

S087265

**IN THE
SUPREME COURT OF CALIFORNIA**

CONSERVATORSHIP OF THE PERSON OF ROBERT WENDLAND, *Appellant.*

ROSE WENDLAND,

Appellant,

vs.

FLORENCE WENDLAND and REBEKAH VINSON,

Respondents.

AFTER A DECISION BY THE COURT OF APPEAL
THIRD APPELLATE DISTRICT, CASE No. C029439

**APPLICATION TO FILE AMICI CURIAE BRIEF;
AMICI CURIAE BRIEF IN SUPPORT OF
ROSE WENDLAND AND ROBERT WENDLAND**

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FRANCISCO MEDICAL SOCIETY, AND 43 INDIVIDUAL BIOETHICISTS
[LISTED ON INSIDE FRONT COVER]**

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**APPLICATION TO FILE AMICI CURIAE BRIEF
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AND ROBERT WENDLAND**

INTRODUCTION

Pursuant to California Rules of Court, rule 14(b), we respectfully request leave to file the attached brief of amici curiae in support of Rose Wendland and Robert Wendland. This application is timely made within 30 days after the filing of the reply brief on the merits.

THE AMICI CURIAE

Organizations (in alphabetical order)

The Alliance of Catholic Health Care represents California's Catholic health systems and hospitals. The Alliance's members operate more than 65 Catholic and community-based affiliated hospitals and more than 40 home health, nursing, assisted living, hospice, and low-income housing facilities in California. Together, Catholic health care providers comprise more than 15 percent of California's hospitals.

The California Healthcare Association (CHA) is the statewide leader representing the interests of hospitals, health systems, and other health care providers in California. Based in Sacramento, CHA is one of the largest health care trade associations in the nation with more than 450 hospital and health system members and nearly 200 affiliate and personal members. The California Medical Association (CMA) is a non-profit, incorporated professional association of more than 30,000 physicians practicing in the State of California. CMA's membership includes California physicians engaged in the private practice of medicine, in all specialties. CMA's primary purpose is to promote the science and art of medicine, the care and well-being of patients, the protection of public health, and the betterment of the medical profession. CMA and its members share the objective of promoting high quality, cost-effective health care for the people of California.

Catholic Healthcare West owns and operates 47 not-for-profit hospitals throughout the western United States.

Mercy Healthcare Sacramento, a Catholic system sponsored by the Sisters of Mercy of Auburn, is the largest health care system in the Sacramento area, with acute care, subacute care, home health, and medical clinic facilities located in Sacramento, Yolo, and Nevada counties.

The San Francisco Medical Society is a component society of the California Medical Association and the oldest professional association for physicians in California.

Individuals (in alphabetical order)

The 43 individual amici curiae are bioethicists working in medicine, nursing, and academia.

Tricia Bell, M.D., is an internist and intensivist at Kaiser Hospital, San Rafael, California, and co-director for the Ethics Department, Northern California Region of the Permanente Medical Group.

Howard Brody, M.D., Ph.D., is a physician on the faculty of the Michigan State University Center for Ethics and Humanities in the Life Sciences.

Robert V. Brody, M.D., is chair of the ethics committee and chief of the Pain Consultation Clinic at San Francisco General Hospital, and a professor at the University of California, San Francisco.

Jeffrey Burack, M.D., M.P.P., B.Phil., is Assistant Adjunct Professor of Bioethics and Medical Humanities at the University of California, Berkeley, Assistant Clinical Professor of Medicine at the University of California, San Francisco, and Attending Physician at the East Bay AIDS Center, Berkeley, California.

Margaret L. Campbell, R.N., is co-chair of the ethics committee at Detroit Receiving Hospital.

Norman L. Cantor, Esq., is Professor of Law at Rutgers Law School in Newark, New Jersey.

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Larry R. Churchill, Ph.D., is Professor of Social Medicine at the University of North Carolina at Chapel Hill, and is director of the University of North Carolina Center for Health Ethics and Policy.

Gail M. Cobe, M.S.N., R.N., works with the elderly at Laguna Honda Hospital in San Francisco.

Theresa Drought, Ph.D., R.N., is co-director of ethics for Northern California Kaiser Permanente and is the founder and director of the Long Term Care Bioethics Consortium.

Gerald Dworkin, Ph.D., is Professor of Philosophy at the University of California, Davis.

Sheila Enders, M.S.W., is Assistant Clinical Professor at the U.C. Davis Medical Center.

Rev. Mark Farnham is a healthcare chaplin at the Medical Center of Ocean County in Brick, New Jersey.

N. Marlene Fleming, Esq., is Director of Human Resources at Friends Hospital in Philadelphia.

Joel Frader, M.D., is Professor of Pediatrics and Professor of Medical Ethics and Humanities at Northwestern University Medical School.

Leslie Pickering Francis, Ph.D., is Professor of Philosophy and Alfred C. Emery Professor of Law at the University of Utah.

Chris Hackler, Ph.D., teaches medical ethics in the College of Medicine at the University of Arkansas for Medical Sciences.

Steve Heilig is director of the Bay Area Network of Ethics Committees.

Elizabeth Heitman, Ph.D., is on the faculty of the University of Texas School of Public Health.

Albert R. Jonsen, Ph.D., is Emeritus Professor of Ethics in Medicine, School of Medicine, University of Washington.

Bernard Lo, M.D., is Professor of Medicine and Director of the Program in Medical Ethics at the University of California, San Francisco, and a member of the National Bioethics Advisory Commission.

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Steven Miles, M.D., is Professor of Geriatric Medicine & Bioethics at the University of Minnesota and a past president of the American Association of Bioethics.

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Virginia A. Sharpe, Ph.D., is Deputy Director of the Hastings Center in Garrison, New York, the nation's oldest independent research and education institution devoted to bioethics.

Howard Slyter, M.D., is chair of the Bioethics Committee at Kaiser Hospital in Sacramento.

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May Waldron, R.N., works as a shift supervisor at Mercy Suburban Hospital in Norriston, Pennsylvania.

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Ernie Young, Ph.D., is a professor of medicine (ethics) in the Stanford University School of Medicine and is co-director of the Stanford University Center for Biomedical Ethics.

Laurie Zoloth, Ph.D., is Professor of Social Ethics and Director of Jewish Studies at San Francisco State University.

