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## ***IN RE WENDLAND: CONTRADICTION, CONFUSION, AND CONSTITUTIONALITY***

*Mary Ann Buckley\**

*This is the hardest case.*<sup>1</sup>

### INTRODUCTION

The issue of medical treatment refusals for incompetent patients is a relatively recent phenomenon, primarily due to advances in medical treatment and technology that provide the capability to support biologic life, if not necessarily cognitive life, in circumstances that would have been impossible until recently.<sup>2</sup>

In *In re Wendland*, the California Supreme Court held that a conservator may not withhold artificial nutrition and hydration from a minimally conscious patient in the absence of clear and convincing evidence either that the patient had previously expressed wishes to forgo such treatment or that doing so is in

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<sup>1</sup> *In re Wendland*, 93 Cal. Rptr. 2d 550, 553 (Ct. App. 2000).

<sup>2</sup> *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 269 (1990); see also Ronald E. Cranford, *Modern Technology and the Care of the Dying*, in *BIRTH TO DEATH: SCIENCE AND BIOETHICS* 191-97 (David C. Thomasma & Thomasine Kushner eds., 1996) (exploring changes in the process of dying since the second World War).

the patient's best interest.<sup>3</sup> With *Wendland*, California joined a small but growing number of states that have adopted the clear and convincing standard in these circumstances.<sup>4</sup> The *Wendland* court, however, was the first to determine that a lesser standard would be unconstitutional.<sup>5</sup> Because of the profound effect this decision could have on a significant number of health care decisions, it is important to examine the court's reasoning to test it for soundness.

This comment examines *Wendland*, challenging the court's reasoning. Part I briefly explores case law regarding medical treatment refusals and legislative enactments based on the Uniform Health Care Decisions Act (UHCDA).<sup>6</sup> Part II discusses the details of the *Wendland* case. Part III challenges the court's reasoning, focusing on four problems with the decision: (1) Stating that its decision would affect only a "narrow class" of patients, the court misperceived the scope of the decision's

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<sup>3</sup> 28 P.3d 151 (Cal. 2001), *reh'g denied*, 2001 Cal. LEXIS 6484 (2001). "Conservator" means a court-appointed conservator having authority to make a health care decision for a patient." CAL. PROB. CODE § 4613 (Deering 2001). A "surrogate" is one, other than a patient's appointed agent or court-appointed conservator, who is authorized to make decisions for a patient. *See, e.g.*, CAL. PROB. CODE § 4643 (Deering 2001).

<sup>4</sup> Other states include Michigan, *In re Martin*, 538 N.W.2d 399 (Mich. 1995); Missouri, *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988), *aff'd sub nom. Cruzan v. Dir.*, Mo. Dep't of Health, 497 U.S. 261 (1990); New Jersey, *In re Conroy*, 486 A.2d 1109 (N.J. 1985); New York, *In re Westchester County Med. Ctr. ex rel. O'Connor*, 531 N.E.2d 607 (N.Y. 1988).

<sup>5</sup> *See generally Wendland*, 28 P.3d 151. The court examined the case in the light of Article I, section 1, of the California Constitution, which specifically lists privacy as an individual right, and noted that the constitutional privacy provision protects against private conduct. *Id.* at 165. While a full discussion of the issue of the existence of a federal constitutional right to privacy is beyond the scope of this article, it is possible that other state courts will adopt reasoning from *Wendland* when construing their own state constitutions. It is also conceivable that the court's reasoning could be considered in examining the issue on a federal level.

<sup>6</sup> UNIF. HEALTH-CARE DECISIONS ACT, 9 U.L.A. pt. I.B, 147-82 (1993) [hereinafter UHCDA], available at <http://www.law.upenn.edu/bll/ulc/fnact99/1990s/uhcda93.htm>.

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applicability;<sup>7</sup> (2) while the court's decision was ostensibly made in the spirit of furthering individual autonomy, the opinion actually has the opposite effect, since Californians are now either forced to make decisions in a manner they would not have chosen themselves or suffer the consequences of a default they likely would not have chosen themselves;<sup>8</sup> (3) the court's dependence on the use of written advance directives is misplaced, as is its belief that oral appointment of surrogates adequately offsets the consequences of failure to execute written advance directives;<sup>9</sup> and (4) clear and convincing evidence, in contrast to the court's holding, is neither required nor appropriate for decisions to withdraw treatment from incompetent patients.<sup>10</sup> Part III also proposes that the California legislature must now specify that the preponderance of the evidence is sufficient for surrogates to withdraw treatment from incompetent patients as long as other statutory requirements are met. Furthermore, the legislature must specify what procedural safeguards are sufficient to resolve

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<sup>7</sup> *Wendland*, 28 P.3d at 175.

<sup>8</sup> *Id.* at 168.

<sup>9</sup> *Id.* at 160-61, 172. The court relied on the use of advance directives and oral appointment of surrogates to provide guidance as to the patient's wishes. *Id.* Advance directives are statements made by competent individuals directing the kinds of care they would like to receive in the event of their subsequent incapacity. See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 152 (5th ed. 2001); see also David Orentlicher, *The Limitations of Legislation*, 53 MD. L. REV. 1255, 1258-59 (1994). Advance directives are governed by state law; California's governing provisions allow for written and oral advance directives and appointment of agents and surrogates. See CAL. PROB. CODE §§ 4670, 4711, 4684, 4714 (West 2003). The United States Congress supported the use of advance directives via the Patient Self-Determination Act (PSDA). Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4206, 104 Stat. 1388, § 4206 (1990) (codified as 42 U.S.C. § 1395 (1991)) (including as a budget amendment the PSDA, which requires healthcare providers to provide written information to patients regarding their right to make advance directives, and to provide additional education to staff and the community regarding advance directives).

<sup>10</sup> See *Wendland*, 28 P.3d at 174 (concluding that clear and convincing evidence is required to prove that a conservatee either wished to refuse life-sustaining treatment or that it would be in his best interest).

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disputes, in order to keep such disputes out of the courts.

I. LEGAL BACKGROUND<sup>11</sup>

Prior to *Wendland*, California case law was clear that competent patients may refuse life-sustaining treatments, even when not terminally ill, based on the California Constitution's Privacy clause.<sup>12</sup> Prior to California's adoption of its version of the UHCDA, decisions for incompetent patients were either made informally,<sup>13</sup> or based on state laws governing advance directives and court-appointed conservators.<sup>14</sup> After the adoption of the Health Care Decisions Act (HCDA), all treatment decisions for incompetent patients, regardless of how the decision maker came by that role, were to be guided by the same provisions of the act.<sup>15</sup>

A. *California Case Law*

The right of competent persons in California to refuse medical treatment was upheld in 1972 in *Cobbs v. Grant*.<sup>16</sup> In

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<sup>11</sup> See generally Norman L. Cantor, *Twenty-Five Years After Quinlan: A Review of the Jurisprudence of Death and Dying*, 29 J.L. MED. & ETHICS 182 (2001) (examining case law on the subject of medical treatment refusals more comprehensively).

<sup>12</sup> CAL. CONST. art. I, § 1. "All people are by nature free and independent and have inalienable rights. Among these are enjoying and defending life and liberty, acquiring, possessing, and protecting property, and pursuing and obtaining safety, happiness, and privacy." *Id.* See *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 301 (Ct. App. 1984); *Bartling v. Superior Court*, 209 Cal. Rptr. 220 (Ct. App. 1984).

<sup>13</sup> *Health Care Decisions Act: Hearing on A.B. 891 Before the Senate Rules Comm.*, 1999-2000 Reg. Sess. (Cal. Sept. 3, 1999) [hereinafter *Senate Rules Comm. Hearing on A.B. 891*].

<sup>14</sup> *Id.*

<sup>15</sup> *Id.*

<sup>16</sup> 502 P.2d 1 (Cal. 1972) (remanding a medical malpractice case for retrial on the basis that it was unclear on what theory the jury reached its verdict when there was insufficient evidence to show negligence but when it was possible that the patient had not given informed consent).

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*Cobbs*, the court held that a patient has the right to disclosure of his choices in regard to treatment, and the risks inherent in those choices.<sup>17</sup> The court based that right on the right of the patient to refuse treatment.<sup>18</sup> The right of competent patients to refuse even life-sustaining treatments was subsequently upheld in *Bartling v. Superior Court* in 1984.<sup>19</sup> In *Bartling*, a competent patient was being treated with mechanical ventilation due to chronic respiratory failure, emphysema, a lung tumor and other serious medical problems.<sup>20</sup> He sought an injunction to order the hospital and his physicians to disconnect the ventilator, but the lower court refused, claiming that such treatments could only be withdrawn if the patient was comatose and only in the absence of a reasonable possibility of recovery.<sup>21</sup> The appellate court reversed, noting that the right to refuse treatment is an “obvious corollary” to the notion expressed in *Cobbs* that treatment given in the absence of informed consent constitutes a battery.<sup>22</sup>

The right to refuse feeding and hydration was extended to patients who are not terminally ill in *Bouvia v. Superior Court of Los Angeles County*.<sup>23</sup> Elizabeth Bouvia was completely immobile as a result of cerebral palsy, quadriplegia and arthritis, and was dependent on others for all aspects of her care.<sup>24</sup> Her physicians

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<sup>17</sup> *Id.* at 10.

<sup>18</sup> *Id.* at 9.

<sup>19</sup> 209 Cal. Rptr. 220 (Ct. App. 1984) (holding that a patient has the right to have mechanical ventilation discontinued despite objections of physicians and hastening of his death).

<sup>20</sup> *Id.*

<sup>21</sup> *Id.*

<sup>22</sup> *Id.*

<sup>23</sup> 225 Cal. Rptr. 297 (Ct. App. 1986). The right to refuse treatment was also held to apply to prisoners in *Thor v. Superior Court of Solano County*, 855 P.2d 375 (Cal. 1993) (holding that, in the absence of evidence of a threat to institutional security or public safety, an inmate may not be denied the freedom to refuse all medical treatment). The *Wendland* court erred in referring to Elizabeth Bouvia as a terminally ill patient; she was paralyzed, confined to a wheelchair, and suffering from cerebral palsy, but was not terminally-ill. See GREGORY PENCE, CLASSIC CASES IN MEDICAL ETHICS 25, 29 (1990).

<sup>24</sup> *Bouvia*, 225 Cal. Rptr. at 299-300.

inserted a feeding tube against her will and she sought an injunction requiring that the tube be removed.<sup>25</sup> The trial court denied her request, but the appellate court granted her relief.<sup>26</sup> In granting relief, the court relied in part on *Cobbs* and *Bartling*.<sup>27</sup>

*B. Development of Case Law on the Use of the “Clear and Convincing” Standard*

Prior to *Wendland*, courts in Michigan, Missouri, New Jersey and New York had adopted the clear and convincing standard for refusal of medical treatment by surrogates.<sup>28</sup> The United States Supreme Court upheld the right of a state to require the standard in *Cruzan v. Director, Missouri Department of Health*.<sup>29</sup>

With *In re Conroy*, New Jersey became the first state to require clear and convincing evidence of a patient’s previously-stated wishes to refuse medical treatment.<sup>30</sup> Claire Conroy was a

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<sup>25</sup> *Id.* at 298.

<sup>26</sup> *Id.* Despite the court’s decision, Ms. Bouvia did not elect to exercise the option granted by the court to starve herself. *See* PENCE, *supra* note 23, at 44.

<sup>27</sup> *Bouvia*, 225 Cal. Rptr. at 300-02. The court also relied on *Barber v. Superior Court of Los Angeles County*, 147 Cal. App. 3d 1006 (Ct. App. 1983) (issuing a writ of prohibition to restrain the lower court from proceeding on murder charges filed against physicians who discontinued medical treatment from a comatose patient) The *Barber* court held that the physicians had no legal duty to act and that failure to act, therefore, was not grounds for proceedings. *Id.* at 1022. Furthermore, the court found that withdrawal of treatment is equivalent to withholding it, *id.* at 1016, and noted that “a murder prosecution is a poor way to design an ethical and moral code for doctors.” *Id.* at 1011.

<sup>28</sup> *See In re Martin*, 538 N.W.2d 399 (Mich. 1995); *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988), *aff’d sub nom. Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261 (1990); *In re Conroy*, 486 A.2d 1209 (N.J. 1984); *In re Westchester County Med. Ctr. ex rel. O’Connor*, 531 N.E.2d 607 (N.Y. 1988).

<sup>29</sup> 497 U.S. 261 (1990). *See infra* notes 45-61 and accompanying text (discussing the case).

<sup>30</sup> 486 A.2d 1209 (N.J. 1984). Courts throughout the United States have looked to New Jersey for guidance in cases regarding medical treatment refusals, since New Jersey was often the first to confront the issues. *See In re*

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terminally-ill, elderly, incompetent patient living in a nursing home.<sup>31</sup> She had a history of refusing medical care and expressing discomfort with hospitals and medical treatment.<sup>32</sup> Her nephew had sought to withdraw artificial nutrition and hydration.<sup>33</sup> Despite Ms. Conroy's death during the course of litigation, the New Jersey Supreme Court seized the opportunity to attempt to clarify decision-making standards by defining three such standards: "subjective," "limited objective" and "pure objective."<sup>34</sup> In an attempt to keep such decisions out of the courts, the *Conroy* court set up procedural methods by which such decisions could be made.<sup>35</sup> The court rejected distinctions between death that results from treatment termination and death

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Peter, 529 A.2d 419 (N.J. 1987) (allowing the withdrawal of feeding tube from a patient in a persistent vegetative state based on clear and convincing evidence of the patient's wishes for such treatment to be withdrawn); *Conroy*, 486 A.2d 1209 (recognizing that the right to refuse treatment survives incapacity and prescribing procedural safeguards for patients in nursing homes); *In re Quinlan*, 355 A.2d 647 (N.J. 1976) (allowing withdrawal of ventilator treatment from a patient in a persistent vegetative state). New Jersey was the first explicitly to find a distinction between suicide and the refusal of treatment. *In re Quinlan*, 355 A.2d at 664 (noting "a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support or radical surgery, for instance"). See Cantor, *supra* note 11, at 183 (reviewing the history of treatment refusal cases).

<sup>31</sup> *Conroy*, 486 A.2d at 1216.

<sup>32</sup> *Id.*

<sup>33</sup> *Id.* at 1218.

<sup>34</sup> *Id.* at 1229-33. The court held that the subjective standard could be used to refuse treatment on an individual's behalf when there is clear evidence that the individual would have made that choice; the "limited objective" test should be used when there is some trustworthy evidence that the individual would have wanted to terminate treatment and the burden of prolonging life, as a result of pain and suffering, significantly outweighed the benefits of a prolonged life; and the "pure objective" test would allow for the termination of treatment only when the individual's physical suffering would make the treatment inhumane. *Id.* at 1231-33.

<sup>35</sup> *Id.* at 1241-42. The procedures included determination of the incompetency of the individual, notification of the Office of the Ombudsman (an office designated to investigate allegations of abuse in nursing homes), and confirmation by two independent physicians confirming the attending physician's assessment of the patient's medical condition and prognosis. *Id.*

that results from allowing a person to die of his disease,<sup>36</sup> and between artificial feeding and other life-sustaining medical treatments.<sup>37</sup> Subsequently, the New Jersey Supreme Court noted that *Conroy* was limited to elderly, incompetent patients with some ability to interact with the environment.<sup>38</sup>

Three years later, in *In re Westchester County Medical Center ex rel. O'Connor*, New York became the next to require clear and convincing evidence of a patient's wishes to have treatment withdrawn.<sup>39</sup> While continuing to recognize the individual's right to refuse treatment, the court refused to allow one to make such an assertion for another on the basis that no court or other person should decide what is an acceptable quality of life for another.<sup>40</sup> Over the objections of family members, the court allowed the hospital to continue providing artificial feeding to Mary O'Connor, who became incompetent after having several strokes.<sup>41</sup> Here, the court failed to find clear and convincing evidence that O'Connor would have chosen to refuse the treatment, despite evidence of repeated expressions of her beliefs over a period of almost twenty years in response to the deaths of a number of her relatives.<sup>42</sup> The court defined "clear and convincing" as the level of proof sufficient to convince the

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<sup>36</sup> *Id.* at 1236 (noting that "[c]haracterizing conduct as active or passive is often an elusive notion, even outside the context of medical decision-making . . . [t]he distinction is particularly nebulous, however, in the context of decisions whether to withhold or withdraw life-sustaining treatment").

