medicine. However, several commentators are noting the limits to the autonomy model and the need to consider others and the community in decision-making in medicine. Futility judgments often contain implicit differences in the ethics model being used, with (for instance) physician standards and community standards being pitched against the autonomous drive for high levels of intervention. To avoid having futility judgments fall into the center of any of these struggles, clarity on the meaning of futility in this kind of clinical context would be helpful.

HAZARDS IN DEFINING MEDICAL FUTILITY

Rationing v. futility

Commentators have noted repeatedly that there is a danger that judgments about futility mask a covert motive to allocate resources. Both futility judgments and allocation decisions are sometimes necessary, but the two should be understood for what they are and not confused.[8] Rationing refers to the withholding of efficacious treatments which cannot be afforded. Futility refers to ineffective treatments. Efforts to define futility for the purpose of cost-saving measures would be just that, not rationing measures. Cost savings that could be realized if a futility standard were followed have been estimated to be large, but estimates based on clinical studies suggest that the savings would be minor.[9, 10] When life and death decisions are being made, cost savings motivations may seem offensive, and further, they are generally not a helpful or realistic feature for defining futility. Futility standards should not be used as covert mechanisms for cost savings by third party payers or others.

Turf and Parentalism

Since many problems of futility arise in the context of a disagreement between parties regarding what constitutes appropriate and what futile care, there is always a danger that the futility debate will be distorted by one party's defense of their authority over the others. In the Wanglie case, the patient's husband successfully asserted that his substituted judgment about his wife's view of appropriate medical intervention should trump the medical team's view that intervention was futile.[11] In a reverse situation, the Massachusetts Superior Court jury upheld the prerogative of the profession to decline medical intervention that it considered futile for a patient named Gilgunn.[12] In such cases as Gilgunn's, and when physicians argue for professional standards, there is often a charge that professionals are parentalistically forcing their standards upon patients.[13, 14]

Value judgment v. Objective definition

Futility is intrinsically a value judgment, and reasonable people will disagree on what constitutes futile treatment in practice.[15] What constitutes futile care will differ depending on the medical setting (rural Africa or a Western hospital intensive care unit), goals for intervention (cure or prolong death until a relative arrives or maintain physiological parameters or secure the symbolic value of the intervention). In other words, this is a context-dependent and person-dependent assessment. A number of commentators have suggested that futility therefore cannot be specifically or concretely defined.[16, 17, 18] Others have instead emphasized the importance of including all stakeholders in assessments of futility and of maintaining a flexible standard that can change with the context.[19,20] Still others have emphasized that the real issue is the dialogue and negotiation of goals between the parties, replacing the issue of defining futility with structured deliberation about goals and a broader ethic of care[21, 22, 23]

Unilateral decisions v. Appropriate discourse

Occasionally, it may appear to a physician that the futility of an intervention allows avoidance of discussion. When an intervention is clearly medically inappropriate this is fair.[6] However, there is some risk in difficult decisions that a patient or patient's family may not agree with the physician's assessment, and that futility could be used as an excuse for avoiding difficult discussions. This should be avoided.

EXISTING EFFORTS TO DEFINE AND IMPLEMENT A POLICY ON FUTILITY

Definitions of futility have been proposed, based on a range of possible approaches. One approach is quantitative. The best known proposal in this category is one by Schneiderman and Jecker[23] that asserts that if the intervention does not work in more than one percent of attempts, it should be considered futile.

The quantitative standard is often combined with a qualitative approach, since what should count as a successful or, "acceptable" outcome for the above quantitative approach is a matter for subjective determination. This functional assessment usually concerns what constitutes a worth-the-effort quality of life. Some emphasize the prerogative of the patient or proxy to determine what counts as an acceptable outcome; others emphasize the role of the physician; others emphasize the importance of multi-party decision-making.

Another approach is to use physiological outcome. The problem here is the same as one that gave rise to the need for a concept of futility in the first place. Individuals do not judge the worth of an intervention by physiological outcomes alone; for instance, successful preservation of renal function should rank differently in the absence or presence of possible quality personal interaction. Similarly, one person's assessment of sufficient mental function is not another's. So physiological function alone cannot measure or define futility. A fourth possibility is to use the intent of the physician or patient/proxy in deciding on an intervention. This proposed standard would require physicians and patients/proxies to decline intervention that had the intent of prolonging dying. The difficulty here is two-fold. First, some intentions to prolong dying are justifiable, as in preserving organs for donation or waiting for a relative to arrive. Second, the occasions when futility disputes arise are usually such that intentions may be disputed and, even if clear, may be difficult to balance against those of another party.