INTEREST OF AMICI CURIAE

The issues presented in this case implicate the philosophy of bioethics and the practice of medicine and nursing. Their resolution will have a direct and profound impact on the health care practices of the organizational amici curiae's members and on the bioethical teachings of the individual amici curiae. For this reason, the amici curiae have a substantial interest in the present matter.

NEED FOR FURTHER BRIEFING

The amici curiae are familiar with the issues before this court and the scope of their presentation. The amici curiae believe that further briefing is necessary to address matters not fully addressed by the parties' briefs: the practical experience of physicians with regard to proof of an incompetent patient's preferences concerning life-sustaining medical treatment, and the guidelines provided by bioethicists for surrogate decision-making on behalf of incompetent patients.

CONCLUSION

For the foregoing reasons, the amici curiae respectfully request that the court accept the attached brief for filing in this case.

Dated: December 18, 2001

Respectfully submitted,

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MEDICAL SOCIETY, AND 43
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COVER]**

**AMICI CURIAE BRIEF IN SUPPORT OF
ROSE WENDLAND AND ROBERT WENDLAND**

INTRODUCTION

Robert Wendland is profoundly brain-damaged from injuries sustained in an automobile accident. He exists in a state of severe cognitive impairment, unable to communicate or to act volitionally. He has been kept alive by surgically-implanted feeding tubes.

Before the accident, Robert told his wife and brother that he would not want to live under such circumstances. His wife, Rose Wendland, is now his legal conservator. She wants his doctors to withdraw artificial feeding so that his previously-expressed wishes may be carried out. Robert's mother and sister – the petitioners in this case – want him to be kept alive.

The law gives Robert the right to refuse medical treatment, including artificial nutrition and hydration. As Robert's conservator, Rose has exclusive authority, under Probate Code section 2355, to exercise that right on Robert's behalf. One of the grounds for such exercise is Rose's knowledge that Robert would refuse treatment if he could speak for himself. If disputed in litigation, section 2355 requires proof by a preponderance of the evidence that a conservator is acting in accordance with the conservatee's wishes. Petitioners contend *constitutional* law requires a higher standard of proof – clear and convincing evidence.

In this amici curiae brief, we explain why, in light of statutory and bioethical safeguards for surrogate decision-making, the heightened standard of proof would unjustifiably infringe the right to refuse medical treatment by

demanding unattainable certainty about a patient's subjective wishes and values.^{1/}

BACKGROUND

A. The Factual Context.

Robert Wendland was gravely injured in an automobile accident in 1993. He was in a coma for 16 months. He emerged from the coma in 1995 with severe cognitive impairment.

The Court of Appeal described Robert's condition as follows: "He is paralyzed on the right side and is unable to communicate consistently, feed himself, or control his bowels or bladder. He wears diapers. He receives food and fluids through a feeding tube. By the late spring of 1995, he was interacting with his environment, but minimally and inconsistently. At his highest level of functioning, he has been able to do (with repeated prompting and cuing [pointing] by therapists) such activities as grasp and release a ball, operate an electric wheelchair with a 'joystick,' move himself in a manual wheelchair with his left hand or foot, balance himself momentarily in a 'standing frame' while grabbing and pulling 'thera-putty,' draw the letter 'R,' and choose and replace requested color blocks out of several color choices. Each activity is performed only after excruciatingly repetitive prompting and

^{1/} The parties have briefed other issues which this amici curiae brief does not address. This brief focuses on matters within the amici's special expertise, including the practical experience of physicians with regard to proof of an incompetent patient's preferences concerning life-sustaining medical treatment and the guidelines provided by bioethicists for surrogate decision-making on behalf of incompetent patients. The amici curiae express neither agreement nor disagreement with Rose's decision, but submit this brief to discuss the standard of proof by which her decision is to be reviewed.

cuing by the therapists. Robert never smiles. What little emotion he does show is negative and combative. Since he has cognitive function, he is *not* considered to be in a ‘persistent vegetative state’ (hereafter PVS).” (*Conservatorship of Wendland* (2000) 78 Cal.App.4th 517, 526-527.)

Robert’s condition worsened after 1995. By the end of 1998, he was unable to communicate in any form and had become far less active. He reacted irritably to procedures performed on his mouth and tracheostomy cover, and he was often agitated, striking out violently at staff members. All restorative therapies had been discontinued. (See Appellant Robert Wendland’s Motion To Admit Additional Evidence, filed Aug. 21, 2000.)

According to the Court of Appeal, expert witnesses testified that “Robert would never be able to communicate meaningfully to express his needs or wants. Those experts acknowledged Robert at times engages in cognitive behavior, which is more than mere reflexive behavior (such as the kick of a knee upon being tapped with a rubber hammer) and more than a mere automatic action (such as scratching a nose that itches). However, those experts did not believe Robert can act on a volitional cognitive level, where people make a cognitive choice and develop a strategy to provide a motor response to stimuli. . . . Robert is unable to think in the manner we conceive humans do, and his responses are simply a matter of rote response to an outside stimulus, or rote execution of exceedingly simple tasks.” (*Conservatorship of Wendland, supra*, 78 Cal.App.4th at p. 530.)

Robert’s condition will not improve. The trial judge concluded that Robert “has no reasonable chance for the return to cognitive and sapient life.” (*Id.* at p. 533.) According to the Court of Appeal, “Doctors testified that, to the highest degree of medical certainty, Robert will never be able to feed himself, bathe himself, control his bladder or bowels, or communicate verbally or in writing.” (*Id.* at p. 529.) Yet, by receiving artificial nutrition and

hydration through a feeding tube, Robert, now age 49, “could survive many years in his current condition” (*Id.* at p. 531.)

Robert’s wife of 22 years, Rose Wendland, believes that Robert’s wish would be to refuse further life-sustaining treatment. Three months before his accident, after Rose’s father died upon termination of life support, Robert told her: “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.” Five days before the accident, Rose and his brother told him they feared he might be badly injured in a drunk-driving accident, and Robert said: “If that ever a [sic] happened to me, you know what my feelings are. Don’t let that happen to me. Just let me go. Leave me alone. [¶] We talked about that with your father. I wouldn’t want my children to ever see me like that.” Rose testified that although Robert never described a condition precisely like that he presently suffers, he made clear “that under no circumstances would he want to live if he had to have diapers or if he had to have life support or if he had to be kept alive with a feeding tube or if he could not be a ‘husband, father, provider.’” (*Id.* at p. 531.) Robert’s brother likewise testified that Robert “indicated he would not want to be a vegetable,” meaning “he did not want to be kept alive with tubes.” (*Id.* at p. 532.)