<sup>37</sup> *Id.* at 1234. The court, however, recognized the "emotional significance" of food. *Id.* What the court did not specify was whether it considered the emotional significance to be for the individual being fed or for those doing the feeding, an important distinction in deciding the benefits and burdens *for the patient* of continuing artificial feeding. *See id.*

<sup>38</sup> *In re Peter*, 529 A.2d 419 (N.J. 1987) (refusing to require the tests and procedures of *Conroy* prior to withdrawal of treatment for patients in a persistent vegetative state).

<sup>39</sup> 531 N.E.2d 607 (N.Y. 1988).

<sup>40</sup> *Id.* at 613.

<sup>41</sup> *Id.* at 608.

<sup>42</sup> *Id.* (noting that O'Connor's statements were primarily in response to deaths from cancer of her husband, stepmother and the "last two" of her nine brothers).

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factfinder “*as far as is humanly possible*, that the strength of the individual’s beliefs and the durability of the individual’s commitment to those beliefs makes a recent change of heart unlikely.”<sup>43</sup> Although the *O’Connor* court rejected the term “substituted judgment,” it utilized what is usually considered a substituted judgment standard.<sup>44</sup>

Missouri followed New Jersey and New York, requiring the clear and convincing standard in *Cruzan v. Harmon*.<sup>45</sup> Nancy Beth Cruzan was in a persistent vegetative state (“PVS”) as a result of injuries sustained in an automobile accident.<sup>46</sup> Here, the Supreme Court of Missouri found that evidence of the patient’s wishes to have artificial nutrition and hydration withdrawn was “inherently unreliable” and refused to authorize her parents to have such treatment discontinued.<sup>47</sup> The court held that the state’s interest in preserving Nancy’s life and that of others like her, in the face of a minimal burden on Nancy to continue living, outweighed her right to have treatment discontinued.<sup>48</sup> Additionally, the court noted that the issue of such decisions is one of policy, which is best left to the legislature, and that legislative action would be required in order to overcome the

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<sup>43</sup> *Id.* at 613 (emphasis added) (citations omitted).

<sup>44</sup> *Id.*

<sup>45</sup> 760 S.W.2d 408 (Mo. 1988).

<sup>46</sup> *Cruzan*, 760 S.W.2d at 410-11. Nancy’s parents requested that her artificial nutrition and hydration be withdrawn, but the hospital refused to do so without court approval. *Id.* at 268. The trial court authorized the termination of treatment but the State Supreme Court reversed, holding that the State Constitution—and probably the U.S. Constitution—provided no broad right to privacy that would allow for unfettered exercise of a right to refuse treatment, that the State had a policy strongly favoring the preservation of life and that Cruzan’s statements to her roommate were insufficient to establish her wish not to receive treatment under her current circumstances. *Id.* PVS is a state in which the patient has sleep/wake cycles but exhibits no cognitive awareness of or substantial reaction to the surroundings. PRINCIPLES OF NEUROLOGY 347 (Raymond D. Adams et al. eds., 6th ed. 1997).

<sup>47</sup> *Cruzan*, 760 S.W.2d. at 426. The trial court found that “Nancy expressed, in ‘somewhat serious conversation’ that if sick or injured she would not want to continue her life unless she could live ‘halfway normally.’” *Id.* at 411.

<sup>48</sup> *See id.* at 426.

current state presumption in favor of life.<sup>49</sup>

The United States Supreme Court granted certiorari.<sup>50</sup> In its subsequent opinion, the Court noted the confusion in the various courts over the basis of the right to refuse treatment and the appropriate standard to apply in cases involving incompetent patients.<sup>51</sup> The sole question before the Court was “whether the United States Constitution prohibits Missouri from choosing the rule of law which it did.”<sup>52</sup> In a plurality opinion, the Court held that the United States Constitution did not bar a state from requiring clear and convincing evidence of an incompetent’s wishes.<sup>53</sup> The Court also recognized a liberty interest under the Due Process Clause for a competent person to refuse unwanted medical treatment, and assumed that such right would include the refusal of nutrition and hydration.<sup>54</sup> Whether such a right has been violated must be determined by balancing the individual’s liberty interest against the relevant state interests.<sup>55</sup>

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<sup>49</sup> *See id.* Specifically, the court stated, “[I]f there is to be a change in . . . policy, it must come from the people through their elected representatives.” *Id.*

<sup>50</sup> *Cruzan v. Dir., Mo. Dep’t of Health*, 492 U.S. 917 (1989).

<sup>51</sup> *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261 (1990) (pointing out that the cases on the subject “demonstrate both similarity and diversity in their approaches to decision of what all agree is a perplexing question with unusually strong moral and ethical overtones”).

<sup>52</sup> *Id.* at 277.

<sup>53</sup> *See id.* at 285. The Court did not explicitly state that the standard was constitutionally required, but discussed it approvingly. *Id.* at 283.

<sup>54</sup> *See id.* at 284.

<sup>55</sup> *Id.* at 279. The Court held that it was permissible for Missouri to apply a clear and convincing evidence standard when the individual interests at stake are particularly important. *Id.* at 283. The Court cited Missouri’s interest as a general interest in the protection and preservation of human life; the Court stated that Missouri may: 1) seek to “safeguard the personal element of [an individual’s] choice” between life and death; 2) guard against “potential abuses” by surrogates who may not act to protect the patient; 3) consider that “a judicial proceeding regarding an incompetent’s wishes may very well not be an adversarial one, with the added guarantee of accurate factfinding that the adversary process brings with it;” and 4) decline “to make judgments about the ‘quality’ of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the

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Additionally, the Court determined that the Constitution does not require a State to accept the substituted judgment of close family members without substantial proof that their views reflect the patient's.<sup>56</sup> The Court further noted that "favored treatment of traditional family relationships . . . may not be turned around into a constitutional requirement that a State *must* recognize" such decision making.<sup>57</sup>

Justice O'Connor noted in her concurring opinion, however, that the plurality decision did not decide whether a State must give effect to the decisions of a surrogate.<sup>58</sup> She concluded that, in order to protect the patient's liberty interest in refusing medical treatment, the State may have a constitutionally required duty to do so.<sup>59</sup> In a dissenting opinion joined by Justices Marshall and Blackmun, Justice Brennan stated that Cruzan had a fundamental right to be free of unwanted artificial nutrition and hydration that is not outweighed by any interest of the State.<sup>60</sup> The dissenters found that the standard required by Missouri impermissibly burdened that right.<sup>61</sup>

Michigan was the first state after *Cruzan*, and the last before *Wendland*, to apply the clear and convincing standard to treatment refusals by surrogates.<sup>62</sup> In *In re Martin*, a case

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constitutionally protected interests of the individual." *Id.* at 281.

<sup>56</sup> *See id.* at 286. The Court did not discuss what might constitute "substantial proof." *See id.*

<sup>57</sup> *Id.* The Court, however, did not disallow states' recognition of such decision making. *Id.*

<sup>58</sup> *Id.* at 289 (O'Connor, J., concurring).

<sup>59</sup> *Id.* Justice O'Connor's suggested means of protecting the liberty interest in refusing medical treatment included durable powers of attorney and health care proxies, but she did not mention statutory appointment of family members or due process procedural safeguards in the absence of any of the above. *Id.* at 290-91.

<sup>60</sup> *Id.* at 302 (Brennan, J., dissenting); *see also id.* at 350 (Stevens, J., dissenting) (opining that the best interests of the individual should prevail over general state policy).

<sup>61</sup> *Id.* at 302 (Brennan, J., dissenting) (arguing that "Nancy Cruzan has a fundamental right to be free of unwanted artificial nutrition and hydration, which right is not outweighed by any interests of the State").

<sup>62</sup> *In re Martin*, 538 N.W.2d 399 (Mich. 1995).

remarkably similar factually to the *Wendland* case, Michael Martin suffered head injuries as the result of an accident, leaving him severely impaired, both physically and neurologically, although he was not in a vegetative state.<sup>63</sup> His wife sought to discontinue artificial nutrition and hydration based on previous statements he had made, but was opposed by his mother and sister.<sup>64</sup> The *Martin* court noted that a “necessary corollary of the . . . right to consent is the right not to consent.”<sup>65</sup> Despite this acknowledgement, the court set the burden of proof for refusals by surrogates significantly higher than for consent.<sup>66</sup>

Thus, by the time the California Supreme Court heard *Wendland*, four states had judicially-mandated standards that required clear and convincing evidence of a patient’s previously expressed wishes to have treatment withdrawn in circumstances

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<sup>63</sup> *See id.* at 402-03.

<sup>64</sup> *Id.* at 402. In *Martin*, Michael Martin’s level of functioning may have been greater than that of Robert Wendland, and there is some question as to the motives of his spouse. *See* Andrew J. Broder & Ronald E. Cranford, “Mary, Mary, Quite Contrary, How Was I to Know?” *Michael Martin, Absolute Prescience, and the Right to Die in Michigan*, 72 U. DET. MERCY L. REV. 787 (1995) (describing Michael as “conscious but unable to communicate, except through head nods, and even then not in a consistent, meaningful manner;” and noting that “Mary consulted with nurses, doctors, lawyers, clergy and a bioethics committee regarding the withdrawal of Michael’s artificial means of life-support. Through those consultations, Mary sought to address all medical, ethical, religious, and legal aspects of the decision to withdraw life-sustaining medical treatment from Michael”). *Cf.* John H. Hess, *Looking for Traction on the Slippery Slope: A Discussion of the Michael Martin Case*, 11 ISSUES L. & MED. 105 (1995) (reporting that Michael’s abilities included smiling frequently, indicating his desire to participate in therapy, using a communication device until Mary transferred him to a different facility and enjoying recreational activities; describing Mary’s attempts to keep information from other family members; and citing others claims that she engaged in extramarital relationships even at the time of the court proceedings, that she had financial motives and that she was biased against persons with disabilities).

<sup>65</sup> *Martin*, 538 N.W.2d at 405.

<sup>66</sup> *See id.* at 407. The court accepted the notion that the right to refuse treatment could survive incompetency and be asserted on a person’s behalf, but allowed only a purely subjective standard. *Id.* at 407-08.

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similar to what the patient was then experiencing.<sup>67</sup> The United States Supreme Court allowed but did not require that standard in order to satisfy constitutional requirements.<sup>68</sup>

*C. California and the UHCDA*

Legislatures have responded to confusion in the courts by enacting legislation regulating advance directives, health care powers of attorney and surrogate decision making.<sup>69</sup> Every state has enacted either a health care power of attorney statute or a living will statute.<sup>70</sup> Thirty-five states have enacted surrogate decision-making statutes of varying degrees of comprehensiveness.<sup>71</sup> California enacted the HCDA in 1999.<sup>72</sup>

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<sup>67</sup> See *supra* Part I.B (discussing the cases from those four states).

<sup>68</sup> *Cruzan*, 497 U.S. 261 (1990). Justice Scalia raised the issue of treatment termination as a deliberate means to end life, stating that refusal of medical treatment is equivalent to suicide. *Id.* at 293-99 (Scalia, J., concurring). The Court rejected that position in 1997. See *Vacco v. Quill*, 521 U.S. 793 (1997). In *Vacco*, physicians challenged the constitutionality of New York statutes criminalizing the act of aiding a person to commit or attempt to commit suicide, on the basis that it violated the Equal Protection Clause of the Constitution. *Id.* at 798. They argued that since patients on life-sustaining treatment could request its discontinuance, knowing it would lead to their death, then patients who were not on life-sustaining treatments were thus treated differently. *Id.* Justice Scalia joined without comment in the majority opinion that rejected this argument, despite his comment to the contrary in *Cruzan*, 497 U.S. at 293-99 (Scalia, J., concurring) (equating decisions to refuse treatment with suicide).

<sup>69</sup> See generally Mark Stephen Bishop, Note, *Crossing the Decisional Abyss: An Evaluation of Surrogate Decision-Making Statutes as a Means of Bridging the Gap Between Post-Quinlan Red Tape and the Realization of an Incompetent Patient's Right to Refuse Life-Sustaining Medical Treatment*, 7 ELDER L.J. 153, 155 (1999) (reviewing various legislative enactments regulating health care decisions).

<sup>70</sup> *Id.* at 155 n.4 (citing American Bar Association Commission on Legal Problems of the Elderly).

<sup>71</sup> *Id.* at 155-56, 168-78 (comparing surrogate statutes from Illinois, New Mexico and Ohio, as representative of the various types).

<sup>72</sup> 1999 Cal. Stat. 658 § 12.

*1. The UHCDA*

The UHCDA was drafted and approved by the National Conference of Commissioners on Uniform State Laws in 1993 and was approved by the American Bar Association in 1994.<sup>73</sup> The purpose of the Act was to achieve more uniformity in decision making from state to state, but it has had limited success due to the number of states that had previously enacted statutes.<sup>74</sup> The UHCDA has been adopted in some form by six states, including California.<sup>75</sup> All of the states other than California that have adopted the UHCDA include “comprehensive provisions” based on the UHCDA for decision making by surrogates.<sup>76</sup>

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<sup>73</sup> UHCDA, *supra* note 6.

<sup>74</sup> David M. English, Note, *The Uniform Health Care Decisions Act and its Progress in the States*, 15 A.B.A. PROB. & PROP. 19-20 (2001) (reviewing the utilization of the UHCDA by states).

<sup>75</sup> *Id.* at 20. The other states are Delaware, Hawaii, Maine, Mississippi, and New Mexico. *Id.* Delaware restricts those eligible to use advance directives to patients who are terminally ill or permanently unconscious, and both Delaware and Maine restrict withdrawal or withholding of life-sustaining treatment decisions by surrogates to patients who are terminally ill or permanently unconscious. *Id.* at 20-21. Hawaii prohibits the withdrawing or withholding of artificial nutrition and hydration by a surrogate unless two physicians certify that the treatment is “merely prolonging the act of dying and that the patient is unlikely to have any neurological response.” *Id.* at 21.

<sup>76</sup> *Id.* at 20. Delaware provides a list from which a surrogate shall be chosen, in descending order of priority: spouse (with some exceptions), adult child, parent, adult sibling or adult grandchild. 16 DEL. CODE ANN. tit. 16, § 2507 (2001). Hawaii requires a consensus among potential surrogates as to who will serve as surrogate, in the absence of which they may seek appointment as guardian. HAW. REV. STAT. § 327E-5 (2002). Maine provides a list similar to Delaware except that the list includes “an adult who shares an emotional, physical and financial relationship with the patient similar to that of a spouse” after spouse in priority, and adds at the end of the list adult nieces or nephews, adult aunts or uncles, and “another adult relative of the patient, related by blood or adoption, who is familiar with the patient’s personal values and is reasonably available for consultation.” ME. REV. STAT. ANN. tit. 18-A, § 5-805 (West 2001). Mississippi also provides a list of surrogates similar to Delaware but without grandchildren. MISS. CODE ANN. § 41-41-211 (2001). New Mexico also provides a list of surrogates similar to Delaware, except but New Mexico also provides for significant others after spouses, and substitutes

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## 2. California's Adoption of the UHCDA

Prior to adopting a version of the UHCDA, California provided no formal rules for making decisions regarding medical treatment of incapacitated individuals.<sup>77</sup> California adopted the Act to create uniform rules and standards for medical decision making for incapacitated persons so the same rules apply regardless of how the decision maker was chosen.<sup>78</sup> California's law does not include the UHCDA's hierarchical ordering of family members for surrogate decision making when incapacitated patients have not named a health care proxy or surrogate, but does specify that domestic partners have the same rights as spouses to make medical decisions.<sup>79</sup> California included provisions allowing for oral advance directives and oral appointment of surrogates, unlike some other states that have

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grandparents for adult grandchildren. N.M. STAT. ANN. § 24-7A-5 (Michie 2002).