A fifth possibility is to use community standards to ascertain which interventions will be provided. This approach has the merit of allowing different communities to define for themselves what they consider to be worthwhile on a scale of possible providable interventions for a full panoply of illness circumstances. The challenges for this approach inhere in securing valid prior decisions by a community, in accommodating a range of different opinions, in allowing suitable exceptions, and in maintaining periodic updates of the standards to keep apace of changes.[24, 25, 26, 27]

A sixth approach is to use institutional standards to define, proactively, what interventions are considered futile for defined circumstances. In the sense that an institution can define a community this standard could be the same as community standards. The unique challenges reside first, in finding a suitably public process of decision-making by the institution's community, and second in providing patients with appropriate informed consent and alternatives to the policy.

A seventh option is to use a due process approach.[28, 29, 30, 31] These process approaches would likely be adopted at the institutional level, but could be used at larger community or

state levels. Therefore, there could be considerable overlap with either the community or institutional standards. The emphasis of the due process approach, however, is on process between parties rather than on definition of the parties. Professional standards, patient rights, intent standards, and family or community involvement can all be accommodated.

The process for declaring futility in a particular case would be defined by the institution or community, within parameters set by a regulatory body. For instance, the process might include: (1) Earnest attempts to deliberate over and negotiate prior understanding between patient, proxy and physician as to what constitutes futile care for the patient, and what falls within acceptable limits for the physician, family, and possibly also the institution. (2) Joint decision-making at the bedside between patient or proxy and physician. (3) Attempts to negotiate disagreements if they arise, with the assistants of consultants as appropriate, to reach resolution within all parties' acceptable limits. (4) Involvement of an institutional committee such as an ethics committee if disagreements are irresolvable. (5) If the outcome of the institutional process coincides with the patient's desires but the physician remains unpersuaded, arrangement may be made for transfer to another physician within the institution. (6) If the outcome of the process coincides with the physician's position but the patient/proxy remains unpersuaded, arrangements for transfer to another institution may be sought and, if done, should be supported by the transferring and accepting institution. (7) If transfer is not possible, the intervention in question need not be offered.

CONCLUSIONS

The Council on Ethical and Judicial Affairs finds great difficulty in assigning an absolute definition to the term futile care since it is inherently a value-laden determination.

Thus, the Council favors the due process approach for determining and withholding or withdrawing what is felt to be futile care. The due process approach can accommodate community and institutional standards, and the perspectives offered by the quantitative and functional approaches. It allows a hearing for patient or proxy assessments of worthwhile outcome, as well as for physician or other provider's perception of intent in treatment and whether the primary purpose of the treatment to be offered is to prolong the dying process without benefit to the patient or others with legitimate interest. It further has the advantage of providing a system for addressing the ethical dilemmas around end-of-life care without need for recourse to the court system.

The Council on Ethical and Judicial Affairs therefore recommends:

(1) That health care institutions, whether large or small, adopt a policy on medical futility.

(2) That policies on medical futility follow a due process approach. The following seven steps should be included in such a due process approach to declaring futility in specific cases.
   (a) Earnest attempts should be made in advance to deliberate over and negotiate prior understandings between patient, proxy and physician on what constitutes futile care for the patient, and what falls within acceptable limits for the physician, family, and possibly also the institution.
   (b) Joint decision-making should occur between patient or proxy and physician to the maximum extent possible.
   (c) Attempts should be made to negotiate disagreements if they arise, and to reach resolution within all parties' acceptable limits, with the assistance of consultants as appropriate.
   (d) Involvement of an institutional committee such as the ethics committee should be requested if disagreements are irresolvable.

(e) If the institutional review supports the patient's position and the physician remains unpersuaded, transfer of care to another physician within the institution may be arranged.

(f) If the process supports the physician's position and the patient/proxy remains unpersuaded, transfer to another institution may be sought and, if done, should be supported by the transferring and receiving institution.

