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Kathleen M. Malone

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THE RIGHT TO REFUSE LIFE-SUSTAINING TREATMENT IN CALIFORNIA: WHO SHOULD DECIDE AND BY WHAT STANDARD?

I. INTRODUCTION

The progression of modern medical technology has erased the bright line of distinction between life and death. Through the use of various equipment, physicians are now able to artificially prolong human life beyond its natural limit. Thus, a decision to terminate or forego life-sustaining treatment is a choice between life and death and should be carefully regulated.

In California, the legislation now in effect allows a person to create a "living will"¹ and to appoint another person to make health care decisions if he should become incompetent or terminally ill.² In the recent past, these legislative acts were hampered by self-imposed requirements and restrictions which limited their applicability to a narrow class of persons in specified circumstances.³ Recent revisions to these acts have eliminated many of these restrictions and have broadened the group of people to which the acts are applicable.

Current case law in California has established a virtually absolute right to refuse medical treatment, including life-sustaining measures,⁴ but there is limited legislation to protect and enforce this right. Specifically, the current legislation fails to address two categories of patients: (1) the fully competent patients who are not terminally ill, but decide to forego life-sustaining treatment; and (2) the patients who are rendered incompetent before they have been able to clearly express their desires. The lack of legislation in this area has forced the determination of these issues on the already overburdened California court system.

Absent the existence of legislation, the courts have given extreme deference to the decisions of competent patients to

1. Cal. Health & Safety Code §§ 7185-7194.5 (West Supp. 1992).

2. Cal. Civ. Code §§ 2430-2444 (West Supp. 1992).

3. See *infra* notes 6-24 and accompanying text.

4. See *infra* notes 75-85 and accompanying text. See also *infra* notes 33-56 and accompanying text and *infra* notes 57-73 and accompanying text.

terminate their own life-sustaining treatment. However, in the haste to establish absolute personal autonomy, the lives of conscious patients making ill-considered decisions have been sacrificed. To remedy this, legislation is needed to ensure that the patient's decision is rational, firm and not overly influenced by the opinions of others.

Additionally, a California court has held that the right to refuse medical treatment survives incompetence and may be exercised on the incompetent patient's behalf by a surrogate.⁵ However, there are no legislative safeguards specifying who may act as a surrogate and the standard by which the surrogate must make his decision.

Without safeguards, restrictions and standards, the potential abuse in the termination of life-sustaining treatment is extremely high. The consequence of a patient or surrogate's decision to withdraw life-sustaining measures is death. The irreversible nature of death and the state's interest in preserving life mandate the need for legislation. This comment proposes standards and tests that should be enacted to protect the right of both competent and incompetent patients to not have their lives artificially prolonged, if that is what the patient desires.

II. BACKGROUND

A. *Statutes*

The California Legislature responded to the need for guidance in the area of death and dying by enacting two statutes: the Natural Death Act⁶ and the Durable Power of Attorney for Health Care⁷. In their original forms these statutes had requirements and restrictions which severely limited their applicability. However, recent revisions which took effect January 1, 1992 have removed some of the restrictions, thereby broadening the range of circumstances in which the statutes could be beneficial.

In 1976, the California Natural Death Act was incorporated into the Health and Safety Code.⁸ The "legislature [found]

5. See *infra* notes 86-98.

6. Natural Death Act, ch. 1439, § 1, 1976 Cal. Legis. Serv. 6274 (West) (repealed 1991).

7. Cal. Civ. Code §§ 2430-2444 (West Supp. 1992).

8. Natural Death Act, ch. 1439, § 1, 1976 Cal. Legis. Serv. 6274 (West) (re-

that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition.⁹ The Act was the first of its kind in the nation.¹⁰ Although it was considered quite radical at the time it was adopted, the Act proved to be very limited in its application.

The Act established the procedure, commonly known as a "living will," which is used by patients to indicate their desire to execute a Natural Death Directive.¹¹ To qualify under the repealed Act a patient had to have his condition diagnosed as terminal by two physicians¹² at least fourteen days prior to the execution of the directive.¹³ In addition, the directive was only valid for five years from the date of execution.¹⁴ There were several restrictions regarding the witnessing and signing of the directive, including the requirement that *both* witnesses were not related to the patient and would not benefit from the patient's estate.¹⁵ Although the Act did recognize that certain individuals in limited circumstances had the ability to enforce their decision to forego life-sustaining treatment, its many

pealed 1991).

9. *Id.* The legislation recognized that the artificial "prolongation of life for persons with a terminal condition may cause loss of patient dignity and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient." *Id.*

10. See Matthew G. Ainley, Comment, *Discontinuing Treatment of Comatose Patients Who Have Signed Living Wills*. 19 Loy. L.A. L. Rev. 61, 82 (1985).

11. Natural Death Act, ch. 1439, § 1, 1976 Cal. Legis. Serv. 6274, 6275 (West) (repealed 1991). This section contained a form that had to be used in a valid living will, as well as the procedure necessary to effectuate it. The document had to be signed by the patient and state the patient's desires had he been rendered incompetent. *Id.* In the repealed Act, the directive allowed an adult person to instruct "his physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition." *Id.* at 6274.