<sup>77</sup> *Senate Rules Committee Hearing on A.B. 891, supra* note 13.

<sup>78</sup> *Id.* According to the California Law Commission, the impetus for the law was a series of cases in which decisions had been made for patients by providers either using or disregarding guidance from surrogates or family members. *Health Care Decisions Act: Hearing on A.B. 891 Before the Senate Judiciary Comm.*, 1999-2000 Reg. Sess. (Cal. 1999) (hereinafter *Senate Judiciary Comm. Hearing on A.B. 891*). The cited cases included *Duarte v. Chino Comm. Hosp.*, 85 Cal. Rptr. 2d 521 (Ct. App. 1999) (holding that since health care providers are immune from damages from failure to comply with advance directives they are therefore also immune when there is no directive); *Barber v. Superior Court*, 195 Cal. Rptr. 484 (Ct. App. 1983) (finding that failure to provide medical treatment when the patient has no chance of recovery is not an unlawful failure to perform a legal duty); and *Cobbs v. Grant*, 502 P.2d 1 (Cal. 1972) (finding that physicians have a duty of reasonable disclosure of available choices of medical therapies and the dangers both potential to as well as inherent in each choice, i.e., a duty of informed consent). The rules were intended to apply equally whether the surrogate is a family member or friend, a surrogate named in an advance directive, a public guardian, or a court "making health care decisions as a last resort." *Senate Judiciary Comm. Hearing on A.B. 891, supra*.

<sup>79</sup> CAL. PROB. CODE § 4716(a) (Deering 2001). See UHCDA § 5, *supra* note 6, at 167-68.

adopted the UHCDA.<sup>80</sup> California also limited oral designation of a surrogate to the course of treatment, illness or other health care institution stay during which the designation was made.<sup>81</sup>

### 3. California Probate Code Section 2355

California adopted the HCDA in 1999, four months after the appellate court filed its decision in *Wendland* and before the California Supreme Court heard the case.<sup>82</sup> The HCDA amended section 2355 of the California Probate Code, governing decisions by conservators.<sup>83</sup>

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<sup>80</sup> Delaware omitted the provision recognizing oral instructions, and both Maine and New Mexico provided additional safeguards. See English, *supra* note 74, at 20.

<sup>81</sup> *Id.* at 23. The act was subsequently amended to limit the authority of orally appointed surrogates to “the course of treatment or illness or during the stay in the health care institution when the surrogate decision is made, or for 60 days, whichever period is shorter.” CAL. PROB. CODE § 4711(b) (West 2003).

<sup>82</sup> 1999 Cal. Stat. 658 § 12. The HCDA became effective July 1, 2000; the appellate court had filed its decision on February 24, 2000. *Wendland*, 93 Cal. Rptr. 2d 550 (Ct. App. 2000).

<sup>83</sup> CAL. PROB. CODE § 2355 (Deering 2001). From the time of its enactment in 1979 to the effective date of its amendment in 2000, section 2355(a) provided:

If the conservatee has been adjudicated to lack the capacity to give informed consent for medical treatment, the conservator has the exclusive authority to give consent for such medical treatment to be performed on the conservatee as the conservator in good faith based on medical advice determines to be necessary and the conservator may require the conservatee to receive such medical treatment, whether or not the conservatee objects.

CAL. PROB. CODE, § 2355(a) (West 1998) (amended 1999), *quoted in Wendland*, 28 P.3d at 163. After amendment, section 2355 provided:

If the conservatee has been adjudicated to lack the capacity to *make health care decisions*, the conservator has the exclusive authority to *make health care decisions for the conservatee* that the conservator in good faith based on medical advice determines to be necessary. *The conservator shall make health care decisions for the conservatee in accordance with the conservatee’s individual health care instructions, if any, and other wishes to the extent known to the conservator.*

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*a. Section 2355 Prior to the HCDA*

Prior to its amendment, section 2355 included no language regarding the applicability of informal statements made by the conservatee while competent.<sup>84</sup> In *In re Drabick*,<sup>85</sup> the California Court of Appeal accepted that the former section 2355 allowed a conservator to withhold artificial nutrition and hydration from a patient in PVS and interpreted section 2355 as restricting the role of courts in supervising conservators' treatment decisions.<sup>86</sup> The *Drabick* court also accepted that the conservator would be bound by the conservatee's formal health care directions, but rejected the idea that a conservator would be bound to honor prior informal statements regarding continuation or cessation of treatment.<sup>87</sup> Finally, the *Drabick* court concluded that the decision would be based on the conservator's assessment of the conservatee's best interests, while considering the conservatee's prior statements as relevant and worthy of consideration in good faith.<sup>88</sup>

Thus, as originally enacted, section 2355 provided that a conservator must follow the dictates of an advance directive, but made no provision for utilization of informal statements as to the patient's wishes. After *Drabick*, conservators could utilize informal statements in determining a patient's best interests but were not required to do so.

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*Otherwise, the conservator shall make the decision in accordance with the conservator's determination of the conservatee's best interest. In determining the conservatee's best interest, the conservator shall consider the conservatee's personal values to the extent known to the conservator. The conservator may require the conservatee to receive the health care, whether or not the conservatee objects.*

CAL. PROB. CODE § 2355(a) (Deering 2001) (altered provisions italicized).

<sup>84</sup> CAL. PROB. CODE § 2355(a) (Deering 2001); CAL. PROB. CODE § 2355(a) (West 1998) (amended 1999); *see supra* note 83 (quoting the older and amended provision).

<sup>85</sup> 245 Cal. Rptr. 840 (Ct. App. 1988).

<sup>86</sup> *Id.* at 857-58.

<sup>87</sup> *Id.* at 856.

<sup>88</sup> *Id.* at 857.

*b. Section 2355 After Amendment*

After its amendment, section 2355 made both formal and informal statements of the conservatee binding on the conservator to the extent that they are known.<sup>89</sup> It codified the provision of the UHCDA that required the conservatee's personal values to be considered in determining his best interests when his wishes are unknown.<sup>90</sup> The new version of section 2355, therefore, provides for decisional standards that utilize to the degree possible the knowledge the conservator has about the wishes and values of the conservatee.<sup>91</sup>

Whereas the old section 2355 recognized only written advance directives, the amended version gives effect to oral directives as well.<sup>92</sup> Lastly, the California Law Commission stated that the burden of proof for the determination of the conservatee's wishes or best interests under section 2355 is met by a preponderance of the evidence.<sup>93</sup>

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<sup>89</sup> CAL. PROB. CODE § 2355(a) (Deering 2001).

<sup>90</sup> *Id.*; see also UHCDA, *supra* note 6.

<sup>91</sup> CAL. PROB. CODE § 2355(a) (Deering 2001). The amended version adds a "substituted judgment" provision that not only shall the conservator "make health care decisions for the conservatee in accordance with the conservatee's individual health care instructions, if any" but shall also use "other wishes to the extent known to the conservator." *Id.*

<sup>92</sup> Compare CAL. PROB. CODE § 2355(a) (Deering 2001) with CAL. PROB. CODE § 2355(a) (West 1998) (amended 1999); see *supra* note 83 (quoting both provisions). The apparent purpose of this change is to honor the wishes of an individual who has not executed a written advance directive. *Id.*

<sup>93</sup> *Wendland*, 28 P.3d at 166.

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II. IN RE WENDLAND<sup>94</sup>A. *Facts and Procedural History*

Robert Wendland was an auto parts salesman from Stockton, California.<sup>95</sup> He developed a drinking problem after the death of his father-in-law, who had been maintained on a ventilator while dying from gangrene.<sup>96</sup> While watching his father-in-law in that condition, Robert told his wife, Rose, “I would never want to live like that, and I wouldn’t want my children to see me like that, and look at the hurt you’re going through as an adult seeing your father like that.”<sup>97</sup> Robert told Rose that her father “wouldn’t want to live like a vegetable” and “wouldn’t want to live in a comatose state.”<sup>98</sup>

Both Rose and Robert’s brother, Michael, became concerned about Robert’s safety because of his drinking.<sup>99</sup> Michael told him, “I’m going to get a call from Rosie one day, and you’re going to be in a terrible accident.”<sup>100</sup> Upon Michael’s warning that he would end up laying in bed “just like a vegetable,” Robert responded, “Mike, whatever you do[,] don’t let that happen. Don’t let them do that to me.”<sup>101</sup> According to one of his children, Robert said during that conversation that “if he could not be a provider for his family, if he could not do all the things

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<sup>94</sup> This comment will follow the convention used by the *Wendland* courts, referring to the members of the Wendland family by their first names. *See* 93 Cal. Rptr. 2d 550 (Ct. App. 2000); *see also* 28 P.3d 151. The purpose of this convention for this comment is to be consistent with the convention in the *Wendland* cases, to distinguish one family member from another, and to distinguish references to the court’s opinion from references to the individuals involved.

<sup>95</sup> Harriet Chiang, *Right-to-Die Case Loses in State Court; Feeding Can’t Halted [sic] if Patient is Conscious*, S. F. CHRON. Aug. 10, 2001 at A1.

<sup>96</sup> *Wendland*, 28 P.3d at 157.

<sup>97</sup> *Id.*

<sup>98</sup> *Id.*

<sup>99</sup> *Id.*

<sup>100</sup> *Id.*

<sup>101</sup> *Id.*

that he enjoyed doing, just enjoying the outdoors, just basic things, feeding himself, talking, communicating, if he could not do those things, he would not want to live.”<sup>102</sup> Rose testified that Robert “made clear” to her that under no circumstances would he want to live if he had to have diapers, if he had to have life support, if he had to be kept alive with a feeding tube or if he could not be a “husband, father, provider.”<sup>103</sup>

Robert was severely injured in an automobile accident in September 1993, as a result of his driving while intoxicated.<sup>104</sup> He remained in a coma for sixteen months.<sup>105</sup> Although he eventually regained consciousness, he was left both mentally and physically disabled.<sup>106</sup>

Prior to regaining consciousness, Robert received fluid and nutrition through a surgically-placed feeding tube inserted into his small intestine.<sup>107</sup> He first began to show signs of

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<sup>102</sup> *Id.*

<sup>103</sup> *In re Wendland*, 93 Cal. Rptr. 2d 550, 557-58 (Ct. App. 2000).

<sup>104</sup> *Wendland*, 28 P.3d at 154.

<sup>105</sup> *Wendland*, 93 Cal. Rptr. 2d at 554. Coma is “a state of profound unconsciousness from which one cannot be roused.” *STEDMAN’S MEDICAL DICTIONARY* 385 (27th ed. 2000); *see also* *PRINCIPLES OF NEUROLOGY*, *supra* note 46, at 346-47 (defining coma and PVS). While Robert was in a coma, Rose visited him daily, sometimes with their children. *Wendland*, 28 P.3d at 154.

<sup>106</sup> According to a medical report submitted to the court, Robert had the following medical conditions:

[S]evere cognitive impairment that is not possible to fully appreciate due to the concurrent motor and communication impairments . . . ; maladaptive behavior characterized by agitation, aggressiveness and non-compliance; severe paralysis on the right and moderate paralysis on the left; severely impaired communication without compensatory augmentative communication system; severe swallowing dysfunction, dependent upon non-oral enteric tube feeding for nutrition and hydration; incontinence of bowel and bladder; moderate spasticity; mild to moderate contractures; general dysphoria; recurrent medical illnesses, including pneumonia, bladder infections, sinusitis; and dental issues.

*Wendland*, 28 P.3d at 155.

<sup>107</sup> *Wendland*, 93 Cal. Rptr. 2d at 554-55.

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responsiveness in late 1994 and early 1995.<sup>108</sup> Between January and July of 1995, Robert's feeding tube dislodged four times.<sup>109</sup> Rose authorized surgical replacement of the tube the first three times but refused the fourth.<sup>110</sup> Dr. Kass, Robert's physician, inserted a nasogastric feeding tube while awaiting review of the situation by the hospital ethics committee.<sup>111</sup> The hospital ethics committee stated no objection to the removal of the feeding tube, and both Dr. Kass and the county patient ombudsman supported the decision.<sup>112</sup> Robert's estranged mother, Florence, and sister were not consulted, however, and filed for a temporary restraining order to block removal of the feeding tube after learning of the decision.<sup>113</sup> Rose then petitioned to be appointed as Robert's conservator and asked the court to confirm her authority to withhold nutrition and hydration.<sup>114</sup>

The court appointed Rose as conservator but delayed deciding whether to authorize her to have the feeding tube removed and ordered her to continue the current course of therapy for sixty days.<sup>115</sup> Sixty days elapsed with no change in Robert's condition, and Rose again asked the court for authority to remove the feeding tube.<sup>116</sup> Florence asked the court to appoint independent counsel for Robert, but the trial court declined and the appellate court denied her petition for writ of mandate.<sup>117</sup> The California

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<sup>108</sup> *Wendland*, 28 P.3d at 154 (citing the medical report submitted to the court, but not specifying what signs of responsiveness were noticed).

<sup>109</sup> *Wendland*, 93 Cal. Rptr. 2d at 555.

<sup>110</sup> *Id.*

<sup>111</sup> *Id.*

<sup>112</sup> *Id.*

<sup>113</sup> *Wendland*, 28 P.3d at 155. See Lawrence J. Nelson & Ronald E. Cranford, *Michael Martin and Robert Wendland: Beyond the Vegetative State*, 15 J. CONTEMP. HEALTH L. & POL'Y 427, 435 (1999) (describing Robert Wendland's relationship with his mother and sister). Florence learned of the plan via an anonymous phone call. *Wendland*, 93 Cal. Rptr. 2d at 555.

<sup>114</sup> *Wendland*, 28 P.3d at 155.

<sup>115</sup> *Id.*

<sup>116</sup> *Id.*

<sup>117</sup> *Id.* A writ of mandate is "an order from an appellate court directing a lower court to take a specified action." BLACK'S LAW DICTIONARY 973 (7th ed. 1999).

Supreme Court ultimately granted review and transferred the case to the appellate court, which directed the trial court to appoint counsel for Robert; his counsel subsequently supported Rose's decision.<sup>118</sup>

Despite support for Rose's decision by his counsel, his physician and the ethics committee, the trial court found that Robert's statements to his wife and brother while he was competent were not enough to show by clear and convincing evidence that he would have wanted to die if he were minimally conscious.<sup>119</sup> The trial court held that a conservator could withhold artificial nutrition and hydration from a minimally conscious conservatee if shown by clear and convincing evidence to be in the conservatee's best interest, considering any wishes the conservatee may have previously expressed.<sup>120</sup> The court found that Rose had not met her burden.<sup>121</sup> Nonetheless, the court found that Rose had acted in good faith and allowed her to continue as conservator, though she would not be permitted to withdraw nutrition and hydration.<sup>122</sup>

The appellate court reversed, upholding the lower court's burden of proof standard but finding that the trial court erred in substituting its own judgment as to Robert's best interest.<sup>123</sup> Applying *In re Drabick*,<sup>124</sup> the court noted that the conservator must make the final treatment decision "regardless of how much or how little information about the conservatee's preferences is available."<sup>125</sup> The appellate court then held that the trial court's sole role should have been to determine whether Rose had

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<sup>118</sup> *Wendland*, 28 P.3d at 155.

<sup>119</sup> *Id.* at 157; *see supra* text accompanying notes 97-103 (discussing Robert's statements).

<sup>120</sup> *See Wendland*, 28 P.3d at 156.

<sup>121</sup> *Id.* at 156-57.

<sup>122</sup> *Id.*

<sup>123</sup> *In re Wendland*, 93 Cal. Rptr. 2d 550, 579 (Ct. App. 2000).

<sup>124</sup> 245 Cal. Rptr. 840 (Ct. App. 1988).

<sup>125</sup> *Wendland*, 93 Cal. Rptr. 2d at 562 (quoting *Drabick*, 245 Cal. Rptr. at 857). The court did not explain why a clear and convincing standard was appropriate in this case; the California Supreme Court later noted that the usual standard is preponderance of the evidence. *Wendland*, 28 P.3d at 166.