(g) If transfer is not possible the intervention need not be offered.

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FEB 10 2009
JOHN F. MALONE
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JACQUELINE BETANCOURT, on behalf of RUBEN BETANCOURT,

Plaintiffs,

vs.

TRINITAS HOSPITAL,

Defendants.

SUPERIOR COURT OF NEW JERSEY
CHANCERY DIVISION - UNION COUNTY
Docket No. UNN-C-12-09

Civil Action

ORDER

THIS MATTER being brought before the Court by James D. Martin, Esq., attorney for plaintiffs, Jacqueline Betancourt, on behalf of Ruben Betancourt, seeking relief by way of temporary restraints pursuant to R. 4:52, based upon the facts set forth in the Verified Complaint; and it appearing that immediate and irreparable damage will probably result before notice can be given and a hearing held and for good cause shown.

It is on this 10 day of FEB, 2009,

ORDERED that plaintiffs' application is hereby granted; and that

1. Defendant, Trinitas Hospital and/or its agents, servants and/or employees shall be restrained from discontinuing or suspending any treatment, including dialyses, feeding tubes and/or ventilation to the patient, Ruben Betancourt; and that

2. Defendant, Trinitas Hospital and/or its agents, servants and/or employees shall immediately re-establish and/or resume treatment, including dialysis, feeding tubes and/or ventilation to patient Ruben Betancourt; and that

3. Defendant, Trinitas Hospital and/or its agents, servants and/or employees shall

remove a Do Not Resuscitate (DNR) order from the plaintiff's chart; and that

4. A hearing in this matter shall be conducted before the Honorable John F. Malone, J.S.C. on February 17, 2009 at 9:00 a.m.; and that

5. A true and complete copy of this Order be served upon all counsel within seven (7) days of the date hereof.

J.S.C.

JOHN F. MALONE, P.J.Ch.

☒ Opposed

☐ Unopposed

SUPERIOR COURT OF NEW JERSEY

CHAMBERS OF
JOHN F. MALONE
PRESIDING JUDGE, CHANCERY

COURTHOUSE
ELIZABETH, NEW JERSEY 07207

March 4, 2009

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Re: Betancourt v. Trinitas Regional Medical Hospital
Docket No. C-12-09

Dear Counsel:

This letter is the court's decision with respect to the referenced matter. Ruben Betancourt, a 73 year old male, is currently an in-patient at Trinitas Regional Medical Center in Elizabeth. Mr. Betancourt had been admitted to Trinitas for surgery for a malignant thymoma. Following the surgery on January 22, 2008, the patient developed anoxic encephalopathy. Mr. Betancourt was deprived of oxygen as a result of an extubation of a breathing tube and lapsed into unconsciousness. Mr. Betancourt has been and remains in an unconscious state unable to communicate with his physicians or family.

Since January 2008, the patient has been admitted to various treatment facilities including JFK Medical Center's Brain Trauma Unit, Genesis Health Care's Ventilation Unit and Elizabeth Nursing Home. Mr. Betancourt was readmitted to

Trinitas on July 3, 2008 with a diagnosis of renal failure. The patient is on an artificial ventilator and receives dialysis. Nutrition is provided by feeding tube.

Representatives of the defendant advised the Betancourt family that Mr. Betancourt is in an unresponsive irreversible vegetative state and that further treatment would be futile. Trinitas representatives indicated to the family that it is the opinion of the medical staff that mechanical life support treatment should be discontinued. Upon termination of such treatment, Mr. Betancourt would expire as a result of his various medical conditions.

Plaintiff, daughter of the patient, initiated the within action by Order to Show Cause and Verified Complaint. Plaintiff sought entry of a temporary restraining order enjoining the defendant from discontinuing treatment pending further proceedings in the matter. On January 23, 2009, the court entered an order requiring the hospital to continue to provide treatment and directing the resumption of dialysis treatment which had been discontinued. On January 30, 2009, the court directed that the January 23rd order remain in effect pending a plenary hearing. On February 17th and 23rd, the court heard testimony from witnesses on behalf of the hospital and Betancourt family.