12. *Id.* at 6275-76. The legislation defined a terminal condition as "an incurable condition . . . which . . . [would] produce death, and where application of life-sustaining procedures serve only to postpone the moment of death of the patient." *Id.* at 6275.

13. *Id.* at 6275-76.

14. *Id.* at 6276.

15. *Id.* at 6275-76. Neither the treating physician nor his employees could act as a witness. *Id.* Additionally, the directive could not be executed by a patient in a nursing home unless one of the witnesses was a patient advocate or ombudsman designated by the State Department of Aging. *Id.* at 6276.

requirements and restrictions did little to lessen the amount of litigation.

The revised Natural Death Act¹⁶ was introduced as Senate Bill 980 and was signed by Governor Pete Wilson on October 12, 1991. The new Act has essentially the same purpose as the Act it repealed: It allows patients to communicate their desire to have life-sustaining procedures withdrawn through the use of a "living will." However, the new Act increases the number of persons who can create a directive by including patients in instances of permanent unconscious condition, as well as patients in terminal conditions.¹⁷ Additionally, the fourteen day and five year restrictions of the old Act have been eliminated. The new Act does not place any time limits on the effectiveness of the declaration. The restrictions regarding the witnesses have also been changed and now one of the witnesses can be related to the patient or entitled to a portion of the patient's estate. Furthermore, the revised Act specifically states that the type of treatment that can be withdrawn includes "artificially administered nutrition and hydration."¹⁸

The time and conditional restrictions found in the original Act limited the use of a "living will" to a narrow class of persons in specified circumstances. The revised Natural Death Act allows a much greater number of people to express their desire to have life-sustaining measures withdrawn and to have these desires legally enforced. However, there are still many situations and conditions that the Natural Death Act does not cover.

As stated earlier, the second statute that was enacted by the California Legislature to regulate the area of death and dying is the Durable Power of Attorney for Health Care, which is incorporated in the California Civil Code.¹⁹ The purpose of this power is to allow a patient to choose and appoint a person

16. Cal. Health & Safety Code §§ 7185-7194.5 (West Supp. 1992). This repealed the Natural Death Act, ch. 1439, § 1, 1976 Cal. Legis. Serv. 6274 (West) (repealed 1991).

17. Cal. Health & Safety Code § 7185.5(a). "The Legislature finds that an adult person has the fundamental right to control the decisions relating to the rendering of his or her own medical care, including the decision to have life-sustaining treatment withheld or withdrawn in instances of a terminal condition or permanent unconscious condition." *Id.*

18. *Id.* § 7186.5(b).

19. Cal. Civ. Code §§ 2430-2444 (West Supp. 1992).

to make the patient's health care decisions for him/her if he/she becomes incompetent or is diagnosed as terminally ill.²⁰ In 1983, the year it was initially enacted, this power was significant because it allowed an attorney-in-fact to be appointed *before* the patient became incompetent or terminally-ill; an act which could not be accomplished by the use of the original Natural Death Act.²¹ Other than that main difference, the requirements and restrictions present in the Durable Power of Attorney for Health Care are similar to the original and revised Natural Death Act.²²

On October 12, 1991 Governor Pete Wilson approved Assembly Bill 793²³ in conjunction with Senate Bill 790 (which repealed the Natural Death Act). The Assembly Bill amended Sections 2433, 2436.5, 2444, 2500 and 2503.5 of the Civil Code, relating to the Durable Power of Attorney for Health Care. The most important revision enacted by the Bill is that the seven year limit on the duration of the power that existed in the original act was eliminated. The new power exists for an indefinite period of time unless specifically limited in duration.²⁴

B. Case Law

In California case law and legislation the concept of a right to die is derived from the right to privacy established in

20. *Id.* § 2430(a) which states that a "[d]urable power of attorney for health care' means a durable power of attorney to the extent that it authorizes an attorney in fact to make health care decisions for the principal."

21. *See supra* notes 12 & 13 and accompanying text. However, Cal. Civ. Code § 2433 also issued an informational warning to the principal that "a court can take away the power of your agent . . . if your agent (1) authorizes anything that is illegal, (2) acts contrary to your known desires, or (3) where your desires are not known, does anything that is clearly contrary to your best interest." *Id.* Thus, the statute stipulated that the agent must use the substituted judgment and best interest standards in making a good faith determination of which medical procedures would be appropriate for the incompetent patient.

22. A similarity to the original Natural Death Act is that the execution of the directive creating a Durable Power of Attorney for Health Care must be witnessed by at least one person who is not related to the declarant and will not benefit from the declarant's estate. *Id.* § 2432(a)(3)(A).

23. Durable Powers of Attorney—Validity and Expiration, ch. 896, § 1, 1991 Cal. Legis. Serv. § 496 (West 1991) (codified in scattered sections of Cal. Civ. Code §§ 2433-2503.5 (West 1992)).