Between January and July of 1995, Robert’s feeding tube – a “jejunostomy” tube surgically inserted through the abdomen wall and attached to the inside of the small intestine – became dislodged four times, requiring surgical reinsertion. After the fourth time, Rose asked the attending physician to cease artificial nutrition and hydration, which the physician continued through other types of feeding tubes pending review by the hospital’s ethics committee. (*Id.* at p. 527.)

The ethics committee determined that it had no objection to Rose’s request. The county patient ombudsman supported Rose’s decision, as did Robert’s attending physician. (*Ibid.*)

Robert's mother and sister, however, oppose the withdrawal of artificial nutrition and hydration. They commenced litigation to prevent it. Shortly thereafter, the probate court appointed Rose to be Robert's conservator – that is, Robert's surrogate decision-maker. (*Id.* at p. 528.)

After an evidentiary hearing, the probate court prohibited Rose from having Robert's feeding tube removed. The judge said that although he had “a ‘strong suspicion’ that Robert would have desired to die under these circumstances,” Robert's pre-accident comments to Rose and his brother “do not establish by clear and convincing evidence that the conservatee would desire to have his life-sustaining medical treatment terminated under the circumstances in which he now finds himself.” (*Id.* at pp. 532-533.)

B. The Bioethical Context.

1. The central value of personal autonomy.

The facts of this case implicate the philosophy of bioethics, which guides the resolution of ethical problems that arise in the practice of medicine, including the ethical issue presented here. Under the bioethical principle respecting a patient's right of *personal autonomy*, Rose, as Robert's surrogate decision-maker, may exercise substituted judgment and choose withdrawal of artificial nutrition and hydration based on her knowledge of Robert's wishes and personal values.

Petitioners claim that “[t]here do not exist today, nor did there exist in July 1995, when this proceeding commenced, or at the time of the evidentiary hearing (1997) *any* medical guidelines, criteria, protocol or authority governing the withdrawal of life-sustaining food and fluids from a cognitively-impaired, disabled patient such as Robert, i.e., a patient who is not in a PVS,

permanently comatose or terminally ill.” (Opening Brief On The Merits p. 35, original italics and underlining.) Petitioners are mistaken.

The bioethical guidelines that apply to this case are described in a publication which is familiar to this court – the Hastings Center’s Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying, cited in *Thor v. Superior Court* (1993) 5 Cal.4th 725, 737-738. The Hastings Center “devotes itself to the research of ethical problems in medicine, biology, and the life sciences” (*Id.* at p. 737.)

As the Hastings Center explains, bioethicists have identified four “central values,” of equal importance, which “come from the moral traditions of medicine and nursing and from the ethical, religious, and legal traditions of our society.” (Hastings Center, Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying (1987) p. 6-7 (hereafter Hastings Center Guidelines).)

One of these values is *beneficence*, which acknowledges that “the proper goal of medicine is to promote the patient’s well-being.” (*Id.* at p. 7.)

Another value is *the integrity of health care professionals*, who “have a right to remain true to their own conscientious moral and religious beliefs. . . . Thus provisions should be made to allow health care professionals to withdraw from particular cases as a matter of conscience” (*Id.* at p. 8.)

Another value is *justice*, which “demands that individuals have an opportunity to obtain the health care they need on an equitable basis” yet “places ethical limits on the patient’s liberty to demand, rather than forgo, scarce medical resources.” (*Id.* at p. 8.)

The remaining value is *personal autonomy*, “which establishes the right of the patient to determine the nature of his or her own medical care.” (*Id.* at p. 7.) Protecting the right of personal autonomy “reflects our society’s long-standing tradition of recognizing the unique worth of the individual. We respect human dignity by granting individuals the freedom to make choices in

accordance with their own values.” (*Ibid.*) And it is accepted that “[i]f a patient lacks decisionmaking capacity, *respecting autonomy means that an appropriate surrogate . . . should make decisions*” on the patient’s behalf. (*Id.* at pp. 7-8, italics added.)

At issue here is the personal autonomy of an incompetent patient.

**2. Surrogate exercise of personal autonomy:
advance directives, subjective wishes, and best
interests.**

The Hastings Center guidelines describe three bioethical models for surrogate exercise of an incompetent patient’s right of personal autonomy, under the guiding principle that “the surrogate should seek to choose as the patient would if he or she were able.” (*Id.* at p. 27.) These guidelines are not restricted to patients in a coma or PVS, but apply to surrogate decision-making for *any* cognitively-impaired patient. (See American Medical Ass’n, Opns. of the Council on Ethical and Judicial Affairs, Opn. E-2.20 (1996) [policies for surrogate exercise of right to refuse life-sustaining medical treatment apply even if patient is not terminally ill or permanently unconscious].)

The first model applies if the patient previously gave an *advance directive* prescribing his or her preferences. “Where a patient who had decisionmaking capacity at the time, has left written directions in an advance directive . . . or another form, or clear oral instructions, and these directions seem intended to cover the situation presented, the surrogate should follow the instructions.” (Hastings Center Guidelines, *supra*, at p. 28.)

The second model is invoked where there is no advance directive but the patient has otherwise made known his or her *preferences and values*. “If the patient has left no directions about the treatment in question, the surrogate

should apply what is known about the patient's preferences and values, trying to choose as the patient would have wanted." (*Ibid.*) This model focuses on the patient's *subjective wishes*.

The third model involves determining the patient's *best interests* when nothing is known about his or her advance directions, preferences, or values. "If there is not enough known about the patient's directions, preferences, and values to make an individualized decision, the surrogate should choose so as to promote the patient's interests as they would probably be conceived by a reasonable person in the patient's circumstances, selecting from within the range of choices that reasonable people would make." (*Ibid.*) This "reasonable person" model has elements of an *objective* standard.