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considered Robert's interests in good faith but remanded to permit Florence to present evidence rebutting Rose's case.<sup>126</sup> The California Supreme Court granted review of the decision.<sup>127</sup> Robert died of pneumonia in July 2001.<sup>128</sup> His death occurred after oral argument but prior to the issuance of an opinion.<sup>129</sup> The California Supreme Court retained the case for decision because it raised "important issues" that tend to "evade review" due to the health of those the cases typically concern.<sup>130</sup>

*B. The Wendland Opinion*

In *Wendland*, the California Supreme Court reaffirmed a fundamental right to refuse medical treatment but was clearly reluctant to authorize the exercise of that right through a third party.<sup>131</sup> The court held that a conservator may not withhold artificial nutrition and hydration from a minimally conscious patient in the absence of clear and convincing evidence either that the patient had previously expressed wishes to forgo such treatment or that doing so is in the patient's best interest.<sup>132</sup>

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<sup>126</sup> *Wendland*, 93 Cal. Rptr. 2d at 579-80.

<sup>127</sup> *Wendland*, 28 P.3d at 158.

<sup>128</sup> Chiang, *supra* note 95. It appears that Rose may have had the authority to refuse to authorize the provision of antibiotics to Robert, given her continued conservatorship, thus allowing him to die from bacterial pneumonia. *Wendland*, 28 P.3d at 157 (noting that Rose had been retained as conservator and that her authority to remove life sustaining medical treatment was restrained by the lower court in regard to withholding nutrition and hydration, without mention of other life sustaining treatments). No mention is made in any source, however, as to whether his pneumonia was viral or bacterial or whether he received antibiotics. Requests by the author for references to public sources for such information from attorneys in this case went unanswered.

<sup>129</sup> *Wendland*, 28 P.3d at 158.

<sup>130</sup> *Id.* at 151 n.1.

<sup>131</sup> *Id.* at 174. The court held that a conservator must prove, "by clear and convincing evidence, either that the conservatee wished to refuse life-sustaining treatment or that to withhold such treatment would have been in his best interest." *Id.*

<sup>132</sup> *Id.* at 175.

Throughout its decision, the court repeatedly characterized the issue as the intentional killing of the patient against his will.<sup>133</sup> This emphasis illustrates the court's disregard for the United States Supreme Court's explicit distinction between killing and allowing the patient to die.<sup>134</sup> Instead of framing the issue as a conflict between the fundamental interest in refusing medical treatment versus a fundamental interest in life, with the state's interest in protecting the individual's choice as operating on both sides of the conflict, the court pitted the decision to withdraw treatment against the state's interest in preserving life.<sup>135</sup>

After reviewing constitutional and common law issues, starting with the principle that a competent person may refuse even life-sustaining treatment,<sup>136</sup> the court noted that California's Constitution also protects against "obvious invasions of . . .

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<sup>133</sup> *Wendland*, 28 P.3d 151, *passim*. For example, the court uses such language as: "a conservator's proposal to end the life of a conscious conservatee," *id.* at 156; "the conservator has claimed the authority to end the conservatee's life," *id.* at 158; "the statute would be understood as authorizing a conservator to deliberately end the life of a conservatee," *id.* at 163; "conservators . . . contemplating a conscious conservatee's death," *id.* at 166; "permitting a conservator deliberately to end the life of a *conscious* conservatee," *id.* at 167; "[t]he ultimate decision is whether a conservatee lives or dies," *id.* at 169; "where a conservator proposes to end the life of a conscious but incompetent conservatee," *id.* at 174; "[t]he result would be to permit a conservator freely to end a conservatee's life," *id.*; and "medical decisions . . . intended to bring about the death of a conscious conservatee," *id.* at 175; *see also* Glenn Griener, *Stopping Futile Treatment and the Slide Toward Non-Voluntary Euthanasia*, 2 HEALTH L.J. 67 (1994) (arguing that courts use the same rationale for setting high evidentiary standards for withholding of treatment as they do for maintaining the prohibition against assisted suicide; i.e., to protect vulnerable persons); Adam J. Hildebrand, *Masked Intentions: The Masquerade of Killing Thoughts Used to Justify Dehydrating and Starving People in a "Persistent Vegetative State" and People with Other Profound Neurological Impairments*, 16 ISSUES L. & MED. 143 (2000) (arguing that all decisions to withdraw nutrition and hydration are based on the intention to kill).

<sup>134</sup> *See* *Vacco v. Quill*, 521 U.S. 793 (1997). None of the *Wendland* courts cited *Vacco*. *See* 28 P.3d 151; 93 Cal. Rptr. 2d. 550 (Ct. App 2000); *Wendland v. Superior Court*, 56 Cal. Rptr. 2d 595 (Ct. App. 1996).

<sup>135</sup> *Wendland*, 28 P.3d at 160, 163.

<sup>136</sup> *Id.* at 158.

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interests fundamental to personal autonomy.”<sup>137</sup> Following this, the court concluded that the decision of a competent adult to refuse life-sustaining treatment must be considered fundamental.<sup>138</sup> Furthermore, the court noted that federal law does not oppose a competent adult’s refusal of medical treatment.<sup>139</sup> Applying *Cruzan*,<sup>140</sup> the California court inferred a constitutionally protected liberty interest in refusing unwanted medical treatment, including the refusal of artificial nutrition and hydration.<sup>141</sup> Consequently, the right to refuse unwanted medical treatment may only be infringed if the state’s interest in preserving life outweighs the interest of the individual.<sup>142</sup>

Accepting that the right of a competent adult to refuse medical treatment would survive that adult’s incapacity, the court limited that survival to instances where it is “exercised while competent pursuant to a law giving that act lasting validity.”<sup>143</sup> Comparing California’s former Natural Death Act with its new HCDA, the court concluded that the new law “give[s] effect to the decision of a competent person, in the form either of instructions for health care or the designation of an agent or surrogate for health care decisions.”<sup>144</sup>

The court, however, distinguished decisions made through an advance directive from those made by court-appointed conservators.<sup>145</sup> Agreeing with the appellate court that the

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<sup>137</sup> *Id.* at 159 (quoting *Hill v. Nat’l Collegiate Athletic Ass’n*, 865 P.2d 633 (Cal. 1994)).

<sup>138</sup> *Id.*

<sup>139</sup> *Id.* at 159-60.

<sup>140</sup> *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261 (1990).

<sup>141</sup> *Id.* at 159; *see supra* Part I.B (discussing *Cruzan*, 497 U.S. 261).

<sup>142</sup> *Wendland*, 28 P.3d at 160.

<sup>143</sup> *Id.* *But see infra* note 241 (arguing that the court confused the issue of the survival of the right with the issue of the sufficiency of the means utilized to prove the patient’s prior wishes).

<sup>144</sup> *Wendland*, 28 P.3d at 161. *See* CAL. HEALTH & SAFETY CODE §§ 7185-7188, *repealed by* 1999 Cal. Stat. 658 (enacting the HCDA). The HCDA is California’s version of the UHCDA. 1999 Cal. Stat. 658 (codified as CAL. PROB. CODE §§ 4600-4805 ).

<sup>145</sup> *Wendland*, 28 P.3d at 162. *But see Health Care Decisions Act: Hearing on A.B. 891 Before the Assembly*, 1999-2000 Reg. Sess. (Cal. 1999)

exercise of a right through another is a “legal fiction,” the court reviewed the alternative basis for treatment choices for incompetent patients offered by the Court of Appeal.<sup>146</sup> That is, while most courts accept the idea that a patient’s right to choose or refuse medical treatment survives incompetence, what actually survives is the patient’s right to have appropriate medical decisions made for him by others in his own best interests.<sup>147</sup> *Wendland* took issue with this position, reasoning that any decision should reflect the conservatee’s own interests and values, that treatment refusal by a court-appointed conservator is not the equivalent of a conservatee’s refusal, and that any decision by a conservator does not necessarily take precedence over the conservatee’s right to life or the state’s interest in preserving life.<sup>148</sup>

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[hereinafter *Assembly Hearing on A.B. 891*] (concurring in Senate Amendments and describing one of the purposes of the Act as “establish[ing] a uniform standard of decision-making for adults without decision-making capacity so that the same rules apply whether the decisionmaker is an agent under a PAHC [power of attorney for health care], another surrogate appointed by the patient, a conservator or a court”). Here, the court closely examined the Court of Appeal’s decision in *Drabick*, 245 Cal. Rptr. 840 (Ct. App. 1988) (authorizing removal of a nasogastric feeding tube from a patient who was not terminally ill but who was in PVS) stating that the court had confused the two concepts. *Wendland*, 28 P.3d at 161. The court examined *In re Drabick* closely because the decision had played a prominent role in both the *Wendland* parties’ arguments and the revision of California Probate Code section 2355, the statute governing *Wendland*. *Id.* The Court of Appeal viewed *Drabick* as a conflict between the right of the conservatee to life and his right to terminate unwanted treatment, and that the choice of those rights was to be vicariously exercised through the conservator. *Id.* at 162. Advance directives are statements, either oral or in writing, in which an individual expresses his wishes in advance as to what kinds of treatments he would or would not like to receive and the circumstances in which he wants those wishes honored. Thaddeus Mason Pope, *The Maladaptation of Miranda to Advance Directives: A Critique of the Implementation of the Patient Self-Determination Act*, 9 HEALTH MATRIX 139, 149 (1999). See *infra* Part III.B (discussing advance directives).

<sup>146</sup> *Wendland*, 28 P.3d at 162-63.

<sup>147</sup> *Id.*

<sup>148</sup> *Id.* at 163. In essence, without so stating, the court rejected the “best interests” standard. See *infra* note 232 and accompanying text. The court then

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The court next turned its attention to California Probate Code section 2355 and noted that the Law Review Commission explicitly incorporated some of *Drabick's* construction of the former statute into the new statute.<sup>149</sup> It compared the language of the former section 2355 with the new language of amended section 2355.<sup>150</sup> The court construed the new language as making informally expressed wishes dispositive rather than merely a factor to be considered.<sup>151</sup> Accepting that the revised section 2355 could be construed as allowing a competent person to use an advance directive to direct all aspects of his or her future health care, not just the withdrawal of life support when the patient is terminally-ill, the court additionally determined that such wishes would be a constitutional basis for withdrawal or withholding of treatment since they would be based on the patient's own wishes.<sup>152</sup>

Nonetheless, the court contrasted decisions made based on statements in an advance directive with decisions made by a conservator, since the conservator is not appointed by the conservatee and cannot be presumed to have special knowledge of the conservatee's wishes.<sup>153</sup> The court briefly noted that the

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pointed out that while no subsequent decision has rejected *Drabick's* reasoning, neither had any court extended that reasoning to any conservatee who was not in PVS, and *Drabick* itself limited its decision to patients "for whom there is no reasonable hope of a return to cognitive life." *Id.* (quoting *Drabick*, 245 Cal. Rptr. 840, 861 n.36 (Ct. App. 1988)). But see *In re Grant*, 747 P.2d 445 (Wash. 1987) cited in *In re Wendland*, 93 Cal. Rptr. 2d 550, 566 (Ct. App. 2000), a case in which the court allowed the withdrawal of artificial nutrition and hydration from a patient who had never been competent and who was not comatose or in PVS but who was terminally ill.

<sup>149</sup> *Wendland*, 28 P.3d at 163. The court characterized *Drabick's* conclusion as holding that "incompetent persons have a right . . . to appropriate medical decisions that reflect their own interests and values." *Id.*

<sup>150</sup> *Id.* at 164. See *supra* note 83 (quoting the former and amended versions of section 2355).

<sup>151</sup> *Wendland*, 28 P.3d at 165. *Drabick* utilized the latter approach, using informally expressed wishes as merely a factor for consideration. 245 Cal. Rptr. 840, 857 (1988).

<sup>152</sup> *Wendland*, 28 P.3d at 160, 168.

<sup>153</sup> *Id.*

law gives preference to spouses and other relations who might have knowledge of the person's wishes but focused on the fact that not all conservators have knowledge of those wishes.<sup>154</sup> Regarding the standard of proof, the court agreed that the default standard in civil cases is the preponderance of the evidence, the same standard cited by the Law Review Commission's explanatory comments.<sup>155</sup> The court, however, found such comments merely persuasive, as opposed to determinative, evidence of the intent of the legislature.<sup>156</sup>

Whereas the United States Supreme Court held only that it was constitutionally *permissible* under the United States Constitution for a state to require clear and convincing evidence of an incompetent's wishes,<sup>157</sup> the California Supreme Court leapt forward and said that it would be unconstitutional under the California Constitution not to *require* clear and convincing evidence in the case of a minimally conscious patient.<sup>158</sup> The

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<sup>154</sup> *Id.* By doing so, the court dismissed the stated intent of the legislature in the HCDA to set a uniform standard for decisions by all surrogates, regardless of the means by which they came to be the decision makers. *Assembly Hearing on A.B. 891, supra* note 145, at Summary § 5.

<sup>155</sup> *Wendland*, 28 P.3d at 166, 169.

<sup>156</sup> *Id.* The court based its dismissal of such intent on lack of evidence that the legislature had read every statement in its 280 page report. *Id.* at 166. But, the explanatory comments merely pointed out that the standard is always the preponderance of the evidence in the absence of specification otherwise; the court does not explain why the legislature would not have known that and would have assumed instead that the clear and convincing standard would apply. *See generally id.*

<sup>157</sup> *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

<sup>158</sup> *Wendland*, 28 P.3d at 170. The court resisted Florence's argument that section 2355 was unconstitutional on its face if read to permit a conservator to "end the life" of a conscious conservatee using only the low preponderance of the evidence standard. *Id.* at 166. Florence's argument was based on Article I, Section 1 of the California Constitution. *See generally id.* Instead, the court construed the statute as requiring clear and convincing evidence to "minimize the possibility of its unconstitutional application" and supported the clear and convincing standard when necessary to protect important rights. *Id.* The court explained that its construction "does not entail a deviation from the language of the statute." *Id.* While the language of the statute remains intact, however, the court has made the best interests standard impossible to apply. *See infra*

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court rejected Rose's argument that her decision did not entail state action and, therefore, did not implicate any constitutional rights.<sup>159</sup> Noting that the state constitutional right of privacy protects against private conduct, the court compared decisions to withdraw life support with issues such as homicide, mercy killing, assisted suicide and euthanasia.<sup>160</sup> Furthermore, the court stated that the issue involved was whether a conservatee lives or dies, and the risk involved is that the conservatee would be subjected to starvation, dehydration and death against the conservatee's wishes, the consequences of which a conscious conservatee would perceive.<sup>161</sup>

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Part III.C.2 (discussing this issue). The court stated that it had previously found that such important rights included the right to reproduce, parental rights, the discipline of judges, the appointment of a conservator to provide for a person's personal needs and involuntary electroconvulsive therapy. *Wendland*, 28 P.3d at 169. Additionally, the court listed fundamental liberty interests recognized by the U.S. Supreme Court, which requires a clear and convincing standard for termination of parental rights, commitment to a mental hospital and deportation. *Id.* According to the court, the standard to be used depends on the "gravity of the consequences that would result from an erroneous determination of the issue involved." *Id.* (quoting *Weiner v. Fleischman*, 816 P.2d 892, 898 (Cal. 1991)).

<sup>159</sup> *Wendland*, 28 P.3d at 165 n.10.