24. Cal. Civ. Code § 2433(a).

the amendments of the United States Constitution²⁵ and Article I of the California Constitution.²⁶ At the federal level the right to privacy was first recognized in a 1965 United States Supreme Court decision, *Griswold v. Connecticut*.²⁷ In this landmark case the court found a protected zone of individual rights penumbrating from the First, Third, Fourth, Fifth and Ninth Amendments to the United States Constitution.²⁸ Additionally, the Court held that these rights were not absolute, and must be balanced against asserted state interests.²⁹

The California Supreme Court expanded on the right to privacy to include a right to refuse medical treatment in its 1972 decision, *Cobbs v. Grant*.³⁰ The Court stated that a patient could assert a battery claim against a doctor who performed an operation to which the patient had not consented.³¹ The court noted that "a person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment."³²

A 1983 decision, *Barber v. Superior Court*³³ attempted to provide solutions to several issues that prior legislation, the Natural Death Act,³⁴ failed to address. In its expansive holding the Barber court refused to find any civil or criminal liability on the part of two doctors who terminated their patient's life support system.³⁵

25. See *infra* note 70.

26. Cal. Const. art. I, § 1 states:

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. (emphasis added).

27. 381 U.S. 479 (1965) (striking down a statute making it a criminal offense to use, counsel or aid in the use of contraceptives). This decision was later affirmed and expanded in *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (striking down a statute limiting the use of contraceptives to married persons) and *Roe v. Wade*, 410 U.S. 113 (1973) (upholding a woman's right to have an abortion).

28. *Griswold*, 381 U.S. at 484.

29. *Id.*

30. 502 P.2d 1 (Cal. 1972) (doctor removed a patient's spleen during an operation that was only supposed to confirm the existence of an ulcer).

31. *Id.* at 8.

32. *Id.* at 9.

33. 195 Cal. Rptr. 484 (Ct. App. 1983).

34. Cal. Health & Safety Code §§ 7185-7195 (West Supp. 1992).

35. *Barber*, 195 Cal. Rptr. at 493. Even though the court found that the doc-

The defendants in *Barber*, Dr. Neil Barber and Dr. Robert Nejdil, had been charged with murder and conspiracy to commit murder in the death of their patient, Clarence Herbert.³⁶ Shortly after being operated on by the defendants, Mr. Herbert suffered a cardio-respiratory arrest.³⁷ He was subsequently revived and placed on life-support equipment.³⁸ At the written request of Mr. Herbert's family, the doctors removed all of the patient's life-sustaining equipment, including nasogastric and intravenous tubes.³⁹ Mr. Herbert died six days later.⁴⁰

The court held that the defendants were not guilty of the murder charges because it found the termination of Mr. Herbert's life support was an omission, not an affirmative act.⁴¹ To employ this legal fiction, the court concluded that every pulsation of the respirator was a renewal of treatment, rather than a continuation of treatment. Therefore, the doctors' refusal to renew the respirator's assistance was an omission not an act.⁴²

In its analysis the court acknowledged a difference between proportionate and disproportionate care, balancing the benefits to be gained against the burdens caused by the use of the life-sustaining treatment.⁴³ The court defined proportionate treatment as "that which . . . has at least a reasonable chance of providing benefits to the patient, [and those] benefits outweigh the burdens attendant to the treatment."⁴⁴ The court further held that a doctor has no duty to provide overly burdensome, disproportionate care.⁴⁵

tors acted intentionally and with the knowledge that the patient would die, the defendants were found not guilty because their actions were found to be an omission. *Id.*

36. *Id.* at 486.

37. *Id.*

38. *Id.*

39. *Id.*

40. *Id.*

41. *Id.* at 493.

42. *Id.* at 490.

43. *Id.* at 491. The court explained the difference in this manner: "[E]ven if a proposed course of treatment might be extremely painful or intrusive, it would still be proportionate treatment if the prognosis was for complete cure or significant improvement in the patient's condition." *Id.*

44. *Id.*

45. *Id.*

In Mr. Herbert's case, the court found that the burdens outweighed the benefits of the life-sustaining treatment because Mr. Herbert's prognosis was virtually hopeless.⁴⁶ Thus, to summarize the analysis, the court found that the doctors' action in removing the life support system was an omission. It is an accepted doctrine that there is no criminal liability for an omission unless there is a duty to act.⁴⁷ The court found that there was no duty to act in Mr. Herbert's case because the treatment was disproportionate. Thus, the doctors' actions were determined to be lawful.

The *Barber* court also stated that it viewed "the use of an intravenous administration of nourishment and fluid, under the circumstances, as being the same as the use of the respirator or other form of life support equipment."⁴⁸ Claiming that the distinction was more emotional than factual, the court found no difference between the removal of the respirator and the removal of the nasogastric and intravenous tubes which had been providing nourishment and hydration.⁴⁹

The *Barber* court voiced its frustration with regard to the absence of legislation involving incompetent patients and their right to have their life-support removed.⁵⁰ To remedy this lack of guidance, the court established three clear guidelines in the general area of decision making. First, the court found no prior judicial approval is necessary to remove any life-sustaining measures.⁵¹ Second, the patient should be the ultimate decisionmaker whenever possible.⁵² Third, legal guardianship procedures are not necessary to have a surrogate become the ultimate decisionmaker.⁵³

46. *Id.* at 492.