In short, surrogate decisions to withhold artificial nutrition and hydration are accepted by bioethicists. "The health care professional who stops or refrains from using a life-sustaining treatment when the patient *or surrogate* makes an ethically appropriate decision to forgo it, acts in keeping with the ethical mandates of his or her profession." (*Id.* at pp. 19-20, italics added.)^{2/}

Such decisions are also accepted by the American public. Studies indicate that at least 20 percent of Americans who are treated with artificial nutrition and hydration have it withdrawn (Campbell & Frank, *Experience with an end-of-life practice at a university hospital* (1997) 25 *Critical Care Medicine* 197, 199), and that at least three-fourths of Americans believe the law should permit such withdrawal of treatment if requested by patients or their families (Blendon et al., *Should Physicians Aid Their Patients in Dying?* (May 20, 1992) 267 *JAMA* 2658, 2659). The present case implicates the second bioethical model for surrogate decision-making: the *subjective wishes*

^{2/} The Hastings Center also prescribes guidelines for *implementing* a decision to withhold artificial nutrition and hydration. (Hastings Center Guidelines, *supra*, at p. 61.)

standard, where the surrogate is guided by the patient's known preferences and values. The pivotal issue presented for this court's decision is not bioethical but *legal*: by what standard of proof must it be demonstrated that Rose is acting according to Robert's known wishes?

C. The Legal Context.

1. The constitutional right of personal autonomy.

The central value of personal autonomy is where bioethics intersects with the law.

No legal right is more important in American society than the right of personal autonomy – “the right of every individual to possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law” (*Thor v. Superior Court*, *supra*, 5 Cal.4th at p. 731, quoting *Union Pacific Railway Co. v. Botsford* (1891) 141 U.S. 250, 251 [11 S.Ct. 1000, 35 L.Ed. 734].) This right includes the right “to decline life-sustaining treatment, even if to do so will cause or hasten death.” (*Id.* at p. 732.) “[U]nder California law a competent, informed adult has a fundamental right of self-determination to refuse or demand the withdrawal of medical treatment of any form irrespective of the personal consequences.” (*Ibid.*) The California Legislature has embraced this right through a legislative finding “that an adult has the fundamental right to control the decisions relating to his or her own health care, including the decision to have life-sustaining treatment withheld or withdrawn.” (Prob. Code, § 4650, subd. (a).)

The right to refuse medical treatment is *constitutional*. The United States Supreme Court places it within the 14th Amendment. (*Cruzan v. Director, Missouri Dept. of Health* (1990) 497 U.S. 261, 279, fn. 7 [110 S.Ct.

2841, 111 L.Ed.2d 224].) California courts place it within the state constitutional right of privacy. (*Conservatorship of Drabick* (1988) 200 Cal.App.3d 185, 206, fn. 20; *Bouvia v. Superior Court* (1986) 179 Cal.App.3d 1127, 1137; see *Thor v. Superior Court, supra*, 5 Cal.4th at p. 736, fn. 6.)

**2. Surrogate exercise of personal autonomy:
Probate Code section 2355.**

When a patient is not competent, the decision whether to refuse medical treatment must be made by a *surrogate*. Standards for exercise of an incompetent California conservatee's right to refuse treatment are prescribed in Probate Code section 2355.

Before section 2355 was amended effective July 1, 2000, it simply gave the conservator "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" The former version of the statute did not parse surrogate decision-making into the three bioethical models of advance directives, subjective wishes, and best interests. The amended version of section 2355 does.

Now, in addition to requiring the conservator to make a decision "in good faith based on medical advice," the statute prescribes a three-pronged rule for surrogate decision-making: "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. 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." (Prob. Code, § 2355, subd. (a).)

The amendment of section 2355 brings the statute fully into the mainstream of bioethics, and in line with the Uniform Health-Care Decisions Act of 1993, from which section 2355 is drawn.^{3/} First, if the conservatee has given any written or oral *advance directives* – in the language of the statute, “individual health care instructions” (see Prob. Code, § 4623) – they must be followed. Second, if there is no advance directive or it is insufficiently specific, the conservator must decide based on what is known about the conservatee’s *subjective wishes* – in the language of the statute, “any other wishes to the extent known to the conservator.” Third, if the conservatee’s wishes are unknown, the conservator has exclusive authority to decide based on the conservator’s determination of the conservatee’s *best interest*, also taking into account a subjective element – the conservatee’s personal values – if known. (Thus, even if Robert had been too vague or had said nothing to Rose or his brother about his wishes, Rose would still have exclusive authority to make a “best interest” decision under the third bioethical model.)

Also, amended section 2355 expressly authorizes a surrogate’s decision to withdraw artificial nutrition and hydration. The statute says “health care decision” has the meaning prescribed by Probate Code section 4617. (Prob. Code, § 2355, subd. (a).) Section 4617 defines “health care decision” as including “[d]irections to provide, withhold, or withdraw artificial nutrition and hydration” (Prob. Code, § 4617, subd. (c).)

^{3/} The Uniform Health-Care Decisions Act provides: “A surrogate shall make a health-care decision in accordance with the patient’s individual instructions, if any, and other wishes to the extent known to the surrogate. Otherwise, the surrogate shall make the decision in accordance with the surrogate’s determination of the patient’s best interest. In determining the patient’s best interest, the surrogate shall consider the patient’s personal values to the extent known to the surrogate.” (West’s U. Laws Ann. (1999) U. Health-Care Decisions Act, § 5, subd. (f).)

At the same time section 2355 was amended, the Legislature amended Probate Code section 4650 to include the legislative finding embracing the right to refuse medical treatment. (See *ante*, p. 17.) The Law Revision Commission explains that this finding *is not limited to persons who are terminally ill or permanently unconscious*. (Cal. Law Revision Com. com., Deering’s Ann. Prob. Code, § 4650 (2000 supp.) p. 201; see also *Thor v. Superior Court*, *supra*, 5 Cal.4th at p. 744 [right of autonomy “does not depend upon the nature of the treatment refused or withdrawn; nor is it reserved to those suffering from terminal conditions”].) Thus, California law, like bioethics, does not restrict surrogate exercise of the right to refuse medical treatment to persons who are in a coma or PVS, but extends the right to everyone, including the cognitively impaired.^{4/}

The present case implicates the second prong of section 2355’s rule for surrogate health care decisions: accord with the conservatee’s “wishes to the extent known to the conservator.” (Prob. Code, § 2355, subd. (a).)

^{4/} Petitioners claim that section 2355 is limited to persons who are terminally ill or permanently unconscious because, petitioners say, it codifies *Conservatorship of Drabick*, *supra*, 200 Cal.App.3d 185, which was expressly limited to the “factual predicate” of “its subject being a patient for whom there is no reasonable hope of a return to cognitive life” (*id.* at p. 217, fn. 36). (Reply Brief On The Merits, p. 9.) Section 2355, however, does not codify *Drabick*. Rather, the Law Revision Commission explains that the statute “is consistent” with language in *Drabick* stating that incapacitated patients retain the right to have medical decisions made on their behalf. (Cal. Law Revision Com. com., Deering’s Ann. Prob. Code, § 2355 (2000 supp.) p. 134.) In other respects section 2355 is *inconsistent* with *Drabick*: the statute says a conservator “shall” decide in accordance with the conservatee’s known wishes (Prob. Code, § 2355, subd. (a)), whereas *Drabick* said the conservator “may” consider the conservatee’s prior informal statements but is not compelled to follow them. (*Conservatorship of Drabick*, *supra*, 200 Cal.App.3d at p. 210.)