<sup>160</sup> *Id.*

<sup>161</sup> *Id.* at 169. While the court accepted the possibility that a conservatee might perceive unwanted efforts to keep him alive as an "unwanted intrusion," it distinguished the two problems by stating that the decision to treat was reversible, but the decision to withdraw is not. *Id.* at 169-70. Technically, this is not true in the case of withdrawal of nutrition and hydration since death would not immediately follow; however, there would most likely be a narrow window in which to reverse the decision. In addition, while the decision to treat is reversible, the unwanted treatment received before treatment termination could not be reversed. See *Nelson & Cranford*, *supra* note 113, at 446-49. The court supported its position with a review of cases from other states that are consistent with its opinion, including *In re Martin*, 538 N.W. 2d 399 (Mich. 1995) (requiring the clear and convincing evidence standard for withdrawal of artificial nutrition and hydration from a minimally conscious patient); see *supra* notes 62-66 and accompanying text (discussing the case), and *Conroy*, 486 A.2d 1209; see *supra* Part I.B (discussing the case). *Wendland*, 28 P.3d at 170-172. The court also noted that Wisconsin has refused to extend its earlier decisions giving conservators of patients in PVS

After addressing the “primary” substituted judgment standard in section 2355, the court turned to the alternative “best interest” standard.<sup>162</sup> This standard requires that a decision be made “in accordance with the conservator’s determination of the conservatee’s best interest . . . consider[ing] the conservatee’s personal values to the extent known to the conservator.”<sup>163</sup> The decision must be made in good faith based on medical advice.<sup>164</sup> Rose argued that the trial court had applied too high a standard of proof, in that section 2355 gave the court the power only to verify that she has made a good faith decision based on medical advice and in consideration of the conservatee’s personal values.<sup>165</sup> The court rejected that argument.<sup>166</sup>

In its holding and throughout the decision, the court was careful to refer to the issue as that of decisions by conservators to refuse life-sustaining treatment for conservatees.<sup>167</sup> Given the court’s attention to the issue of whether court-appointed conservators could be assumed to have special knowledge of the personal beliefs and values of the conservators, one could conceivably interpret *Wendland* as applying only to conservators and not to other surrogates’ decisions.<sup>168</sup> This interpretation is

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the power, as a matter of law, to withhold life-sustaining treatments. *Wendland*, 28 P.3d at 171 (discussing *In Re Edna M.F.*, 563 N.W.2d 485 (Wis. 1997) (finding that a woman with Alzheimer’s dementia, who had previously stated she would rather die from cancer than lose her mind, had not made a sufficiently clear statement of a desire to refuse treatment)). But, the *Wendland* court acknowledged that the Wisconsin court had only required a preponderance of the evidence standard. *Id.* But see Kathleen M. Boozang, *An Intimate Passing: Restoring the Role of Family and Religion in Dying*, 58 U. PITT. L. REV. 549, 577-78 (1997) (noting other courts that have rejected or altered the clear and convincing standard for medical decisions).

<sup>162</sup> *Wendland*, 28 P.3d at 173-74.

<sup>163</sup> *Id.*

<sup>164</sup> *Id.*

<sup>165</sup> *Id.* at 174.

<sup>166</sup> *Id.* The court rejected Rose’s position despite her recitation of the language of the section and the Law Revision Commission commentary supporting her position. *Id.*

<sup>167</sup> *Wendland*, 28 P.3d 151 *passim*.

<sup>168</sup> *Id.* Other surrogates could be those family members making medical

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unlikely to be accurate, however; while the court specified that the decision applied only to “conscious conservatees who have not left formal directions for health care and whose conservators propose to withhold life-sustaining treatment for the purpose of causing their conservatees’ deaths,” the court then proceeded to list those who would not be affected.<sup>169</sup> The list failed to include patients with nonappointed surrogates.<sup>170</sup> The list also failed to include the terminally ill.<sup>171</sup> Given the above and the rarity of patients’ use of advance directives and oral appointment of surrogates, *Wendland* will reach a vast number of medical decisions and will have a profound effect on health care decisions in California.<sup>172</sup>

## III. THESIS

There are four problematic issues with the court’s decision. First, the *Wendland* court underestimated the sweeping effects of its decision, which will affect a much greater number of patients

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decisions for the patient without formal appointment. *See* CAL. PROB. CODE § 4714 (Deering 2001) (providing standards for surrogate decision makers, including those “acting as a surrogate”); CAL. PROB. CODE § 4716 (Deering 2001) (allowing domestic partners the “same authority as a spouse . . . to make a health care decision for his or her incapacitated spouse”).

<sup>169</sup> *Wendland*, 28 P.3d at 175.

Our conclusion does not affect permanently unconscious patients, including those who are comatose or [in PVS] . . . , persons who have left legally cognizable instructions for health care . . . , persons who have designated agents or other surrogates for health care . . . , or conservatees for whom conservators have made medical decisions other than those intended to bring about the death of a conscious conservatee.

*Id.*

<sup>170</sup> *Id.*

<sup>171</sup> *Id.*

<sup>172</sup> *See* discussion *infra* Part III (arguing that the combination of a greater number of affected patients than the *Wendland* court apparently realized, the rarity of advance provisions by patients for health care decisions and the contrast between the *Wendland* standard and the understanding of most patients will lead to a major change in the way health care decisions are made in California).

than the court acknowledged.<sup>173</sup> Second, the court's reliance on patient-provided directives to afford incompetent patients the care they would have chosen for themselves was misplaced.<sup>174</sup> Third, the court's understanding of the means by which patient autonomy is promoted is extraordinarily limited.<sup>175</sup> Fourth, as a result of the court's incorrect balancing of the interests involved, the court erroneously concluded that protecting patients' interests requires application of the clear and convincing evidence standard.<sup>176</sup>

The result of *Wendland* is that family members in California are proscribed from making many decisions for their loved ones when those loved ones did not have the requisite foresight or knowledge to appoint them as surrogates.<sup>177</sup> *Wendland* essentially

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<sup>173</sup> See *infra* Part III.A (arguing that the court misperceived the frequency of the need for decisions for life-sustaining treatment for patients in a minimally conscious state).

<sup>174</sup> See *infra* Part III.B (noting the rarity of the execution of advance directives and appointment of surrogates).

<sup>175</sup> See *infra* Part III.C. Studies have shown that most people in this country prefer to have their families make medical decisions for them when they are incapacitated. The *Wendland* court, however, intervened and removed the decision making ability from the family out of the contradictory fear that the decision is not what the patient would have wanted. See generally *Wendland*, 28 P.3d 151. In doing so, the court failed to recognize its own conflict of interest. That is, the standard the court applies in the instant case must be designed to protect future patients, even if that results in a decision in the instant case that may not have been what the patient wanted.

<sup>176</sup> See *infra* Part III.D (arguing that the clear and convincing standard is not constitutionally required). See also Marybeth Herald, *Until Life Support Do Us Part: A Spouse's Limited Ability to Terminate Life Support for an Incompetent Spouse with No Hope of Recovery*, 24 T. JEFFERSON L. REV. 207, 212 (2002) (arguing that *Wendland* "places a nearly insurmountable burden of proof on the conservator of a person in a minimally conscious state" and that "[t]he [c]ourt's decision makes it virtually impossible to stop feeding and hydration when the family member has not made any written advance directive").

<sup>177</sup> *Wendland*, 28 P.3d 151. In addition to the insufficiency of the means on which the court relied to mitigate the adverse effects of the court's decision, there are other unintended effects that the court appears not to have anticipated. For example, a person appointed as conservator by the patient but who has only a professional relationship with the patient and/or who is a

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coerces patients to exercise their autonomy, a contradictory concept.<sup>178</sup>

To protect the rights of patients, the California legislature must now amend the HCDA. The amendments should clearly state that those closest to the patient are the appropriate decision makers, absent evidence to the contrary. In addition, the amendments must specify the procedural safeguards to be used, and must clearly identify “preponderance of the evidence” as the desired standard for decisions made in the face of such

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relative stranger to him, would be free under the court’s interpretation to withdraw or withhold treatment with little to no beneficial knowledge of the patient’s wishes or values. *See id.* Yet, ironically, family members with an intimate understanding of the patient would still be subject to the clear and convincing standard. *See id.* Lastly, the opinion’s reliance on the distinction between unconscious patients and those who are minimally conscious leaves the door open to terminate treatment while the patient is comatose. *See id.* at 175. A surrogate’s hesitation—most likely in hopes that the patient will awaken to a life of greater functioning—thus leads to the inability to honor a patient’s wishes once the surrogate becomes convinced it is time to do so. The unspoken, and likely unintended, message the court has thus sent to surrogates is that they should discontinue support for their unconscious family members as soon as a claim for “permanent” unconsciousness can be made, rather than risk them waking into what they believe the patient would consider to be an unacceptable state. In hindsight, Robert’s coma was not permanent; however, it is doubtful that a claim of permanent unconsciousness that was made after more than a full year would have been challenged. *See id.* at 154. The court’s opinion glossed over the fact that Rose had authorized treatment for Robert during the period in which he was not conscious. *Id.* In the California Supreme Court’s recitation of the facts, it referred to Robert’s coma as lasting only “several months.” *Id.* According to the appellate court, however, Robert was in a coma for sixteen months. *In re Wendland*, 93 Cal. Rptr. 550, 554 (Ct. App. 2000).

<sup>178</sup> Autonomy is the voluntary exercise of a personal choice. BEAUCHAMP & CHILDRESS, *supra* note 9, at 58. The choice of most adults is to have their family make whatever medical decisions they deem necessary on their behalf in the event of incapacity. *See infra* Part III.C.2. In addition, most adults resist executing advance directives. *See infra* Part III.C.2. *Wendland* severely restricts the choices available to decision makers that have not been appointed by the patient. *See generally Wendland*, 28 P.3d 151. In order to avoid such restriction under *Wendland*, potential patients will be forced to appoint a surrogate or execute an advance directive; as a result, the voluntary aspect of the choice is missing, and the choice is, therefore, coerced.

safeguards.

*A. Applicability of Wendland*

Despite the court's assurances that its decision affects only a "narrow class of persons" and not "the vast majority of health care decisions," *Wendland* will affect more individuals than the court anticipated.<sup>179</sup> *Wendland* will have a profound impact on decisions for the terminally-ill, those suffering from dementia but who are not considered terminally-ill, all adults who have never been competent and all minors. Given the low rate of execution of advance directives and the inability of many to utilize the options of oral directives and appointment of surrogates, it is reasonable to assume that surrogates other than those appointed by the patient will make the majority of the decisions in these cases and will be subject to *Wendland*'s constraints.<sup>180</sup>

Of the approximately six thousand deaths that occur daily in the United States, it is estimated that approximately seventy percent involve decisions to forgo life-sustaining treatment.<sup>181</sup> Many, if not the majority, of such cases involve terminally ill patients for whom, therefore, a different legal standard might logically apply.<sup>182</sup> Still, there would remain a significant number

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<sup>179</sup> *Wendland*, 28 P.3d at 166. "[W]e see no constitutional reason to apply the higher evidentiary standard to the majority of health care decisions made by conservators not contemplating a conscious conservatee's death." *Id.*

<sup>180</sup> See *infra* Part III.B (discussing the limited utilization of advance directives and oral appointment of surrogates).

<sup>181</sup> See Rebecca Dresser, *Missing Persons: Legal Perceptions of Incompetent Patients*, 46 RUTGERS L. REV. 609, 614 (1994) (citing estimates from the American Hospital Association, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, and other authors). The percentage may be as high as seventy-five percent. Steven Miles, *Personal Dying and Medical Death*, in BIRTH TO DEATH: SCIENCE AND BIOETHICS 163, 167 (David C. Thomasma & Thomasine Kushner eds., 1996)

<sup>182</sup> Cantor, *supra* note 11, at 184. The purpose of a higher standard is to avoid the risk of erroneous decisions. *Wendland*, 28 P.3d at 170. Terminally ill patients will die in a short time whether treatment is withheld or not; therefore, the risk of an erroneous decision is less and courts presumably

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of cases that would not involve terminally ill patients.<sup>183</sup> For example, patients with dementia often retain some level of cognitive functioning before they are deemed terminally ill, yet after questions of life-sustaining treatments arise.<sup>184</sup> In addition, given the rarity of PVS, it is reasonable to assume that the majority of such decisions involve patients who are at least minimally conscious.<sup>185</sup> As a result, the “narrow class” that *Wendland* affects in fact includes a significant number of

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would be willing to utilize a lower standard. It is not clear, however, that the court intended a different standard for those cases, since the court exempted “permanently unconscious patients, including those who are comatose or in a persistent vegetative state,” but did not exempt the terminally ill. *Id.* at 175.

<sup>183</sup> See *infra* notes 184-85.

<sup>184</sup> Dresser, *supra* note 181, at 614. Dementia may occur as a result of chronic conditions such as chronic liver or renal disease, Parkinsons disease or metabolic problems. NEUROLOGY FOR THE NON-NEUROLOGIST 233-41 (William J. Weiner & Christopher G. Goetz eds., 4th ed. 1999). Dementia as a result of AIDS, cerebrovascular injury and Alzheimer’s disease affects an increasing number of people, and the incidence is likely to increase with the aging of the population and the increasing ability of medical technology to prolong biologic life. See Dresser, *supra* note 181, at 614. The mean incidence of moderate to severe dementia in persons over the age of sixty in the U.S. has been calculated at 4.8 %. PRINCIPLES OF NEUROLOGY, *supra* note 46, at 1049. Alzheimer’s alone was the eighth leading cause of death in both 1998 and 1999, with 35,306 and 44,536 deaths per year, respectively. NAT’L CTR. FOR HEALTH STATISTICS, CTRS. FOR DISEASE CONTROL AND PREVENTION, 49 NAT’L VITAL STATISTICS REPORT NO. 11 (2001) [hereinafter NAT’L VITAL STATISTICS REPORT], available at [http://www.cdc.gov/nchs/data/nvsr/nvsr49/nvsr49\\_11.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr49/nvsr49_11.pdf). Alzheimer’s disease is progressively debilitating, leading to the gradual loss of cognitive ability and diminishing ability to care for one’s own needs, including feeding. PRINCIPLES OF NEUROLOGY, *supra* note 46, at 1050-51; see also NEUROLOGY FOR THE NON-NEUROLOGIST, *supra*, at 234-35. Decisions relating to the care of those in the later stages of Alzheimer’s alone warrant concern over the applicability of the court’s decision.

<sup>185</sup> See Cranford, *supra* note 2, at 196. It is estimated that there are approximately 15,000 to 35,000 patients in PVS in the United States. *Id.* Such patients may linger for many years. *Id.* It is estimated that there are approximately 2,190,000 deaths per year in the United States. Dresser, *supra* note 181, at 614. Therefore, even if all PVS patients were suddenly to die in the same year, it would still only represent .7 to .16 % of the deaths for that year.

individuals.

While the court's holding specifically referred to conservators and did not mention other surrogates, the reasoning of the court indicates that its holding applies to all surrogates making treatment refusals.<sup>186</sup> In addition, minors, who are not legally competent, and never-competent adults would always be subject to the heightened standard of "best interests," which the court declined to define.<sup>187</sup> As a result, such cases will be decided on an individual basis, despite the legislature's finding that courts are the decision-makers of last resort.<sup>188</sup>

*B. The Court's Attempt to Mitigate the Decision's Effect*

*Wendland's* reliance on patient-provided directives and appointment of surrogates is unjustified.<sup>189</sup> The *Wendland* court

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<sup>186</sup> *Wendland*, 28 P.3d at 175. The court rejected the argument that genuine treatment desires would be frustrated, basing the rejection on the availability of advance directives and oral appointment of surrogates; the court appears to assume that all decisions will either be made by conservators or surrogates appointed by the patient. *Id.* at 172. *But see infra* Part III.B (explaining that few adults have appointed surrogates or made advance directives).

<sup>187</sup> *Wendland*, 28 P.3d at 174. "We need not in this case attempt to define the extreme factual predicates that, if proved by clear and convincing evidence, might support a conservator's decision that withdrawing life support would be in the best interests of a conscious conservatee." *Id.*

<sup>188</sup> CAL. PROB. CODE § 4650 (Deering 2001).

(b) Modern medical technology has made possible the artificial prolongation of human life beyond natural limits. In the interest of protecting individual autonomy, this prolongation of the process of dying for a person for whom continued health care does not improve the prognosis for recovery may violate patient dignity and cause unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the person.

(c) In the absence of controversy, a court is normally not the proper forum in which to make health care decisions, including decisions regarding life-sustaining treatment.

*Id.* at § 4650(b)-(c).