47. 1 B.E. Witkin & Norman L. Epstein, California Criminal Law § 115 (2d ed. 1988).

48. *Barber*, 195 Cal. Rptr. at 490.

49. *Id.*

50. *Id.* at 489. The court stated that "there is no clear authority on the issue of who and under what procedure is to make the final decision." *Id.* at 492. The court concluded that the only long term solution to this problem is necessarily legislative in nature. *Id.* at 491.

51. *Id.* at 493. The court stated that "in absence of legislative guidance, we find no legal requirement that prior judicial approval is necessary before any decision to withdraw treatment can be made." *Id.*

52. *Id.* at 492.

53. *Id.* The court stated: "In the absence of legislation requiring such legal proceedings, we cannot say that failure to institute such proceedings made

Regarding the standard to be used by a surrogate in making the decision to forego life-sustaining treatment, the *Barber* court held that the surrogate must first make every attempt to ascertain the choice the patient would have made, but, if this is not possible, the surrogate should be guided by the patient's best interests. To evaluate the patient's own choice, the court stated that the surrogate ought to be guided by "his knowledge of the patient's own desires and feelings, to the extent that they were expressed before the patient became incompetent."⁵⁴ If this should fail to produce any conclusive evidence, the surrogate may take into account the "relief of suffering, the preservation or restoration of functioning and the quality as well as the extent of life sustained."⁵⁵ Finally, the surrogate should evaluate the impact of the decision on those people closest to the patient.⁵⁶

In 1986 the California courts once again expanded the class of persons able to exercise a right to die in *Bartling v. Superior Court*.⁵⁷ The court in *Bartling* upheld the right of a competent seventy year old man, who had not been diagnosed as terminally ill, to have his life support system removed.⁵⁸ When Mr. Bartling entered Glendale Adventist Medical Center in April 1984, to have a biopsy performed on a malignant lung tumor, he was already suffering from emphysema, arteriosclerosis, and an abdominal aneurysm.⁵⁹ During the operation one of his lungs deflated.⁶⁰ When the lung failed to reinflate, Mr. Bartling was placed on a respirator.⁶¹

Mr. Bartling filed a complaint in June of 1984, after his requests to have himself removed from the respirator were ignored and after several attempts to actually physically remove

petitioners' conduct unlawful. Whether such proceedings are to be required in the future is again a question for the Legislature to decide." *Id.* at 492-93.

54. *Id.* at 493.

55. *Id.* Regarding Mr. Herbert, the court stated that "[t]here was evidence that Mr. Herbert had, prior to his incapacitation, expressed to his wife his feeling that he would not want to be kept alive by machines" *Id.*

56. *Id.*

57. 209 Cal. Rptr. 220 (Ct. App. 1984).

58. *Id.* at 220.

59. See Elizabeth Scherer, Recent Case, *Bartling v. Superior Court: The Right to Die. The Right to Heal: Conflicts in the Bartling Decision*. 12 West St. U. L. Rev. 907, 907-08 (1984).

60. *Bartling*, 209 Cal. Rptr. at 221.

61. *Id.*

himself failed.⁶² In the complaint, Mr. Bartling sought an injunction restraining the hospital and doctors from continuing unwanted medical treatment.⁶³ In addition, he requested damages for battery, violation of state and federal constitutional rights, breach of a fiduciary duty owed him by the doctors and hospital, intentional infliction of emotional distress and conspiracy.⁶⁴

Attached to the complaint were several documents.⁶⁵ Mr. Bartling had executed a living will which stated that if there were "no reasonable expectation of my recovery from extreme physical or mental disability, I direct that I be allowed to die . . ."⁶⁶ Mr. Bartling had also included a Durable Power of Attorney for Health Care appointing Mrs. Bartling as Mr. Bartling's attorney in fact.⁶⁷ In addition, Mr. Bartling attached releases, signed by Mr. and Mrs. Bartling and Mr. Bartling's daughter, which relieved the hospital and doctors from civil liability.⁶⁸

Citing *Cobbs, Barber* and the California Natural Death Act, the *Bartling* court held that the right to the removal of life support equipment is not limited to comatose, terminally-ill patients.⁶⁹ Recognizing the patient's right to privacy and self determination as constitutionally grounded rights,⁷⁰ the court held that these rights outweighed the state's interest in protecting against suicide: "If the right of the patient to self deter-

62. *Id.* The doctors treating Mr. Bartling placed his wrists in soft restraints to prevent him from accidentally or deliberately disconnecting himself from the respirator. Mr. Bartling's requests that these restraints be removed were denied. *Id.*

63. *Id.* at 221-23.

64. *Id.* at 221.

65. *Id.* at 222.

66. *Id.*

67. *Id.*

68. *Id.*

69. *Id.* at 224. The trial court made several findings of fact that were later used in the appellate court's analysis: "(1) Mr. Bartling's illnesses were serious but not terminal and had not been diagnosed as such; (2) although Mr. Bartling was attached to a respirator to facilitate breathing, he was not in a vegetative state and was not comatose; and (3) Mr. Bartling was competent in the legal sense." *Id.* at 223.