3. The standard of proof.

Which *standard of proof* is required to demonstrate that a conservator is acting in accordance with the conservatee’s known wishes – preponderance of the evidence, or clear and convincing evidence?

An early California decision on the right to refuse medical treatment said in 1988: “There is no necessity or authority for adopting a rule to the effect that the conservatee’s desire to have medical treatment withdrawn must be proved by clear and convincing evidence or another standard.” (*Conservatorship of Drabick, supra*, 200 Cal.App.3d at p. 212.) Two years later, the United States Supreme Court said in *Cruzan v. Director, Missouri Dept. of Health, supra*, 497 U.S. at pages 281-284, that under the federal constitution the states “may” – *not must* – require clear and convincing evidence. *Cruzan* does not prevent the states “from developing other approaches for protecting an incompetent individual’s liberty interest in refusing medical treatment.” (*Id.* at p. 292 (conc. opn. of O’Connor, J.).)

The California Legislature has chosen *not* to require clear and convincing evidence. The Law Revision Commission comment for amended Probate Code section 2355 states: “This section does not specify any special evidentiary standard for the determination of the conservatee’s wishes or best interest. Consequently, the general rule applies: *the standard is by preponderance of the evidence. Proof is not required by clear and convincing evidence.*” (Cal. Law Revision Com. com., Deering’s Ann. Prob. Code, § 2355 (2000 supp.) p. 134, italics added; see *Brian W. v. Superior Court* (1978) 20 Cal.3d 618, 623 [Law Revision Commission comments “are persuasive evidence of the intent of the Legislature in subsequently enacting its recommendations into law”].)

The central legal issue posed by petitioners in this case is whether a heightened standard of proof is *constitutionally* required. Petitioners argue for

a *presumption* against a conservator’s withdrawal of artificial nutrition and hydration, rebuttable only by *clear and convincing evidence* of the conservatee’s wishes or best interests. In this amici curiae brief, we explain why Probate Code section 2355 does not compromise the state’s interest in preserving life, whereas the proposed presumption and heightened standard of proof would infringe the right to refuse medical treatment and violate California’s constitutional right of privacy.^{5/}

^{5/} The Court of Appeal rejected petitioners’ proposed presumption and held that, under the pre-amendment version of Probate Code section 2355, a conservatee’s subjective wishes need not be proven at all. (*Conservatorship of Wendland, supra*, 78 Cal.App.4th at p. 544.) The court also held, however, that due process requires conservators to prove by clear and convincing evidence the statutory requirement that they have decided *in good faith based on medical advice*. (*Id.* at pp. 549-558.) The two points – proof that the conservator is acting according to the conservatee’s wishes, and proof that the conservator has decided in good faith based on medical advice – are related but distinct. This brief addresses only the former point. The latter is not seriously at issue in this case: the trial judge expressly found that the evidence of Rose’s good faith was clear and convincing (*id.* at p. 533) and although petitioners claim they have not had an opportunity to present opposing evidence (see Reply Brief On The Merits, pp. 8-9), they do not say how they could rebut Rose’s proof.

LEGAL DISCUSSION

I.

A REQUIREMENT OF CLEAR AND CONVINCING EVIDENCE TO REBUT A PRESUMPTION AGAINST WITHDRAWING ARTIFICIAL NUTRITION AND HYDRATION WOULD PRECLUDE MANY SURROGATES FROM EXERCISING THE RIGHT TO REFUSE MEDICAL TREATMENT.

A. Because People Seldom Give Precise Instructions for Medical Treatment in the Event of Catastrophe, Surrogates Usually Must Rely on Evidence That Would Not Meet the Heightened Standard of Proof.

The problem with petitioners' argument for a heightened standard of proof is that their advocacy is contrary to reality. Most people – whether because of tradition, culture, religion, discomfort, or just plain fear – don't confront life-and-death issues with the lawyer-like precision required for proof by clear and convincing evidence. Health care professionals know, from daily experience, that people tend to avoid discussing catastrophic debility and death, especially when healthy.

The preference is for an advance directive such as a living will or power of attorney for health care. But studies show that advance directives, written or oral, are provided by no more than 10 to 20 percent of Americans. (See Recommendation: Health Care Decisions for Adults Without Decisionmaking Capacity (Dec. 1998) 29 Cal. Law Revision Com. Rep. (1999) p. 16.) Even where there *are* written directives, they often are not made available to health

care providers, languishing in a secure but forgotten place outside the patient's medical record. (See Lynn & Teno, *A Care Provider Perspective on Advance Directives and Surrogate Decision Making for Incompetent Adults in the United States* in *Advance Directives and Surrogate Decision Making in Health Care* (Sass, Veatch & Kimura edits., 1998) p. 18.) And some advance directives might be too general or uncertain for the specific issue presented. (See Meisel, *Legal Issues in Decision Making for Incompetent Patients* in *Advance Directives and Surrogate Decision Making in Health Care*, *supra*, p. 54; Cantor, *Making Advance Directives Work* (1998) 4 *Psychology, Public Policy, and Law* 629, 632-639.) Thus, the first bioethical model for surrogate decision-making is seldom invoked.

“Best interests” decisions under the third bioethical model are equally uncommon, for usually something is known about the patient's wishes and values. One study showed that a “best interests” decision was required for only 18 percent of incompetent patients. (Campbell & Frank, *Experience with an end-of-life practice at a university hospital*, *supra*, 25 *Critical Care Medicine* at p. 200.)

Thus, “most decisions to limit treatment are made as substituted judgments, that is, a surrogate infers the decision the patient would have made if capable, based on the surrogate's knowledge of the patient's wishes and values.” (*Id.* at p. 199.) In other words, the second bioethical model – a decision according to the patient's known wishes – is the one most frequently invoked.