<sup>189</sup> *See Wendland*, 28 P.3d at 172. In order for such reliance to be justified, there would have to be evidence that the vast majority of such

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focused heavily on written advance directives as a means for competent individuals to plan for their care in the event they become incapacitated.<sup>190</sup> Advance directives, also known as Living Wills, were proposed for just such purposes.<sup>191</sup> Nevertheless, only ten to twenty-five percent of adults in the United States have executed advance directives.<sup>192</sup> Despite legislative and academic support, aggressive programs to increase their use have failed.<sup>193</sup>

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decision are made for adults who were once competent, that competent adults are aware that they are available, are aware of the importance of executing them, are not resistant to executing them and do not assume that their families will be able to make whatever choices seem appropriate to them. *See infra* notes 192-95, 229-31 and accompanying text (arguing that such conditions do not exist).

<sup>190</sup> *Wendland*, 28 P.3d at 160-61. The court discussed advance directives extensively and dismissed the contention that a high evidentiary burden of proof would “frustrate many genuine treatment desires,” based on the availability of advance directives, including oral health care instructions. *Id.* at 172. *But see* Dresser, *supra* note 181, at 632 (noting the inevitable general nature of the instructions in advance directives and the failure of even aggressive programs to increase the use of advance directives). *See also* Patricia D. White, *Appointing a Proxy Under the Best of Circumstances*, 1992 UTAH L. REV. 849 (1992). White argues that

a living will is a very crude instrument to use for making actual medical decisions . . . . [A]ll it can express is what a competent person thought she would want were she to become incompetent and be in a situation generically like the one she turns out actually to be in . . . . [I]t is a mistake to conceive of an advance directive as expressing an incompetent patient’s autonomous choice in any specific circumstance.

*Id.* at 857.

<sup>191</sup> *See* Orentlicher, *supra* note 9, at 1256.

<sup>192</sup> Pope, *supra* note 145, at 154. Some studies show that the percentage may be as low as five. *See* Orentlicher, *supra* note 9, at 1270. Even health care professionals tend not to complete advance directives. *Id.* at 1273. In addition, African-American patients are more likely to fear that executing an advance directive will adversely affect their care. Orentlicher, *supra* note 9, at 1276.

<sup>193</sup> *See, e.g.*, The SUPPORT Principal Investigators, *A Controlled Trial to Improve Care in Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments*,

Even when executed, advance directives often fail to provide clear guidance; they are often vague and do not address the specific circumstances of the patient.<sup>194</sup> In any case, such directives reflect only what the competent person thinks he may want in a situation he is not then experiencing.<sup>195</sup> In addition, strict adherence to statements in advance directives may frustrate the state's interest in preserving life in cases where the family

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274 JAMA 1591 (1995) (describing a study in which the interventions were designed to improve communication between patients and physicians on end-of-life decision making but which failed to improve the incidence or timing of discussions relating to patient wishes for cardiopulmonary resuscitation); *see also* Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4206, 104 Stat. 1388, § 4206 (1990) (codified as 42 U.S.C. § 1395 (1991)) (including as a budget amendment the PSDA, encouraging the execution of advance directives by requiring healthcare providers to provide information to patients regarding advance directives); *see generally* Edward J. Larson & Thomas A. Eaton, *The Limits of Advance Directives: A History and Assessment of the Patient Self-Determination Act*, 32 WAKE FOREST L. REV. 249 (1997) (discussing the PSDA).

<sup>194</sup> Dresser, *supra* note 181, at 632 (stating that “[i]n most real cases, our knowledge of the incompetent patient’s past is limited to fuzzy comments and ambiguous behavior”); *accord*, Linda C. Fentiman, *Privacy and Personhood Revisited: A New Framework for Substitute Decisionmaking for the Incompetent, Incurably Ill Adult*, 57 GEO. WASH. L. REV. 801, 824 (1989) (blaming in part “the pervasive use in the living will statutes of vague and sometimes circular definitions of such crucial terms as ‘terminally ill,’ ‘imminent death,’ [and] ‘artificial’ life sustaining treatment”); *see also* Cantor, *supra* note 11, at 190 (describing “the imprecision or vagueness frequently present in advance directives”).

<sup>195</sup> *See* White, *supra* note 190, at 857 (describing any choice made in a living will as “a choice which the patient has necessarily made on the basis of incomplete information”); *see also* Susan Adler Channick, *The Myth of Autonomy at the End-of-Life: Questioning the Paradigm of Rights*, 44 VILL. L. REV. 577, 610 (1999) (arguing that “the potential for mistake or abuse is compounded by the possibility that the advance directive no longer represents the patient’s wishes”). Evidence suggests that even competent adults cannot accurately predict what their wishes will be in a given situation until they actually experience it. *See* Dresser, *supra* note 181, at 632 (noting that “even the most carefully considered advance choices are not as informed as we would like them to be, since typically the patient has never actually faced the situation that eventually emerges”).

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believes the patient would have changed his mind.<sup>196</sup> Courts should rely on written advance directives only if competent adults actually execute such documents, if the directives are unambiguous and if individuals can both accurately predict what type of care they would or would not want in the future and be unlikely to change their minds.<sup>197</sup>

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<sup>196</sup> *In re Westchester County Med. Ctr. ex rel. O'Connor*, 531 N.E.2d 607, 613 (N.Y. 1988) (noting that “human beings are incapable of perfect foresight”); *accord* Dresser, *supra* note 181, at 632 (discussing a “risk that uninformed people will inadvertently issue directives that substantially threaten their interests as incompetent persons”); White, *supra* note 190, at 857 (arguing that the problems inherent in advance directives make “it [ ] a mistake to conceive of an advance directive as expressing an incompetent patient’s autonomous choice in any specific circumstance”). Absolute reliance on advance directives requires family members to withhold treatment based on a loved one’s advance directives, despite their current belief that the condition the patient is in is not as distasteful as the patient had anticipated. Dresser, *supra* note 181, at 631 (arguing that “[e]ven when people exercise due diligence and provide an explicit indication of their wishes, those who remain still may be uncertain of what the patient ‘would want’ in treatment situations that later materialize”). Written advance directives also allow patients to appoint someone to make decisions for them; however, there is no guarantee that the choices made by that appointee would be any more consistent with what the patient would have wanted. THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, NEW YORK STATE DEP’T OF HEALTH, WHEN OTHERS MUST CHOOSE: DECIDING FOR PATIENTS WITHOUT CAPACITY 7 (1992) [hereinafter TASK FORCE]. In fact, studies have shown that choices made by surrogates often differ from those the patient would have made; however, in most cases, the surrogates would have accepted the treatment while the patient would have refused it. Orentlicher, *supra* note 9, at 1279; *see also* Cantor, *supra* note 11, at 189 (arguing that advance directives are most useful for evidence of “well developed and enduring notions of dignity, religion, and consideration for loved ones, which they want reflected in their future medical handling”); TASK FORCE, *supra*, at 7.

<sup>197</sup> *But see* Cantor, *supra* note 11, at 189 (noting that some commentators “doubt the utility of advance directives” due to the need for a “declarant [to] anticipate a multitude of possible medical scenarios” and “project how he or she will feel in a variety of inherently unknowable incompetent mental states”); Dresser, *supra* note 181 (arguing that competent persons’ statements on death and dying are only “a piece of the puzzle, for their situations and experiences are now vastly altered” and proposing a revised “best interests” standard looking at their current experience more than what their predictions

In addition to the limited utility of advance directives, the high evidentiary burden set in *Wendland* frustrates the ability to honor genuine treatment desires, particularly in the case of the young and the poor.<sup>198</sup> The court dismissed these concerns, pointing out that the law allows for oral instructions and oral appointment of surrogates.<sup>199</sup> While oral appointment of surrogates and oral instructions may mitigate the problem in some cases, it is not clear that it will do so in a significant percentage of cases. Since oral instructions and designations are valid in California only during the course of treatment, illness or health care institution stay in which the designation was made, the court apparently assumed that the patient will be competent when treatment is initiated and that either the patient or the physician will initiate a conversation for the purpose of eliciting such statements.<sup>200</sup> To the contrary, studies show that neither physicians nor patients do, in fact, initiate discussions about patients' wishes for future treatment, even when they are seriously ill.<sup>201</sup> Moreover, it is reasonable to assume that a significant number of patients arrive at health care facilities incompetent due to the severity of their illness or injury. Since young people are more likely to be injured than to be taken ill,

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for what their experience would be, in order to protect patients from burdensome decisions either to treat or withhold treatment).

<sup>198</sup> *In re Wendland*, 28 P.3d 151, 172 (Cal. 2001) (citing an unnamed Brief of Amici Curiae) (citation omitted).

<sup>199</sup> *Id.* at 172.

<sup>200</sup> See generally *Wendland*, 28 P.3d 151. California law was further amended in 2001 to limit the applicability of oral designation of surrogates to "the course of treatment or illness or during the stay in the health care institution when the surrogate designation is made, or for 60 days, whichever period is shorter." CAL. PROB. CODE § 4711(b) (Deering 2002) (emphasis added to new provisions). As a result, the designation of a surrogate at the beginning of what becomes a lengthy hospital stay may expire prior to the patient, leaving the patient without a surrogate who can legally effectuate his wishes for termination of treatment by the time the patient would most have wanted his wishes to be followed.

<sup>201</sup> Orentlicher, *supra* note 9, at 1268-69 (citing studies showing that physicians believe that they know what the patients want, but in fact matched their patients wishes no better than chance would provide).

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they may be disproportionately affected by an inability to make an oral instruction.<sup>202</sup> Additionally, as a result of lack of health insurance, the poor may be more likely to delay seeking health care until they are past the point of being able to make decisions for themselves.<sup>203</sup> There is also evidence that nonwhite patients are less likely to discuss treatment preferences with their physicians.<sup>204</sup>

Given that written advance directives and oral appointment of surrogates are not available to all patients, are not widely used and are often ambiguous, these means of expressing choices are unlikely to pass the *Wendland* court's high standard of proof and reliance on them as a means to protect patients from burdensome treatments is misplaced.<sup>205</sup> The result of the court's interpretation of advance directives is that patients will be forced to appoint proxies or execute advance directives to avoid decisions they would not necessarily approve later.<sup>206</sup>

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<sup>202</sup> See Fentiman, *supra* note 194, at 803 (noting that the young are less likely to suffer from chronic disease and disability). Accidents were the fifth leading cause of death in the U.S. in both 1998 and 1999, with 97,835 and 97,860 deaths per year, respectively. NAT'L VITAL STATISTICS REPORT, *supra* note 184.

<sup>203</sup> SUSAN SHERWIN, NO LONGER PATIENT: FEMINIST ETHICS AND HEALTH CARE 222 (1992).

<sup>204</sup> Orentlicher, *supra* note 9, at 1276 (noting that the studies showed that the disparity persists even after correcting for income and education).

<sup>205</sup> By definition, advance directives are executed by competent adults; minors and developmentally disabled adults thus cannot make advance directives. Cantor, *supra* note 11, at 189-90; see also Ardath A. Hamann, *Family Surrogate Laws: A Necessary Supplement to Living Wills and Durable Powers of Attorney*, 38 VILL. L. REV. 103, 124 (1993).

<sup>206</sup> See generally *In re Wendland*, 28 P.3d 151 (Cal. 2001). In addition, the reliance on advance directives, even oral directives, to correct the potential for providing unwanted care is not only unwarranted, it could also leave *Wendland*'s interpretation of section 2355 open to attack on Equal Protection grounds. In an Equal Protection Analysis, the court must utilize strict scrutiny when assessing the validity of state intervention in decisions affecting suspect classifications such as race or affecting fundamental rights. GERALD GUNTHER & KATHLEEN SULLIVAN, CONSTITUTIONAL LAW 630 (13th ed. 1991). Here, it could be argued that the *de facto* requirement of *Wendland* that a competent adult must complete an advance directive in order to avoid unwanted life-

*C. The Court's Attempt to Honor Autonomy*

The *Wendland* court based its reasoning on the need to honor Robert's autonomy.<sup>207</sup> Throughout its opinion, however, the court neglected to acknowledge that the exercise of autonomy involves the choice between two fundamental rights directly opposed to each other: the fundamental right to life and the fundamental right to refuse life-sustaining treatment.<sup>208</sup> Instead, the court focused on the state's interest in preserving life as measured against each of those choices.<sup>209</sup> As a result, the court clearly gave greater weight to the state's interest, despite the apparent equality of the individual's conflicting rights. The court failed to reconcile these rights.<sup>210</sup>

*1. Basis for the Court's Concern*

The *Wendland* court's emphasis on the need for stringent protection of Robert's right to life appears to have been based on assumptions about the nature of the minimally conscious state and the motives of those choosing to withdraw treatment in that

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sustaining medical care when incompetent not only has a disparate impact on minorities, since they are more resistant to completing such directives, but additionally affects the fundamental right to privacy on which the *Wendland* court based the right to refuse medical care. *Wendland*, 28 P.3d at 165 n.10.

<sup>207</sup> See *Wendland*, 28 P.3d at 159, 168.

<sup>208</sup> *Id.*, *passim*. To avoid unconstitutional application of section 2355, the court construed the statute to require proof by clear and convincing evidence. *Id.* at 166. But, the court had earlier accepted the notion that an individual also has the fundamental right to refuse treatment and that such right would survive incapacity "if exercised while competent pursuant to a law giving that act lasting validity." *Id.* at 160. The court specifically refused to equate the right to refuse treatment with the "right to an appropriate decision by a court-appointed conservator." *Id.* at 163.

<sup>209</sup> *Id.* But see Hamann, *supra* note 205, at 141-46 (arguing that the state's interest in preserving life does not extend to personal decisions by an individual regarding his own life).

<sup>210</sup> See generally *Wendland*, 28 P.3d 151. The court did note that neither may be infringed unless clearly outweighed by the state's interest. *Id.* at 160, 163.

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circumstance.<sup>211</sup> The court appeared convinced that there is a distinct, relevant difference between PVS and a minimally conscious state and stated concern that “a person whose permanent unconsciousness prevents him from perceiving that artificial hydration and nutrition are being withdrawn arguably has a more attenuated interest in avoiding that result than a person who may consciously perceive the effects of dehydration and starvation.”<sup>212</sup> The potential that a minimally conscious patient will perceive physical or psychological discomfort during treatment, however, has led some to claim that a minimally conscious patient has an even greater interest in having treatment withheld.<sup>213</sup> Moreover, some have argued that there is more similarity than dissimilarity between PVS and a minimally conscious state.<sup>214</sup>

The court also assumed that Robert’s statement that he wouldn’t want to live “like a vegetable” meant that he was referring specifically to PVS.<sup>215</sup> Not only is there no evidence that Robert understood the distinction or intended to limit his request to PVS, but he specifically made statements that would indicate otherwise.<sup>216</sup> The court also distinguished Robert’s

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<sup>211</sup> See Hamann, *supra* note 205, at 138-59 (listing numerous assumptions courts tend to make when deciding cases involving personal medical decisions).

<sup>212</sup> *Wendland*, 28 P.3d at 163.

<sup>213</sup> See, e.g., Nelson & Cranford, *supra* note 113, at 447-48. Additionally, it has been argued that any physical discomfort could be alleviated. *Id. Accord*, Michelle M. Mello, Note, *Death Life, and Uncertainty: Allocating the Risk of Error in the Decision to Terminate Life*, 109 YALE L.J. 635 (1999).

<sup>214</sup> See, e.g., Nelson & Cranford, *supra* note 113, at 449 (arguing that the two states are more alike than dissimilar, where both states offer little more than biological existence, neither offers a reasonable chance of recovery, most patients would desire release from that state, and both lead to the wish “not to kill the patient but to let nature take its course by removing unwanted and nonbeneficial treatment”).

<sup>215</sup> *Wendland*, 28 P.3d at 157, 173.

<sup>216</sup> *Id.* at 157. His daughter recalled Robert saying that “if he could not do all the things that he enjoyed doing, just enjoying the outdoors, just basic things, feeding himself, talking, communicating, if he could not do those things, he would not want to live.” *Id.* Robert’s description is consistent with

situation from that of the terminally-ill patient,<sup>217</sup> yet at the same time the court recognized the precarious health of those whom the cases typically concern.<sup>218</sup> In addition, the court appears to have assumed that the motives of family members who request treatment termination for their incompetent relatives are suspect and the motives of family members who choose to treat are not.<sup>219</sup> The court, however, provided no support for any of its

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a minimally conscious state and not as limited as PVS. *See supra* note 46 for a description of patients in PVS.