70. *Id.* at 225:

The right of a competent adult patient to refuse medical treatment has its origins in the constitutional right of privacy. This right is specifically guaranteed by the California Constitution (art. I, § 1) and has been found to exist in the 'penumbra' of rights guaranteed by the Fifth and Ninth Amendments to the United States Constitution.

mination as to his own medical treatment is to have any meaning at all, it must be paramount to the interests of the patient's hospital and doctors."⁷¹

Rejecting the state's argument that the removal of Mr. Bartling's respirator was tantamount to aiding suicide,⁷² the court stated that the state only had an interest in protecting against "irrational self-destruction."⁷³ The court held that Mr. Bartling's decision was a rational refusal of treatment and that "[t]here is no connection between the conduct here in issue and any state concern to prevent suicide."⁷⁴

A highly publicized 1986 case that is very similar factually to *Bartling* is *Bouvia v. Superior Court*.⁷⁵ In *Bouvia* the court found that a person's right to privacy encompasses a virtually absolute right to refuse medical treatment, even when the treatment may be life-saving and its absence leads to an earlier death.⁷⁶ At the time of trial, Elizabeth Bouvia was a twenty-eight year old woman who had been afflicted with cerebral palsy since birth.⁷⁷ Although she had been bedridden for most of her life, Ms. Bouvia had been married and had earned a college degree.⁷⁸

Ms. Bouvia's inability to care for herself or earn a living had forced her to reside in a public hospital.⁷⁹ While at the hospital she developed chronic, severe, arthritis and was in constant pain despite periodic morphine injections.⁸⁰ Against Ms. Bouvia's wishes, the hospital inserted a nasogastric tube into her stomach to provide her with nourishment.⁸¹ Conse-

71. *Id.* at 225.

72. *Id.* The court found that the doctors had not brought Mr. Bartling's death by unnatural means. Rather, they had hastened his inevitable death by natural causes. *Id.*

73. *Id.* at 226 (quoting *Superintendent of Belchertown v. Saikewicz*, 370 N.E.2d 417, 426 n.11 (Mass. 1977)).

74. *Id.* (quoting *Superintendent of Belchertown v. Saikewicz*, 370 N.E.2d 417, 426 n.11 (Mass. 1977)).

75. 225 Cal. Rptr. 297 (Ct. App. 1986).

76. *Id.* at 302.

77. *Id.* at 299.

78. *Id.* at 300.

79. *Id.* Ms. Bouvia's husband left her and she had lived with her parents until they informed her that they could no longer care for her. *Id.*

80. *Id.* at 300.

81. *Id.* On several occasions Ms. Bouvia had expressed the desire to die. Her treating physicians thought that she was attempting to commit suicide when they discovered that she was not eating enough and was attempting to starve herself to

quently, Ms. Bouvia filed a complaint with the court requesting the removal of the tube from her body.⁸²

Using the same analysis found in the *Bartling* case, the *Bouvia* court held the right to refuse medical treatment is virtually an absolute right.⁸³ Criticizing the trial court's evaluation of the motives behind Ms. Bouvia's decision to exercise her rights, the court stated that "[i]f a right exists, it matters not what 'motivates' its exercise."⁸⁴ Thus, the court did not find it necessary to evaluate the level of rationality behind the refusal of medical treatment. Upholding Ms. Bouvia's right to have the feeding tube removed, the court stated that it "certainly is not illegal or immoral to prefer a natural, albeit sooner, death than a drugged life attached to a mechanical device."⁸⁵

The most recent California decision involving the right to terminate life-support is *Conservatorship of Drabick*⁸⁶ decided in 1988. Relying to a great extent upon the *Barber* case, the *Drabick* court held that the right to refuse treatment survives incompetence and may be executed on behalf of the incompetent patient by a court-appointed conservator.⁸⁷ The court found that California Probate Code section 2355,⁸⁸ which allows a conservator to make health care decisions for a conservatee, authorized such a decision by a conservator, if it

death. *Id.*

82. *Id.* at 298. Ms. Bouvia had previously petitioned a court in Riverside, California to allow her to "starve[] herself to death" while in a public hospital. She was denied judicial assistance and she abandoned an effort to appeal. *Id.* at 300.

83. *Id.* at 302. The *Bouvia* court held that:

It is not a medical decision for her physicians to make. Neither is it a legal question whose soundness is to be resolved by lawyers or judges. It is not a conditional right subject to approval by ethics committees or courts of law. It is a moral and philosophical decision that, being a competent adult, is her's [sic] alone.

Id. at 305.

84. *Id.* at 306.

85. *Id.*

86. 245 Cal. Rptr. 840 (Ct. App. 1988).

87. *Id.* at 854. However, the court stated that "this opinion should not be read as suggesting that conservatorship proceedings are always necessary." *Id.* at 848.

88. Cal. Prob. Code § 2355 (West 1991). This section states in part that "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."

was made in good faith, based upon medical advice and in the conservatee's best interest.