Robert's pre-accident comments to his wife and brother are typical of how most of us speak about the prospect of having our lives sustained by ventilators, feeding tubes, and the like – in plain, everyday language. Some people indicate they would abhor the notion: “I wouldn't want to live like a vegetable.” “I don't want to be kept alive by machines and tubes.” “I want to die with dignity.” Others indicate they would want such measures to be taken:

“Life is precious.” “People shouldn’t play God.” “Do everything possible.” In either case, however, the choice is perhaps the most personal of decisions – the ultimate assertion of autonomy – and, when expressed, is usually stated in lay terms that will not be as “explicit and unequivocal” as is required for clear and convincing proof. (See *In re Jost* (1953) 117 Cal.App.2d 379, 383.)

Indeed, the law acknowledges – and accommodates – the difficulties in proving *any* subjective thought processes. “A subjective state of mind will rarely be susceptible of direct proof; usually the trial court will be required to infer it from circumstantial evidence.” (*Knight v. City of Capitola* (1992) 4 Cal.App.4th 918, 932.)

Recognizing that prior conversations with family and friends are usually the best source for determining an incompetent patient’s wishes and values, physicians and bioethicists now encourage such dialogue in order to facilitate subsequent end-of-life decision-making. If the law demands an unrealistically high level of conversational precision, such dialogue will too often be deprived of its intended effect, sometimes with tragic consequences. That seems to be petitioners’ goal: they say that under the heightened standard of proof, Rose could “*never* meet her burden.” (Opening Brief On The Merits, pp. 13-14, fn. 8, original italics.)

B. The Heightened Standard of Proof Would Preclude Many Surrogates From Exercising the Right to Refuse Medical Treatment By Requiring Unattainable Certainty and Forcing Physicians to Demand Judicial Approval.

Physicians, like other people, fear lawsuits. If this court decides that physicians may not follow a surrogate's instruction to withdraw life-sustaining treatment unless the evidence of the patient's wishes satisfies a "clear and convincing" standard of proof, many physicians will refuse to do so without judicial approval. This is not just common sense, it is empirically demonstrable: for example, a survey of 295 physicians indicated that 96 percent worried or modified their practice because of perceived legal vulnerability in treating terminally-ill patients, and over 45 percent might refuse a family member's request to comply with a formerly-competent patient's stated preferences to have life-sustaining treatment withdrawn, in large part for fear of legal action. (McCrary et al., *Treatment Decisions for Terminally Ill Patients: Physicians' Legal Defensiveness and Knowledge of Medical Law* (Winter 1992) 20 Law, Medicine & Health Care 364, 369, 371.)

Petitioners urge that judicial oversight is essential. But the California courts have repeatedly said that judges should *not* be the arbiters of the right to refuse medical treatment. "Judicial intervention in 'right to die' cases should be minimal. 'Courts are not the proper place to resolve the agonizing personal problems that underlie these cases. Our legal system cannot replace the more intimate struggle that must be borne by the patient, those caring for the patient, and those who care about the patient.'" (*Conservatorship of Morrison* (1988) 206 Cal.App.3d 304, 312, quoting *Matter of Jobes* (1987) 108 N.J. 394 [529 A.2d 434, 451]; accord, *Conservatorship of Drabick, supra*, 200 Cal.App.3d at pp. 198-200; *Barber v. Superior Court* (1983) 147 Cal.App.3d 1006, 1021-1022.)

The Legislature agrees. Legislation effective July 1, 2000, says: “A health care decision made by a surrogate for a patient is effective without judicial approval.” (Prob. Code, § 4750, subd. (c).) The Law Revision Commission explains: “This section makes clear that judicial involvement in health care decisionmaking is disfavored.” (Cal. Law Revision Com. com., Deering’s Ann. Prob. Code, § 4750 (2000 supp.) p. 232.) This legislative policy encompasses decision-making by conservators under Probate Code section 2355, where judicial intervention “is neither required by statute, nor desired by the courts.” (Cal. Law Revision Com. com., Deering’s Ann. Prob. Code, § 2355 (2000 supp.) p. 134.)

Petitioners would have this court deprive physicians of this legislative assurance and hold them to a standard of proof requiring unattainable certainty as to an individual patient’s wishes – with the result that, absent judicial approval, physicians would be more likely to refuse to follow a surrogate’s instructions to withdraw life-sustaining treatment. Thus, as a practical matter, because people seldom give precise instructions for treatment in the event of catastrophe, imposing the heightened standard of proof *would in many cases destroy the right to refuse medical treatment*. “When a person tells family or close friends that she does not want her life sustained artificially, she is ‘express[ing] her wishes in the only terms familiar to her, and . . . as clearly as a lay person should be asked to express them. To require more is unrealistic, and for all practical purposes, it precludes the right of patients to forego life-sustaining treatment.’” (*Cruzan v. Director, Missouri Dept. of Health, supra*, 497 U.S. at p. 324, original brackets and ellipsis (dis. opn. of Brennan, J.).)

II.

THE STATE’S INTEREST IN PRESERVING LIFE IS AMPLY PROTECTED BY PROBATE CODE SECTION 2355 AND SAFEGUARDS WITHIN THE HEALTH CARE PROFESSIONS.

A. A Sound Decision Is Ensured By the Statutory Requirements That a Conservator Make Health Care Decisions Based on Medical Advice and in Accordance With the Conservatee’s Known Wishes and Values.

If the heightened standard of proof would preclude much surrogate exercise of the right to refuse medical treatment, does the normal standard of proof leave conservatees without adequate protection for the right to life guaranteed by the United States and California constitutions? (See U.S. Const., 14th Amend.; Cal. Const., art. I, §1.) The answer is no.

Exercise of the right to refuse medical treatment can implicate any one of four countervailing state interests: preserving life, preventing suicide, maintaining the integrity of the medical profession, or protecting innocent third parties. (*Thor v. Superior Court, supra*, 5 Cal.4th at p. 738.) The countervailing state interest at issue here is *preserving life*, which this court has called a “paramount concern.” (*Ibid.*) In the context of surrogate exercise of the right to refuse medical treatment, the state’s interest in preserving life is adequately protected by Probate Code section 2355 and safeguards within the health care professions.

Probate Code section 2355 ensures a sound decision consistent with the *conservatee’s* own interest in preserving his or her life, in two ways. First, the statute requires that conservators make health care decisions “in good faith based on medical advice.” (Prob. Code, § 2355, subd. (a).) “[T]he purpose

of seeking advice is to obtain information enabling the conservator to formulate a judgment about what is in the patient's best interest." (*Conservatorship of Morrison, supra*, 206 Cal.App.3d at p. 310.) Medical advice operates as a check on the possibility of a self-interested decision by the conservator contrary to the conservatee's interest in staying alive. The conservator is not statutorily required to *follow* the medical advice (*ibid.*), but failure to do so might call into question the conservator's good faith.