<sup>217</sup> *Id.* at 153.

<sup>218</sup> *Id.* at 154 n.1. “[A]s this case demonstrates, these issues tend to evade review because they typically concern persons whose health is seriously impaired.” *Id.*

<sup>219</sup> *See generally Wendland*, 28 P.3d 151. Some commentators share the court’s concern. *See, e.g.*, Aaron N. Krupp, *Health Care Surrogate Statutes: Ethics Pitfalls Threaten the Interests of Incompetent Patients*, 101 W. VA. L. REV. 99 (1998). However, based on personal experience as a consultant on a tertiary care hospital’s Ethics Consultation Service, the author believes this assumption to be the opposite of the norm. While there are undoubtedly some instances where family members are operating out of suspect motives in asking to withdraw treatment, the more common scenario in the author’s experience is that it is the estranged family member and the one with the strained relationship with the patient who is most likely to resist termination of treatment. While the author is not aware of any studies specifically looking at this issue, there are cases in the literature where the decision maker may have insisted on continuing treatment as a result of a strained relationship. *See, e.g.*, “Code Him ‘Til He’s Brain Dead!,” in INTRODUCTION TO CLINICAL ETHICS 169-70 (John C. Fletcher et al. eds., 1995) (hereinafter CLINICAL ETHICS) (describing a case in which the estranged daughters of an abusive alcoholic insisted on providing aggressive treatment for their father despite his physicians’ recommendations to the contrary). One commentator argues that there has not been one case in which it has been shown that the family was “motivated by financial considerations,” despite courts’ frequent mention of this potential problem. Hamann, *supra* note 205, at 152. In addition, family members could simply “walk away” if they wish to avoid financial or emotional burdens of caring for the patient. *Id.* at 153. In contrast to the courts’ concern, studies have shown that family members are less likely to discontinue treatment for another than they would be for themselves. *Id.* at 152. In the *Wendland* case, it was Robert’s estranged mother and sister who opposed treatment termination; neither had visited Robert’s home for ten years, neither acknowledged or celebrated birthdays or holidays with him, and Robert had refused to attend his sister’s wedding. Nelson & Cranford, *supra*

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assumptions.<sup>220</sup>

2. *The Court's Application of the Concept of Autonomy*

The *Wendland* court concluded that the guiding principle underlying the changes to section 2355 was a respect for personal autonomy.<sup>221</sup> The court's decision, however, has the anomalous effect of limiting that autonomy. The court struggled with somewhat competing goals: to respect and protect Robert's autonomy by ensuring that any decisions made for him are made based on his own wishes, not for the benefit of others,<sup>222</sup> and to protect future, similarly situated individuals.<sup>223</sup> These goals are fundamentally at odds inasmuch as it is difficult, at best, to honor the idiosyncratic choices of one individual while simultaneously striving to achieve consistent results in future cases of other idiosyncratic individuals.<sup>224</sup> Similarly, it is contradictory to claim that an individual requires protection from choices made for the benefit of others and simultaneously apply a next-to-impossible standard to the instant case in order to protect future individuals.<sup>225</sup> Such a standard may be a reflection of the court's

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note 113, at 435. While the psychological implications of decisions to withdraw treatment are beyond the scope of this article, there appears to be at least enough of a question on the issue to reject the presumption that treatment termination decisions are more suspect than treatment continuation decisions.

<sup>220</sup> See generally *Wendland*, 28 P.3d 151.

<sup>221</sup> *Id.* at 168 (noting that the "only apparent purpose of requiring conservators to make decisions in accordance with the conservatee's wishes, when those wishes are known, is to enforce the fundamental principle of personal autonomy").

<sup>222</sup> *Id.* at 172. Granted, this is a legal fiction since Robert had already died at the time of the decision; however, the same argument could be made for each case decided under the court's standard. See *id.* at 158.

<sup>223</sup> JANE C. GINSBURG, *LEGAL METHODS* at 1 (1996).

<sup>224</sup> See *White*, *supra* note 190, at 860 (arguing that "a presumption in favor of a specified family decision maker would at least allow for the possibility that different decisions would be made for different patients, and thus acknowledge the fact that people's preferences, as expressed when they are competent, differ.")

<sup>225</sup> See generally *Wendland*, 28 P.3d 151.

own worldview and desire for a particular outcome rather than those of the patient.<sup>226</sup>

Autonomy, according to the court, is exercised only through specific statements of a competent adult.<sup>227</sup> This is unnecessarily strict. Autonomy may be equally exercised by delegating one's choices to another.<sup>228</sup> For example, studies indicate that most patients trust their family members to make decisions for them.<sup>229</sup> Additionally, many patients prefer to have surrogates determine the patient's best interests rather than decide on the basis of the surrogate's view of the patient's preferences.<sup>230</sup> After *Wendland*,

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<sup>226</sup> *Id.* at 170 (referring to providing care against the patient's wishes as the "less perilous result" when compared to withdrawing treatment). See Boozang, *supra* note 161 (arguing that courts have taken either a "vitalist" stance, favoring life above all other considerations, or a "qualitist" stance, considering quality of life issues in the determination of best interests); see also Matthew S. Ferguson, Note, *Ethical Postures of Futility and California's Uniform Health Care Decisions Act*, 75 S. CAL. L. REV. 1217, 1244 (2002) (arguing that the *Wendland* court was interested "in the results, rather than the process of patient decisionmaking" and "focused on the ends, not means"). The court is not alone in viewing the case with an eye toward future patients; eight amicus briefs were filed on behalf of Rose and Robert and thirteen amicus briefs were filed on behalf of Florence. See *Wendland*, 28 P.3d 151. But see Hamann, *supra* note 205, at 165-66 (arguing that "strangers with political agenda[s]" should not be allowed to intervene in cases involving personal medical decisions since such groups "do not see the patient as a person but as a symbol of a cause").

<sup>227</sup> *Wendland*, 28 P.3d at 172 (noting that requiring clear statements is for the purpose of effectuating the patient's right to refuse).

<sup>228</sup> See Orentlicher, *supra* note 9, at 1280 (arguing that "[t]he important point is that the patient has decided how the decision will be made"). Such delegation need not be formal, as with legal appointment by adults of surrogates. *Id.*

<sup>229</sup> TASK FORCE, *supra* note 196, at 6-7. One survey showed that eighty-five percent of those polled believed that the family and the patient's physicians should make end-of-life treatment decisions for incapacitated patients. *Id.* at 6 n.2 (citing a Time Magazine/CNN poll conducted in October of 1989).

<sup>230</sup> Orentlicher, *supra* note 9, at 1280 nn.156-57 (noting various studies showing that greater than ninety percent of those surveyed preferred to have family members serve as surrogates, and that greater than fifty percent favored the best interests standard over the substituted judgment standard). Studies

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however, failure to name a health care proxy must be interpreted as an indication that decisions by family members would be unwelcome.<sup>231</sup> This interpretation fails to honor the autonomous wishes of the majority to have their families choose for them.

The anomalous result of *Wendland* is that the very changes to section 2355 that embodied the principle of respect for autonomy have been eliminated. In effect, the court rejected the best interest standard of section 2355 by requiring a standard of proof that cannot be met in any case in which section 2355 would apply.<sup>232</sup> By requiring clear and convincing evidence and ignoring the amended statute's attempt to increase the use of the conservatee's wishes and values in decisions when his wishes in the instant situation are unclear, the court clearly favored the right to life over the right to refuse treatment.<sup>233</sup> In effect, this

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have also shown that most patients would want family members to have at least "a little leeway" to override their directives if necessary to protect their future interests. Dresser, *supra* note 181, at 631 (citing a study of dialysis patients, in which "sixty-one percent wanted surrogates to have 'a little leeway' to override the directives if necessary to protect their future best interests, while thirty-one percent wanted surrogates to have 'complete leeway'"). Such future interests could include the interest in preserving life when the individual actually enjoys a quality of life greater than what he had anticipated. *Id.* at 624 (citing the hypothetical example of a musician who executed an advance directive requiring discontinuance of treatment in the event of incapacity and inability to experience music but who later appears to be enjoying her life in the face of senile dementia and a curable illness; citing also the opposite hypothetical of a person who had directed that all efforts be expended to prolong her life but who subsequently suffers "unremitting, unremediable pain and distress," while incompetent, toward the end of her terminal illness).

<sup>231</sup> See generally *Wendland*, 28 P.3d at 174. The court rejected subjective proof of Robert's best interest, despite the fact that the best interest standard is only applied when there is no objective proof of the patient's wishes. *Id.* (stating that Rose had "no basis for such a finding other than her own subjective judgment that the conservatee did not enjoy a satisfactory quality of life and legally insufficient evidence to the effect that he would have wished to die").

<sup>232</sup> *Id.* at 172. In effect, the court reset the standard to the degree of the old section 2355 prior to *In re Drabick*, 245 Cal. Rptr. 840 (Ct. App. 1988), only without any best interest standard at all.

<sup>233</sup> *Wendland*, 28 P.3d at 174 (noting that the decision "threatens the

favors the state's interests in preserving life over the individual's interests to choose between life and forgoing treatment. As such, the court's decision fails to honor the autonomy it admits the statute sought to enhance.<sup>234</sup>

*D. The Court Erred as to the Appropriate Standard of Proof*

There are various approaches to the issue of safeguards for decision making for incompetent patients. Such approaches include different standards of proof,<sup>235</sup> family health care decisions acts<sup>236</sup> and alternative ways to view the needs of incompetent patients.<sup>237</sup> These approaches share with *Wendland* the common element of indirectly addressing issues related to a due process analysis: the rights and interests of the individuals, the interests of the state and procedural safeguards.<sup>238</sup>

Despite language relating to individual rights balanced against the state's interest, *Wendland* never fully addresses the issue of

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conservatee's fundamental rights to privacy and life").

<sup>234</sup> *Id.* at 161, 168.

<sup>235</sup> *Id.* at 169-70 (discussing the use of the clear and convincing evidence standard when fundamental rights are implicated).

<sup>236</sup> *See, e.g.,* Hamann, *supra* note 205 (arguing that families had always been the locus of medical decisions for incompetent patients until the advent of medical technology, and that returning the decisions to families is appropriate). *See also* A.B. A6315, 2003-2004 Reg. Sess. (N.Y. 2003) (proposing the Family Healthcare Decisions Act), at <http://www.assembly.state.ny.us/leg/?bn=A06315&sh=t>.

<sup>237</sup> *See, e.g.,* Dresser, *supra* note 181, at 627-30 (arguing that competent persons do not have a right to make advance choices that lead to serious harms); *see also* Nelson & Cranford, *supra* note 113, at 447-48 (arguing that, contrary to the opinions judges tend to hold that patients in PVS have a greater interest in having treatment withdrawn than those who are minimally conscious, patients in the minimally conscious state have a greater need to avoid the pain and humiliation of continued treatment because they may be able to perceive such problems).

<sup>238</sup> *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976). For state interests in cases involving withdrawal of medical care, *see In re Grant*, 747 P.2d 445 (finding four state interests that might weigh against termination of treatment: preservation of life, protection of "innocent third parties," suicide prevention, and maintaining the integrity of the medical profession).

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due process.<sup>239</sup> Instead, the court implicitly stated that due process in the case of a fundamental right to life requires a higher standard of proof than is normally required for civil matters as a safeguard against erroneous deprivation of a fundamental right.<sup>240</sup> The disadvantage of this approach in the case of refusal of medical care for incompetent patients is that avoiding the risk of violating the fundamental right to life creates an equal risk of violating the fundamental right to refuse medical care.<sup>241</sup> In such cases, the risk of error will always be borne by the patient. As such, this issue is different from many other due process situations, where the purpose of higher standards of proof and increased procedural safeguards is to transfer the risk of error

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<sup>239</sup> *Wendland*, 28 P.3d at 160.

<sup>240</sup> *Id.* at 169.

The function of a standard of proof is to instruct the fact finder concerning the degree of confidence our society deems necessary in the correctness of factual conclusions for a particular type of adjudication, to allocate the risk of error *between the litigants* and to indicate the relative importance attached to the ultimate decision.

*Id.* (emphasis added). While the court mentions the allocation of the risk between the litigants, it assumed that the litigants here are the state and the conservator rather than the conflicting rights of the patient and concentrated instead on the relative importance it attached to the ultimate decision. *Id.*

<sup>241</sup> *Id.* at 160. See *In re Drabick*, 245 Cal. Rptr. 840 (Ct. App. 1988) (noting that the state's interest is in protecting the patient's right to have appropriate decisions made on his behalf and further noting that "[t]he problem is not to preserve life under all circumstances but to make the right decisions. A conclusive presumption in favor of continuing treatment impermissibly burdens a person's right to make the other choice"). According to *Wendland*, the right to refuse medical treatment survives incapacity only "if exercised while competent pursuant to a law giving that act lasting validity." *Wendland*, 28 P.3d at 160. In that determination, the court confused the survival of the right with procedural safeguards to determine the validity of the choice made in exercising the right. The court, in essence, converted advance directives into a new form of statute of frauds with a choice to receive all medical treatment as the default in the absence of compelling evidence (usually written) to overcome the default. *Id.* See BLACK'S LAW DICTIONARY 1422 (7th ed. 1999) (defining "statute of frauds" as a statute "designed to prevent fraud and perjury by requiring certain contracts to be in writing and signed by the party to be charged").

from the individual to the state.<sup>242</sup>

The preponderance of the evidence standard, on the other hand, results in a roughly equal allocation of the risk of error between litigants.<sup>243</sup> Such a standard creates a “fair balance” between conflicting interests.<sup>244</sup> Other standards, by design, favor the interests of one side.<sup>245</sup> Preponderance of the evidence is the standard applied “most frequently in litigation between private parties in every State.”<sup>246</sup> The preponderance of the evidence may be considered insufficient if the majority of jurisdictions have adopted a stricter burden of proof.<sup>247</sup> Higher standards of proof may be required when the competing interests are those of an individual and the state.<sup>248</sup> The Supreme Court, however, recognizes a distinction between those proceedings and those in

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<sup>242</sup> *Santosky v. Kramer*, 455 U.S. 745, 755, 760 (1982) (refusing to apply the preponderance of the evidence standard for fact findings in proceedings to terminate parental rights, since the interests of the parents and the child are not in conflict with each other prior to a finding of parental neglect but are instead in conflict with the interests of the state).

<sup>243</sup> *Grogan v. Garner*, 498 U.S. 279, 286-87 (1991) (applying the preponderance of the evidence standard in Chapter 11 reorganization proceedings in order to balance the conflicting interests of the creditor in recovering full payment and the debtor’s interest in a fresh start).

<sup>244</sup> *Id.* at 287.

<sup>245</sup> *Herman & Maclean v. Huddleston*, 459 U.S. 375, 390 (1983) (noting that other standards “express[] a preference for one side’s interests” and applying the preponderance of the evidence standard in a class action suit seeking recovery for violations of section 10(b) of the Securities Exchange Act, in order to balance defendants’ risk of “opprobrium that may result from a finding of fraudulent conduct” with the plaintiff’s risk of inability to recover under the act).

<sup>246</sup> *Rivera v. Minnich*, 483 U.S. 574, 577 (1987) (applying the preponderance of the evidence standard in paternity proceedings in order to balance the conflicting rights of the individuals involved, as distinct from balancing the rights of an individual against the interests of the state).

<sup>247</sup> *Duncan v. Louisiana*, 391 U.S. 145, 155 (1968) (noting that adherence to a standard by the majority of jurisdictions reflects “a profound judgment about the way in which law should be enforced and justice administered”). California, however, is one of only five states to require clear and convincing evidence in treatment termination decisions for incompetent patients. *See supra* Part I.B.

<sup>248</sup> *Minnich*, 483 U.S. at 581.