In addition, the court specified that the type of medical advice that would support a decision to forego life-sustaining treatment must include the "prognosis that there is no reasonable possibility of return to cognitive and sapient life."⁸⁹ Regarding the good faith determination, the court noted that the decision must not be affected by a material conflict of interest. The conservator must consider all available information relevant to the conservatee's best interest, including a directive under the Natural Death Act and prior informal statements by the conservatee.⁹⁰

The *Drabick* case involved a forty-four year old man who had existed in a persistent vegetative state following an automobile accident which occurred in 1983.⁹¹ Although Mr. Drabick's condition was not terminal, his conservator petitioned the superior court for an order to withhold all medical treatment, including procedures utilized to deliver nutrition and hydration.⁹² The superior court denied the petition on the ground that continued feeding was in the patient's best interest. The court of appeals reversed, stating that prior judicial approval was not necessary in the discontinuation of life-sustaining treatment.⁹³

The court acknowledged that "to claim that [Mr. Drabick's] 'right to choose' survives incompetence is a legal fiction at best," however, "it does not by any means follow that he has no protected, fundamental interest in the medical treatment decisions that affect him."⁹⁴ The court determined it

89. *Drabick*, 245 Cal. Rptr. at 861.

90. *Id.*

91. *Id.* at 842.

92. *Id.* at 842-43.

93. *Id.* at 860. The *Drabick* court stated that a conservator who has been appointed under Probate Code section 2355 to make medical decisions does not need further judicial approval for decisions to terminate life-sustaining measures:

This case arose because the conservator chose to seek the [superior] court's approval. The conservator did not file his petition because there was opposition but, in his own words, 'to obtain a court order that would remove any doubts about the legality or propriety of such action and, thereby, protect the medical care providers from potential action - legal, administrative, other - against them.'

Id. at 850.

94. *Id.* at 855.

could best preserve the rights of the incompetent patient by allowing a conservator to act as a surrogate decisionmaker.⁹⁵

Regarding evidence of prior statements made by Mr. Drabick that he would never want to be kept alive by artificial means, the court held that the statements should *not* "compel either the continuance or cessation of treatment in a particular case," rather the statements should be considered as evidence of intent.⁹⁶ Specifically, the court stated that the "clear and convincing evidence" standard,⁹⁷ adopted by some courts to determine the wishes of the patient, presented "several serious problems."⁹⁸ Thus, the *Drabick* court directly criticized the standard upheld in 1990 by the United States Supreme Court in its first right to die decision, *Cruzan v. Director, Missouri Department of Health*.⁹⁹

On January 11, 1983, Nancy Beth Cruzan was severely injured in an automobile accident.¹⁰⁰ She was found "lying face down in a ditch without detectable respiratory or cardiac function."¹⁰¹ Although paramedics were able to restore her heartbeat and breathing in a matter of twelve to fourteen minutes, Ms. Cruzan sustained permanent brain damage.¹⁰² After three weeks in a coma, Ms. Cruzan "progressed to an unconscious state in which she was able to orally ingest some nutrition"¹⁰³ but further rehabilitative efforts proved unavailing.¹⁰⁴ Nancy Cruzan existed in what is commonly referred to as a persistent vegetative state.¹⁰⁵ She exhibited lim-

95. *Id.*

96. *Id.* at 856.

97. *Id.* at 856. The Court describes this standard as "the position that an incompetent patient's hypothetical desire to forego life-sustaining treatment must be proved by clear and convincing evidence or some other standard and, when so proved, is [found] conclusive." *Id.*

98. *Id.* at 856. The court describes three problems: (1) there is no authority, other than cases on the subject, to support the idea that a person can exercise or waive a fundamental right unintentionally through informal statements, (2) there would be no consistent basis for a decision when a patient had been silent on the matter, and (3) the approach is contrary to the Probate Code section 2355 which allows a conservator's decision to be absolute, whether or not the conservatee objects. *Id.* at 856-57.

99. 110 S. Ct. 2841 (1990).

100. *Id.* at 2845.

101. *Id.*

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.* Medical experts testified that Ms. Cruzan could live for thirty more

ited motor reflexes, but had virtually no chance of regaining any significant cognitive function.¹⁰⁶

Upon learning this devastating information, Ms. Cruzan's family sought a court order directing the withdrawal of their daughter's artificial feeding and hydration equipment.¹⁰⁷ The Cruzans' petition was successful at the trial court level.¹⁰⁸ However, the Missouri Supreme Court reversed, stating that Ms. Cruzan's parents lacked the authority to effectuate the request to remove the life-sustaining measures because there was no clear and convincing evidence of Nancy's desires.¹⁰⁹

Although it recognized a constitutionally protected liberty interest in refusing medical treatment,¹¹⁰ the United States Supreme Court upheld the Missouri Supreme Court decision in *Cruzan*.¹¹¹ The Court expressed, implicitly and explicitly, a general desire to defer to state judgments in the area of termination of life-sustaining medical treatment.¹¹²

The United States Supreme Court noted that "[a]lthough many state courts have held that a right to refuse treatment is encompassed by a generalized constitutional right of privacy, [this court has] never so held."¹¹³ Instead, the Court stated that the issue was "more properly analyzed in terms of a Fourteenth Amendment liberty interest."¹¹⁴ Thus, the United States Supreme Court favored the liberty interest analysis over the right of privacy analysis on which California law in this area is based.

years in this state. *Id.* at 2845 n.1.