Mr. Betancourt's daughter (plaintiff), son and wife testified regarding the patient's condition. All of the family members related their belief that the medical personnel at Trinitas are incorrect in their assessment of Mr. Betancourt. They dispute the findings that he is in an unresponsive, persistent vegetative state. The family recounts their impression that Mr. Betancourt is responsive to

certain stimuli. They state their observation that the patient recoils when approached by medical providers in anticipation of medical services and responds by opening his eyes or turning his head to the sound of certain voices. The family further disputes the contention that treatment is futile and harmful. The testimony of Carl S. Goldstein, M.D., a Board Certified Nephrologist, was presented. Dr. Goldstein indicated his opinion that dialysis treatments were appropriate for Mr. Betancourt who suffers from end stage of renal disease. It was the doctor's opinion that the treatment was not harmful to the patient. The family further argues that their position is supported by notations in the charts by medical staff indicating that Mr. Betancourt was observed to be "awake".

The family members also testified regarding what they believe would be Mr. Betancourt's wishes in connection with continued treatment. The family described Mr. Betancourt as an active person. Before retiring his worked involved manual labor and he continued to be active in retirement. They note that Mr. Betancourt suffered some medical conditions, diabetes and high blood pressure, for which he sought medical treatment and followed directions of his physician. The family describes Mr. Betancourt as a strong willed person who would not give up. It is the opinion of the family members that Mr. Betancourt would want to continue to receive treatment.

The plaintiff seeks an order of the court restraining the defendant from discontinuing or suspending treatment including dialysis, feeding tubes and

ventilation. Further, the plaintiff requests that she be appointed guardian of Mr. Betancourt.

Various treating physicians testified with respect to Mr. Betancourt's current medical condition. In the opinion of these physicians, Mr. Betancourt is in a persistent vegetative state from which he will never recover. The physicians do not expect the patient to live more than a few months. The physicians indicate that Mr. Betancourt is actively dying; his body is decomposing and often septic. The patient suffers from ulcers on his bones due to chronic bone infection and bed sores.

The physicians indicate that Mr. Betancourt does open his eyes and make spontaneous eye movement, however, these movements are reflexive and he does not make eye contact. The patient does not respond to pain or spontaneously move his extremities. It is the opinion of the physicians that continuation of treatment is contrary to the standard of care where, as here, it is futile. The physicians expressed the view that dialysis treatment is medically and ethically inappropriate and inhumane.

The hospital opposes the plaintiff's application for an order requiring the continuation of treatment.

The issue before the court, as stated by the plaintiff, is whether a medical provider on its own initiative can terminate life support services for a patient. The defendant argues that the issue is better framed as whether a medical provider may be required to provide medical care to a patient where the

treatment is futile, against the standard of care and inhumane. However stated, counsel for both parties suggests that the issue has not been addressed by the courts of this state.

The resolution of the question requires consideration of the body of law developed in the right to die cases.

Plaintiff argues that New Jersey cases such as *In Re Quinlan*, 70 *N.J.* 10 (1976) and *In Re Conroy*, 98 *N.J.* 321 (1985) consistently held that the decision to withhold treatment is that of the patient or his surrogate decision maker. The plaintiff contends that these cases dealing with patients in either persistently vegetative states or the later stages of a prolonged dying process support the patient's right as expressed through his guardian to make the choice regarding the continuation of medical treatment. It is the role of that surrogate to determine and effectuate what the patient would have chosen if he were able.

It is the hospital's position that these cases are not applicable to the present matter before the court. Trinitas argues that the issue is not whether treatment should be withdrawn but whether physicians should be forced to provide futile medical care when they believe that such treatment is against the standard of care and inhumane. Acknowledging that the issue as framed by the hospital is one of first impression in New Jersey, the hospital argues that support for its position may be gleaned from New Jersey public policy and is supported by decisions of other jurisdictions.

The hospital contends that there is a public interest in allowing physicians to provide quality health care even though the course of treatment may be contrary to the wishes of the patient's family to sustain life at all costs. Public interest is served by promoting dignity when death is inevitable and elevating the quality of life over longevity.

Trinitas further agues that the rational of *Causey v. St. Francis Medical Center,* 719 So.2d 1072 (LA. App.2d. Cir. 1998) be applied by this court. In *Causey,* the treating physician withdrew dialysis treatment from a 31 year old comatose quadriplegic with end stage renal failure over the objections of the patient's family. The physician believed that continuing dialysis would have no benefit. Dialysis was discontinued, the ventilator removed and the patient died.