Second, the amended statute's adoption of the three bioethical models for surrogate decision-making ensures that the decision is made under the guidance provided by accepted principles of bioethics. "The duty of the State to preserve life must encompass a recognition of an individual's right to avoid circumstances in which the individual himself would feel that efforts to sustain life demean or degrade his humanity." (*Thor v. Superior Court, supra*, 5 Cal.4th at p. 739, brackets omitted, quoting *Brophy v. New England Sinai Hospital, Inc.* (1986) 398 Mass. 417 [497 N.E.2d 626, 635].) The conservator's challenge is to decide, on behalf of the conservatee, whether the conservatee would choose or reject efforts to preserve life under the circumstances presented. In making that choice, the conservator is statutorily required, consistent with bioethical guidelines, to call upon any knowledge of the conservatee's expressed "wishes" or "personal values." (Prob. Code, § 2355, subd. (a).) By embracing the mainstream of bioethics, Probate Code section 2355 provides a reliable framework for responsible decision-making, focusing the decision-making process on what the *conservatee* would want.^{6/}

^{6/} Petitioners claim that because of the requirement that the conservator make a best-interests decision "in good faith" and "in accordance with the *conservator's determination* of the conservatee's best interest" (Prob. Code, § 2355, subd. (a), italics added), the "entire thrust" of inquiry under section 2355 is on the conservator's intent and motives rather than the conservatee's rights and interests. (Reply Brief On The Merits, pp. 10-11.) Petitioners are (continued...)

B. A Sound Decision Is Ensured By Ethics Committees and Other Safeguards Within the Health Care Professions.

The interest in preserving life is further protected by various safeguards within the health care professions – chief among them the *hospital ethics committee*.

Since 1992, the Joint Commission on Accreditation of Health Care Organizations “has required that hospitals and other health care organizations establish organizational mechanisms for formulating ethics policy and addressing ethical conflicts within the health care setting. In most health care institutions this mechanism is the ethics committee. . . . Hospital ethics committees have already become commonplace in the United States and are playing a vital role in addressing bioethical questions.” (Minogue, *Bioethics: A Committee Approach* (1996) p. 1 (hereafter Minogue).)

Ethics committees serve various functions: they devise educational programs, they formulate institutional policies and guidelines, and they give advice on particular cases. (*Id.* at pp. 5-6; Hastings Center Guidelines, *supra*, p. 100.) They draw their membership from a variety of disciplines in order to ensure consideration of a broad range of views. (Minogue, *supra*, p. 3.) The Hastings Center guidelines state: “Committee membership should be diverse, including representatives from many areas of the institution and at least one person from outside the institution. Members might include doctors (both senior and junior), nurses, social workers, administrators, lawyers, chaplains or other religious representatives, and people familiar with medical ethics.”

6/ (...continued)

mistaken. Under section 2355, the conservator’s *first consideration* is the conservatee’s *wishes*, whether expressed in an advance directive or in some other way. The conservator’s determination of best interests is required only if the conservatee’s wishes are unknown – which is not the situation here.

(Hastings Center Guidelines, *supra*, pp. 101-102.) Even lay persons are represented: “The voice of the lay person is vital because patients belong to this group; modern technological medicine needs to hear the opinions, values, and feelings of those it serves.” (Minogue, *supra*, p. 3.)

As so composed, ethics committees are capable of an interdisciplinary review that no trial or appellate court could ever match, without the polarizing effects of an adversarial legal process. Such review occurred here: a 20-member ethics committee “determined it had no objection to Rose ordering withdrawal of the nutrition/hydration tubes.” (*Conservatorship of Wendland, supra*, 78 Cal.App.4th at p. 527.) By such review, the ethics committee confirmed that Rose’s decision is ethically sound and reflects Robert’s wishes and personal values – and thus does no violence to the state’s interest in preserving life.

Another safeguard within the health care professions is the patient “ombudsman” – a disinterested advocate for patients in long-term care and residential facilities. (See Welf. & Inst. Code, § 9700 et seq., 15600 et seq.) A local ombudsman coordinator can review a decision to withdraw life-sustaining treatment and, if appropriate, ask for investigation by the Office of the State Long-Term Care Ombudsman, which may then refer the case to any appropriate state or local government agency. (See Welf. & Inst. Code, §§ 9710, 9720, 9721.) Here again, such review occurred: “The San Joaquin County patient ombudsman . . . supported Rose’s decision” (*Conservatorship of Wendland, supra*, 78 Cal.App.4th at p. 527.)

Finally, as a matter of professional ethics, a physician shall not accept a surrogate’s decision to forgo treatment if the physician believes that the decision is “clearly not what the patient would have decided if competent” or is “not a decision that could reasonably be judged to be in the patient’s best interests.” (American Medical Ass’n, Opns. of the Council on Ethical and Judicial Affairs, Opn. E-2.20, *supra*.) Robert’s attending physician properly

observed this ethical principle and agreed with the decision of the ethics committee. (*Conservatorship of Wendland, supra*, 78 Cal.App.4th at p. 527.)

Thus, all three safeguards were brought to bear in this case. The hospital ethics committee, an ombudsman, and the attending physician confirmed the propriety of Rose's decision.

III.

IN LIGHT OF EXISTING SAFEGUARDS, A HEIGHTENED STANDARD OF PROOF FOR PROBATE CODE SECTION 2355 IS NOT CONSTITUTIONALLY REQUIRED.

A. The Right to Refuse Medical Treatment Is Not Trumped By, But Ordinarily Outweighs, the Interest in Preserving Life.

Requiring clear and convincing evidence to prove a conservatee's subjective wishes under Probate Code section 2355 would infringe the right of personal autonomy by preventing many surrogates from exercising that right. Yet withdrawal of life-sustaining treatment may implicate the state's interest in preserving life.

Should the interest in preserving life trump the interest in personal autonomy? Or should there be a balancing of interests, in which personal autonomy ordinarily prevails? Petitioners argue for the former. They urge that "Robert's right to autonomy cannot be exalted over his right to life." (Opening Brief On the Merits p. 12.)