106. *Id.* at 2845.

107. *Id.* at 2846.

108. *Id.* at 2846.

109. *Id.* The evidence that the Court found to be inconclusive was of comments made by Ms. Cruzan "in [a] somewhat serious conversation with a housemate friend that if sick or injured she would not wish to continue her life unless she could live at least halfway normally." *Id.*

110. *Id.* at 2842.

111. *Id.* at 2856.

112. *Id.* "All of the reasons . . . for allowing Missouri to require clear and convincing evidence of the patient's wishes lead us to conclude that the state may choose to defer only to those wishes, rather than confide the decision to close family members." *Id.* See *The Supreme Court, 1989 Term: Leading Cases*, 104 Harv. L. Rev. 129 (1990).

113. *Cruzan*, 110 S. Ct. at 2851 n.7.

114. *Id.*

III. IDENTIFICATION OF THE PROBLEM

California case law regarding right-to-die issues has far surpassed current applicable legislation. The courts have established a virtually absolute right to refuse medical treatment, including life-sustaining treatment. However, the present legislation totally ignores two categories of patients: (1) the competent patients who are not terminally ill, but refuse life-sustaining treatment; and (2) the incompetent patients who never created a living will or designated another person to make health care decisions for him.

IV. ANALYSIS

A. *Legislation*

The California Natural Death Act and the Durable Power of Attorney for Health Care have not provided the guidance that is necessary to lessen or alleviate litigation in the area of death and dying in the California courts. It is possible for a non-comatose, fully competent person to indicate his desire to terminate life-support through the use of a Natural Death Directive. However, there is no legislation regulating the ability of a competent, non-terminally ill, person to have his life support terminated. Additionally, there is no legislation regulating a comatose or incompetent person who was not able to create a Natural Death Directive or a Durable Power of Attorney for Health Care before he was rendered incompetent.

B. *Case Law Involving Competent Patients*

In its haste to establish an absolute right of personal autonomy, the courts have ignored the distinction between rational and irrational decisions by competent patients to terminate their own life-sustaining treatment. The court readily admits that the state has an interest in preserving life and in the prevention of suicide.¹¹⁵ Yet, it holds that the state's interest is limited to "irrational self-destruction."¹¹⁶

115. *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 304 (Ct. App. 1986). There are four state interests recognized by the court: (1) the preservation of life, (2) the prevention of suicide, (3) the protection of innocent third parties, and (4) the maintenance of the ethical standards of the medical profession. *Id.*

116. *Bartling v. Superior Court*, 209 Cal. Rptr. at 220, 226 (Ct. App. 1984)

Current case law in California, regarding the rights of competent patients, is derived from the decisions in the *Bartling* case and the *Bowvia* case. *Bartling* established the right to refuse life-sustaining treatment for competent, non terminally ill, adult patients and created a judicially recognized distinction between this right and suicide.¹¹⁷ *Bowvia* elaborated on *Bartling*, holding that the right to refuse treatment is absolute and because of this, the courts would not evaluate the motivation underlying the patient's decision to terminate his own life.¹¹⁸ Supporting both of these decisions is the holding in *Barber*, which states that no prior judicial approval is necessary in any type of situation involving the termination of a patient's life-sustaining treatment.¹¹⁹

The court in *Bartling* placed emphasis on the patient's right of self-determination. It stated that if this right was to have any meaning at all it should be paramount to the interests of the doctors and the hospital.¹²⁰ Rejecting the argument raised by the doctors and the hospital that terminating Mr. Bartling's respirator would be tantamount to aiding suicide, the court stated that it found a "real distinction between the self infliction of deadly harm and a self-determination against artificial life-support or radical surgery."¹²¹

Black's Law Dictionary defines suicide as "self- destruction; the deliberate termination of one's own life."¹²² Although there is no mention of cognitive reasoning in the standard legal definition of suicide, the *Bartling* court used a rationality test to distinguish suicide from the right to refuse treatment. A rational decision by a patient to terminate his own life-sustaining measures and ultimately, his life, would not be considered suicide and would not implicate the state's interests, because the court found that the state only had an interest in *irrational* suicide.¹²³

(quoting Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 417, 426 n.11 (Mass. 1977)).

117. See *supra* notes 57-73 and accompanying text.

118. See *supra* notes 75-85 and accompanying text.

119. *Barber v. Superior Court*, 195 Cal. Rptr. at 484, 493 (Ct. App. 1983).

120. *Bartling*, 209 Cal. Rptr. at 225. The court stated that "the right of a competent adult patient to refuse medical treatment is a constitutionally guaranteed right which must not be abridged." *Id.*

121. *Id.* at 225-26 (quoting *In re Quinlan*, 355 A.2d 647, 665 (N.J. 1976)).

122. *Black's Law Dictionary* 1434 (6th ed. 1990).