The *Causey* court citing *In Re Quinlan* acknowledged the patient's right to participate in medical decision making and the right of a guardian or next-of-kin to act for an incapacitated patient. The court however held that "the court, as the protector of incompetents, however, can override an intolerable choice by a surrogate decision maker." Ultimately, the *Causey* court held that a physician would not be compelled to "provide interventions that in his view would be harmful, without effect or 'medically inappropriate'." *Id.* at 1075.

Defendant argues that in the instant matter the patient is in a persistent vegetative state with no chance of recovery. The treating physicians argue that continuing dialysis is not only against the standard of care, but is also medically and ethically inappropriate. The hospital argues that the court should deny the

plaintiff's request for injunctive relief requiring Trinitas to provide the medical treatment requested by the family.

The resolution of the issue presented in this case must be guided by the principles enunciated by the Supreme Court in *Matter of Jobes*, 108 *N.J.* 394 (1987). The Court decided that a husband could authorize the removal of a life sustaining nutrition system from his 31 year old wife who was in an irreversible vegetative state. The Court held that it is not the role of the trial court to decide whether treatment should be removed from a comatose patient but rather to establish criteria that respect the right to self determination and protect incapacitated patients.

The Court stated that in cases regarding the withdrawals of life sustaining treatment the "patients' right to self-determination is the guiding principle." Thus, concluded the Court, the goal of the surrogate decision maker was to determine and effectuate what the patient would want. This approach, referred to as the "substituted judgment" doctrine, allows the surrogate decision maker to consider the patient's personal value system to determine if life support systems should be removed.

The decision to continue or terminate life support systems is not left to the courts. The position of the hospital argues that the court take the role of surrogate decision maker. The hospital seeks to have the court exercise its judgment in determining the proper course of treatment for Mr. Betancourt, a task which the Court in *Jobes* ruled is outside the role of the court.

This court concludes that Mr. Betancourt is in a persistent vegetative state and unable to communicate his wishes with respect to the continuation of life supporting treatment. Accordingly, the appointment of a guardian is required. The court grants the application of plaintiff Jacqueline Betancourt to be the guardian of her father. Mr. Betancourt's son, wife and other family members who may be considered did not petition the court to be the guardian nor did they object to Ms. Betancourt's application.

As guardian for Mr. Betancourt, Ms. Betancourt is his surrogate decision maker. The plaintiff's application to restrain the defendant from discontinuing or suspending treatment of Mr. Betancourt is granted. The guardian is authorized to make decisions respecting medical treatment of Mr. Betancourt.

Attorney for the plaintiff shall submit an order consistent with this decision within 10 days.

Very truly yours,

JOHN F. MALONE, P.J.Ch.

JFM/pfk

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JACQUELINE BETANCOURT, on behalf of RUBEN BETANCOURT,

Plaintiffs,

vs.

TRINITAS HOSPITAL,

Defendants.

SUPERIOR COURT OF NEW JERSEY
CHANCERY DIVISION - UNION COUNTY
Docket No. UNN-C-12-09

Civil Action

ORDER

THIS MATTER being brought before the Court by James D. Martin, Esq., attorney for plaintiffs, Jacqueline Betancourt, on behalf of Ruben Betancourt, and the Court having considered the matter and for good cause shown,

It is on this 20 day of MARCH, 2009,

ORDERED that Jacqueline Betancourt shall and hereby is appointed Guardian of Ruben Betancourt, an incompetent; and it is further

ORDERED that as Guardian, Jacqueline Betancourt, shall make, among others, all decisions respecting medical treatment for Ruben Betancourt; and it is further

ORDERED that Trinitas Hospital, its agents, servants and employees are permanently restrained from discontinuing or suspending treatment for its patient, Ruben Betancourt, and further that Trinitas Hospital, its agents, servants and employees shall refrain from placing "Do Not Resuscitate" orders in the plaintiff's chart; and it is further

ORDERED that a true and complete copy of this Order be served upon all counsel within seven (7) days of the date hereof.

JOHN F. MALONE, P.J.C.

☒ Opposed

☐ Unopposed