In *Thor*, however, this court said otherwise. The state's interests in preserving "the life of the particular patient and . . . the sanctity of all life can only assert themselves at the expense of self-determination and bodily integrity" (*Thor v. Superior Court, supra*, 5 Cal.4th at pp. 738-

739.) Thus, “the state has not embraced an unqualified or undifferentiated policy of preserving life at the expense of personal autonomy.” (*Id.* at p. 740.) Rather, any clash of interests is to be resolved by balancing. The interest in preserving life is not a trump card, but is a “countervailing consideration[] in determining the scope of patient autonomy” (*Id.* at p. 738.) Each circumstance must be examined to determine whether the “countervailing state interest in the preservation of life” will supersede “the right to refuse unwanted medical treatment.” (*Id.* at p. 740.) And in the application of this balancing test, the right to refuse medical treatment “ordinarily outweighs any countervailing state interest.” (*Id.* at p. 744.)

B. Because of Existing Safeguards, the Interest in Preserving Life Does Not Require Infringement of the Right to Refuse Medical Treatment By Imposing the Heightened Standard of Proof.

If the right to refuse medical treatment “ordinarily outweighs” the state’s interest in preserving life (*ibid.*), this case is not extraordinary. The interest in preserving life is amply protected by Probate Code section 2355 (which requires a decision based on medical advice pursuant to accepted principles of bioethics) and by safeguards within the health care professions (where the propriety of a surrogate’s decision is subject to review by a hospital ethics committee, an ombudsman, and the attending physician). Because of these protections, under the present circumstances, the right to refuse medical treatment supersedes any state interest in preserving life.

In contrast, a requirement of clear and convincing evidence to rebut a presumption against withdrawing artificial nutrition and hydration would infringe the right to refuse medical treatment by precluding surrogates from exercising that right on behalf of those of us – the majority – who express our

thoughts on death and dying in everyday language. While a heightened standard of proof for Probate Code section 2355 is not necessary to protect the interest in preserving life, the heightened standard would seriously infringe the interest in personal autonomy. Contrary to *Thor* and principles of bioethics, the heightened standard would, in its application, invariably make the right to refuse medical treatment subordinate to the interest in preserving life.

In the present case, the rule of *Thor* tips the balance in favor of the right to refuse medical treatment. A heightened standard of proof for Probate Code section 2355, though permitted by *Cruzan* (see *ante*, p. 21), is not constitutionally required.

C. The Heightened Standard of Proof Would Violate California's Constitutional Right of Privacy.

A heightened standard of proof is not just unnecessary here – it would violate the right of privacy guaranteed by the California constitution. (Cal. Const., art. I, § 1.)

The state constitutional guarantee of privacy includes the right to refuse medical treatment. (*Conservatorship of Drabick, supra*, 200 Cal.App.3d at p. 206, fn. 20; *Bouvia v. Superior Court, supra*, 179 Cal.App.3d at p. 1137; see *Thor v. Superior Court, supra*, 5 Cal.4th at p. 736, fn. 6.) Thus, any infringement of that right must be justified by a compelling interest. (*White v. Davis* (1975) 13 Cal.3d 757, 775; *Kees v. Medical Board* (1992) 7 Cal.App.4th 1801, 1812.) In light of existing protections for the state's interest in preserving life, there is no compelling interest to justify infringing

the right of privacy by requiring a heightened standard of proof for surrogate decision-making under Probate Code section 2355.^{7/}

IV.
**CASE-BY-CASE ADJUDICATION OF NEW-
IMPRESSION ISSUES WILL AVOID THE “SLIPPERY
SLOPE.”**

Petitioners raise the specter of a “slippery slope” toward wholesale killing of disabled persons, asking this court to “take a proactive stance before a pattern of abuse, documented through conservatees’ gravestones, is allowed to be established.” (Opening Brief on the Merits pp. 30, 47-48, original underlining.) Similar concerns were voiced by two amici curiae in the Court of Appeal: one expressed fear that disabled people might be subjected to forced euthanasia because of their disabilities; another worried that the present case might lead to judicial approval of the “medical futility” theory, which allows physicians unilaterally to withhold a treatment that offers no therapeutic benefit to the patient. Petitioners want a “bright line” drawn at PVS, precluding surrogates from exercising the right of personal autonomy on behalf of anyone with any degree of cognition.

Petitioners misapprehend the role of the judiciary in American society. Our judges are supposed to be *reactive*, not proactive, deciding only actual controversies that are brought to court. Broad societal pronouncements are normally for the Legislature, not the courts, which function case by case.

^{7/} *Cruzan* is no impediment to this conclusion, having decided only that the heightened standard of proof does not violate the federal constitutional guarantee of due process. (See *Cruzan v. Director, Missouri Dept. of Health, supra*, 497 U.S. at pp. 281-282.)

Here, the California Legislature has *rejected* both a heightened standard of proof for Probate Code section 2355 and a restrictive application of the statute to permanently unconscious or terminally ill conservatees. (See *ante*, pp. 20-21.)

The role of the judiciary in the present case is to decide whether a decision in accordance with Robert’s known wishes is constitutionally required to be proven by clear and convincing evidence. An appropriately narrow decision of that issue will avoid the feared “slippery slope.” Petitioners wrongly assume that this court cannot be trusted to know where to stop. We have faith, however, that when this court is presented with questions about medical futility and forced euthanasia (which are not at issue here), the court will decide with the care and sensitivity demonstrated in *Thor*, which acknowledged that “many individuals with profound disabilities courageously confront and overcome daunting physical challenges to lead productive and satisfying lives, reflecting the vast potential and determination of the human spirit.” (*Thor v. Superior Court, supra*, 5 Cal.4th at p. 741, fn. 12.)

Thor gives competent persons the right to refuse life-sustaining medical treatment. Probate Code section 2355 allows conservators to exercise that right on behalf of incompetent conservatees. If this court were to prevent conservators from acting on behalf of incompetent conservatees who are not in a coma or PVS – whether by imposing the heightened standard of proof or by drawing a “bright line” at PVS – it would create a cruel nether world between competence and PVS, where people like Robert Wendland could be deprived of personal autonomy and consigned to years of dependence on artificial sustenance against all indications of their wishes and personal values. Even the competent prisoner in *Thor* and the PVS patient in *Morrison* were spared that fate.

CONCLUSION

For the foregoing reasons, we urge this court to allow Rose Wendland to carry out her husband's wishes, free of an unrealistically high standard of proof that would prevent her from exercising Robert Wendland's right to refuse medical treatment.

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Respectfully submitted,

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