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which risks of an adverse ruling for private individuals exist regardless of the ultimate outcome of the case.<sup>249</sup> In such cases, the “equipoise of the private interests that are at stake . . . supports the conclusion that the standard of proof normally applied in private litigation is also appropriate for these cases.”<sup>250</sup> Standards of proof are designed to protect against the risk of error in the majority of cases, rather than the “rare exceptions.”<sup>251</sup> In addition, practical considerations may affect the choice of a constitutionally based burden of proof.<sup>252</sup> That is, imposing a burden that cannot be met erects an “unreasonable barrier,”<sup>253</sup> and it may be appropriate to use lower standards of proof when evidentiary problems could arise using a higher standard.<sup>254</sup> In addition, “professional review” is sufficient to mitigate risks created by lower standards of proof.<sup>255</sup>

In *Wendland*, Rose’s decision to withdraw nutrition and

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<sup>249</sup> *Id.*

<sup>250</sup> *Id.*

<sup>251</sup> See *Matthews v. Eldridge*, 424 U.S. 319, 344 (1976) (stating that “procedural due process rules are shaped by the risk of error inherent in the truthfinding process as applied to the generality of cases, not the rare exceptions”); *supra* note 219 (arguing that there is no reason to assume that a family member seeking to terminate medical treatment for an incompetent relative is doing so out of inappropriate motives).

<sup>252</sup> See *Addington v. Texas*, 441 U.S. 418, 430 (1979) (allowing a lower standard of proof for civil commitment of minors since “[p]sychiatric diagnosis . . . is to a large extent based on medical ‘impressions’ drawn from subjective analysis and filtered through the experience of the diagnostician”).

<sup>253</sup> *Id.* at 432.

<sup>254</sup> *Santosky v. Kramer*, 455 U.S. 745, 769 (1982) (refusing to require evidence beyond a reasonable doubt in parental rights termination proceedings because of evidentiary problems); see also *Addington*, 441 U.S. 427-31 (refusing to require evidence beyond a reasonable doubt in civil commitment proceedings because of a question as to whether a state could ever meet such a high standard and because of the inherent lack of certainty in diagnosis); *supra* Part III.B (arguing that *Wendland* requires a level of proof that can rarely be met).

<sup>255</sup> *Addington*, 441 U.S. at 428-29 (noting that “layers of professional review and observation of the patient’s condition, and the concern of family and friends generally will provide continuous opportunities for an erroneous commitment to be corrected”).

hydration met all of the requirements of due process, and should have been honored by the court. Rose based her decision on what she believed Robert would have wanted, considering his values, beliefs and statements about medical care.<sup>256</sup> Her evidence was more than sufficient to show by a preponderance of the evidence that Robert would have wanted his treatment discontinued,<sup>257</sup> and a preponderance of the evidence is all that should have been required.<sup>258</sup> The family members who supported her decision had demonstrated the strongest emotional ties to Robert, while those opposed were estranged from him.<sup>259</sup> His physician, the institutional ethics committee, his guardian *ad litem* and the county patient ombudsman all supported the decision.<sup>260</sup> Thus,

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<sup>256</sup> *In re Wendland*, 28 P.3d 151, 174 (Cal. 2001) (recognizing that “[t]he trial court . . . found by clear and convincing evidence that [Rose] had acted ‘in good faith, based on medical evidence and after consideration of the conservatee’s best interests, including his likely wishes, based on his previous statements’”). See *supra* Part II.A (describing Robert’s statements to Rose and the support she received from the medical hierarchy).

<sup>257</sup> See *supra* text accompanying notes 97-103 (describing Robert’s statements). In addition, Rose was Robert’s wife and presumptively knew his wishes and values better than anyone else. See Hamann, *supra* note 205, at 165. Hamann states that

what is unclear to the judge, who is a stranger, may be obvious to a family member who understands the person’s attitudes towards medical care and general view of life and the world. The family knows “the motives and considerations that would control the patient’s medical decisions.” There is a special bond between family members based on their shared experience that allows them to understand each other much better than those outside the family understand them. Nonetheless, this knowledge is often intuitive, causing difficulties when family members attempt to translate this knowledge into evidence to be presented at a hearing.

*Id.* (citations omitted).

<sup>258</sup> See *supra* notes 240-55 and accompanying text (discussing the purposes for different standards of proof and concluding that clear and convincing evidence is neither required nor desirable to effectuate a patient’s wishes).

<sup>259</sup> See *supra* note 113 and accompanying text (describing Robert’s relationship with his family).

<sup>260</sup> *Wendland*, 28 P.3d. at 155-56 (acknowledging such support but choosing to downplay the support of the guardian *ad litem* by referring only to

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Rose met the burden that is appropriate in such cases and Robert had the safeguard of multiple layers of professional review.<sup>261</sup>

The *Wendland* court, however, misperceived its role and set a standard designed to allow for withdrawal of treatment only when there is little, if any, doubt that the decision is precisely what the patient would have chosen.<sup>262</sup> Such exactitude is not required by due process,<sup>263</sup> and the attempt to achieve it violates the very autonomy on which the court based the standard.<sup>264</sup> This attempt to honor autonomy has the contradictory result that patients who would have refused treatment no longer have the right to have their family assert that choice on their behalf.

*E. Recommendations to the Legislature*

California's legislature must respond to *Wendland* to protect incompetent patients from receiving care they likely would have refused.<sup>265</sup> The legislature should amend the HCDA to specify

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Rose "for brevity's sake"); *see also In re Wendland*, 93 Cal. Rptr. 550, 555 (Ct. App. 2000).

<sup>261</sup> *See* Addington v. Texas, 441 U.S. 418, 432 (relying on professional review to decrease the possibility of erroneous decisions).

<sup>262</sup> *See Wendland*, 28 P.3d at 172 (noting that the purpose of requiring clear statements is to effectuate the wishes of the patient).

<sup>263</sup> *See* Hamann, *supra* note 205, at 146-47 (noting that courts often refuse to discontinue medical treatment because of the risk of error, but that absolute certainty is not required by the law).

<sup>264</sup> *Wendland*, 28 P.3d at 168.

<sup>265</sup> *See supra* note 196 (citing sources noting that studies show that patients would choose to refuse treatment more often than their surrogates would refuse it for them). In amending the act, the legislature should address the areas of decision making that satisfy due process concerns but that keep such cases out of court. While there are currently procedural safeguards in place in California, many of those safeguards are optional or apply only in limited circumstances. *See, e.g.*, CAL. PROB. CODE § 4659 (Deering 2001) (prohibiting persons with certain conflicts of interest from serving as agents under a power of attorney for health care or acting as surrogates); CAL. PROB. CODE § 4674 (Deering 2001) (prohibiting persons with certain conflicts of interest from serving as witnesses to written advance directives); CAL. PROB. CODE § 4675 (Deering 2001) (requiring the signature of a patient advocate or ombudsman to written advance directives executed by patients in skilled

that, absent proof to the contrary, the family is the basic unit within which health care decisions should be made.<sup>266</sup> The legislature should specify a process for selecting surrogates for patients who have not appointed surrogates and give validity to the informal decision-making process that is in place in California.<sup>267</sup>

It should be made clear that the same process applies to all types of decisions, including the refusal of life-sustaining medical treatment for minimally conscious patients. Section 2355, providing for the use of the patient's prior instructions and wishes and values, to the extent known, should be reaffirmed.<sup>268</sup> Amendments to section 2355 could include guidance for the

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nursing facilities); CAL. PROB. CODE § 4677 (Deering 2001) (prohibiting health care providers, insurers, etc., from requiring or prohibiting the execution of advance health care directives as a condition for providing service or coverage); CAL. PROB. CODE § 4697 (Deering 2001) (automatically revoking the designation of a spouse as agent to make health care decisions on the dissolution or annulment of the marriage). Nothing in the Probate Code provides for physician or ethics committee review of decisions to refuse treatment on behalf of incompetent patients. *See generally* CAL. PROB. CODE §§ 4600-4805 (constituting the state's Health Care Decisions Law).

<sup>266</sup> Hamann, *supra* note 205, at 169 (arguing that a "rebuttable presumption that family members act in the person's best interest allows the rare cases involving abuse to be litigated"); *accord* Nancy K. Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375 (1988); HILDE LINDEMANN NELSON & JAMES LINDEMANN NELSON, *THE PATIENT IN THE FAMILY* 6-25 (1995) (describing the evolution of the participation of families in the medical care of family members).

<sup>267</sup> *Health Care Decisions Act: Hearing on A.B. 891 Before the Senate Rules Comm.*, 1999-2000 Reg. Sess. (Cal. Aug. 26, 1999). *See also* Herald, *supra* note 176, at 214 (arguing that the "default position" in the absence of a patient directive should be to honor the decisions of close family members and life partners). Alternatively, the legislature could require a consensus-based model. Thomas L. Hafemeister, *End-of-Life Decision Making, Therapeutic Jurisprudence, and Preventive Law: Hierarchical v. Consensus-Based Decision-Making Model*, 41 ARIZ. L. REV. 329 (1999) (arguing that a consensus of family, the patient and health care providers in end-of-life decision making would respect the intent and needs of the patient while also preserving family relationships and reducing litigation).

<sup>268</sup> *See generally* CAL. PROB. CODE § 2355 (Deering 2001).

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determination of a patient's best interests.<sup>269</sup> The legislature should specifically recognize advance directives and health care proxies as merely an opportunity for those few who desire to control their future treatment or identify a specific decision maker to do so. This schema would respect the choice of the majority who want their family to make decisions for them, and also protect those for whom this is not the best choice.<sup>270</sup>

Amendments to the HCDA could mandate safeguards to prevent decisions made with suspect motives.<sup>271</sup> Such safeguards

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<sup>269</sup> See, e.g., *In re Conroy*, 486 A.2d 1209 (N.J. 1985) (stating that treatment may be withdrawn without any evidence of the patient's wishes when the patient is in "recurring unavoidable and severe pain"). Best interests considerations could include the "relief of suffering, the preservation or restoration of functioning and the . . . extent of life sustained." Boozang, *supra* note 161, at 581. Other considerations could include:

Patient's present level of physical, sensory, emotional, and cognitive functioning . . . the degree of humiliation, dependence, and loss of dignity probably resulting from the condition and treatment; the life expectancy and prognosis for recovery with and without treatment; the various treatment options; and the risks, side effects, and benefits of each of those options.

*Div. of Family Serv. v. Carroll*, No. CN00-09299, 2000 WL 33324536, at \*12 (Del. Fam. Ct. Sept. 19, 2000). Some commentators have proposed that the family's interests should also be considered. See, e.g., Fentiman, *supra* note 194. Many people factor such considerations into their own decisions for themselves. Channick, *supra* note 195, at 639. One pair of commentators suggests that a best interests analysis should ask the following question:

Does *this woman, as she is now*, experience something good when her hair is brushed or when she sits in the sunlight, when she tastes split-pea soup or feels the caress of a nurse's hand—and is this of sufficient value to her to count as a reason to go on?

LINDEMANN NELSON & LINDEMANN NELSON, *supra* note 266, at 89.

<sup>270</sup> Provision already exists for those who wish to prevent participation in decisions by certain people. See CAL. PROB. CODE § 4715 (Deering 2001) (providing for the patient's disqualification of specific individuals from serving as surrogates). See *supra* note 230 and accompanying text (noting that most adults would choose to have family members make treatment decisions in the event of incapacity).

<sup>271</sup> *But see* Hamann, *supra* note 205, at 151-54 (arguing that "there is no evidence . . . that families are allowing financial concerns to override the best interests of the person when making medical care decisions").

could include mandatory involvement of healthcare providers in assessing the motives of the decision maker,<sup>272</sup> ethics committee involvement in assisting the parties to consider the issues in assessing motives,<sup>273</sup> and mediation of disputes.<sup>274</sup> Additionally,

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<sup>272</sup> See Boozang, *supra* note 161, at 554 (arguing that “[h]ealth care teams are well-attuned to such issues and have legal and ethical consultants as well as bioethics committees at their disposal for consultation in case of any question about the family’s motivation or decision”). In essence, this would simply be a variation on the ethical concept of informed consent, adding the requirement that surrogates express their reasons for the decisions they choose. See CLINICAL ETHICS, *supra* note 219, at 89-100 (discussing the concept of informed consent). To address the court’s concern about the basis for the decisions, the legislature should provide guidance for determining whether a surrogate is acting in good faith, and define what would constitute abuse of discretion. Other considerations may include “preservation or restoration of functioning, quality and extent of life sustained, satisfaction of present desires, opportunities for future satisfaction, and the possibility of developing or regaining the capacity for self-determination.” Deborah K. McKnight and Maureen Bellis, *Foregoing Life-Sustaining Treatment for Adult, Developmentally Disabled, Public Wards: A Proposed Statute*, 18 AM. J.L. & MED. 203, 210 (1992). For example, the legislature could require clinicians who receive requests from surrogates to withhold or withdraw life-sustaining treatment to “ensure that an accurate diagnosis and prognosis has been made, that the family is truly representing the patient interests, and that those patients without close family members or friends to act on their behalf are not abandoned.” Fentiman, *supra* note 194, at 856. For an example of legislation incorporating safeguards against inappropriate treatment refusals by surrogates, see N.Y. PUB. HEALTH LAW §§ 2963, 2965, 2972 (2002) (requiring physicians to assess the capacity of the patient prior to accepting a surrogate’s decision to refuse to consent to the provision of cardiopulmonary resuscitation [CPR] in the event of cardiac and pulmonary arrest; limiting the circumstances under which the decision can be made; requiring a second physician’s concurrence that those circumstances exist; requiring witnesses to the decision; and providing for dispute resolution procedures prior to court intervention). For safeguards required by courts, see *In re Conroy*, 486 A.2d 1109 (N.J. 1985) (requiring ombudsman approval for decisions to forgo treatment made on behalf of nursing home residents); *In re Grant*, 747 P.2d 445 (Wash. 1987) (requiring that two physicians agree that the patient is in an advanced stage of a terminal and permanent illness).

<sup>273</sup> See Boozang, *supra* note 161, at 553 (noting that bioethics committees are available for consultation in case of “any question about the family’s motivation or decision”).

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appointment of a guardian *ad litem* could be required for those cases in which the procedures fail to resolve a dispute.<sup>275</sup> The legislature should provide that the role of the courts in disputes should be limited to ascertaining whether the procedural safeguards were met, and that the court should not substitute its own determination of the best decision when due process safeguards are in place.<sup>276</sup>

## CONCLUSION

The *Wendland* court misapprehended the scope of its decision, the means necessary to honor autonomy, the usefulness of advance directives to mitigate the decision's negative effects and the need to require clear and convincing evidence. The court failed to recognize that its perception of individual autonomy in the context of health care decisions for incompetent patients is out of sync with that of the majority of adults in this country. As a result, the court incorrectly balanced patients' right to life and right to refuse medical treatment and violated the very autonomy it sought to protect.

The California legislature must now respond and amend the HCDA to restore the role of those closest to the patient in the decision making process. The amendments should focus on the family as the proper locus for such decisions, make a clear statement that the preponderance of the evidence is sufficient, and rely on procedural safeguards to detect rare decisions made out of improper motives. Such a framework is consistent with the

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<sup>274</sup> See, e.g., Robert Gatter, *Unnecessary Adversaries at the End of Life: Mediating End-of-Life Treatment Disputes to Prevent Erosion of Physician-Patient Relationships*, 79 B.U.L. REV. 1091 (1999) (discussing the use of mediation in medical decision making); see also Diane E. Hoffman, *Mediating Life and Death Decisions*, 36 ARIZ. L. REV. 821 (1994).

<sup>275</sup> Herald, *supra* note 176, at 214 (arguing that independent attorneys can be appointed to stand up for the patient's rights).

<sup>276</sup> See THOMAS L. HAFEMEISTER & PAULA L. HANNAFORD, *RESOLVING DISPUTES OVER LIFE-SUSTAINING TREATMENT* app. B, at 125-29 (1996) (describing examples of state-mandated models for resolution of disagreements regarding medical decisions).

choices of most patients and would reduce the risk of error.