123. *Bartling*, 209 Cal. Rptr. at 225. The court stated: "[w]hat we consider

The *Bouvia* court effectively eliminated the *Bartling* rationality test by holding that the right to refuse life-sustaining treatment is absolute. As the court stated, "if a right exists, it matters not what 'motivates' its exercise."¹²⁴ Thus, the court held that it could not base its determination of Ms. Bouvia's decision on her rationality, because it was excluded from evaluating the decision at all.¹²⁵

The analysis of the *Bartling* court was well supported. The *Bouvia* court relied upon the distinction between suicide and the right to refuse medical treatment created in *Bartling*. However, *Bouvia* also rejected the rationality test used to create this distinction. Without the rationality test, there is no way to determine if a patient is actively advocating his own death or passively refusing treatment. The purpose of the rationality test was to avoid ill-considered, hastily-made decisions to terminate one's own life, which is "suicide."¹²⁶ Without this test, there are no existing safeguards protecting the competent patient from making an irreversible decision he may not have been prepared to make.

California case law adds another element to this problem; the patient does not have to be terminally ill to have his life-sustaining treatment terminated.¹²⁷ As in the *Bartling* and *Bouvia* cases, a patient could have a potential life expectancy of any number of years. Although a competent adult patient deciding to forego treatment is presumptively rational, this presumption should be rebuttable if the patient is deciding to forego the possibility of a potentially productive life.

Due to the length of time it took the legal system to address their complaints, the patients in *Bartling* and *Bouvia* had more than enough time to reflect upon the consequences of their decisions. It is interesting to note that after finally being granted the right to disconnect her life-sustaining equipment, Ms. Bouvia changed her mind and decided to postpone her death.¹²⁸ In addition, Mr. Bartling's doctors questioned his

here is a competent, rational decision to refuse treatment when death is inevitable and the treatment offers no hope of cure or preservation of life." *Id.* (quoting *Saikevicz*, 370 N.E.2d at 426 n.11). See also *supra* notes 52-66 and accompanying text.

124. *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 306 (Ct. App. 1986).

125. *Id.*

126. Black's Law Dictionary 1434 (6th ed. 1990).

127. *Bartling*, 209 Cal. Rptr. at 220.

128. See L.A. Times, Oct. 8, 1986, § 2, at 3 (quoting one of Bouvia's

ability to make a meaningful decision because of his vacillation.¹²⁹ Apparently, Mr. Bartling had expressed to his doctors and nurses his desire to live and to not be taken off the respirator.¹³⁰ The nurses testified about instances in which Mr. Bartling's ventilator tube had become disconnected and he had signalled frantically for them to reconnect it.¹³¹

Yet, these cases eliminated the requirement of prior judicial approval. The potential now exists for the ill-considered, hastily-made decisions that the rationality test was implemented to prevent. Without some type of safeguard, there are many patients likely to become victims of their own irrationality.

If the state is going to enforce its interest in preventing irrational self-destruction, it must be allowed to evaluate the reasons behind a patient's decision to terminate life-sustaining treatment, especially in instances in which the patient's condition is not terminal. Thus, legislation must be implemented which would govern the competent patient's right to terminate life-sustaining treatment.

C. *Case Law Involving Incompetent Patients*

The courts have attempted to adjudicate the rights of incompetents in the absence of legislative authority. To its credit, the *Barber* court stated that "the long term solution to this problem is necessarily legislative in nature."¹³² Nevertheless, the courts found that the rights of a patient survive incompetency and those rights may be enacted on the patient's behalf by a surrogate decisionmaker.¹³³

As the first California case involving an incompetent patient whose life-support system was removed, *Barber* laid the groundwork and set the standard to be later used in *Drabick*. Although the surrogate in *Drabick* was a court-appointed conservator,¹³⁴ the decisionmakers in *Barber* had not acquired prior judicial approval of the termination of the patient's life sup-

attorney's as stating that suicide remains "an option [Bouvia] holds in abeyance," because "she wants to go out with some dignity").

129. *Bartling*, 209 Cal. Rptr. at 223.

130. *Id.*

131. *Id.*

132. *Barber v. Superior Court*, 195 Cal. Rptr. 484, 488 (Ct. App. 1983).

133. *See supra* notes 86-98.

134. *Conservatorship of Drabick*, 245 Cal. Rptr. 840, 842.

port system. However, the court stated that "in the absence of legislation requiring such legal proceedings, we cannot say that failure to institute such proceedings make petitioners' conduct unlawful."¹³⁵ The court indicated that the legislature was the appropriate body to determine the need and implementation of such procedures.¹³⁶ As of yet, the legislature has not responded.

In addition, the case law is not in agreement as to the determinative test to be used by the surrogate to guide him in his decision. The *Barber* court cited a report of a presidential commission investigating the legal and ethical issues involved the decision to forego life-sustaining treatment.¹³⁷ The report stated that the surrogate "ought to be guided in his or her decisions first by his knowledge of the patient's own desires and feelings, to the extent that they were expressed before the patient became incompetent."¹³⁸ If the incompetent's wishes are not known, then the surrogate should act in the best interests of the patient.¹³⁹

In contrast, the *Drabick* court relied upon the section of the California Probate Code¹⁴⁰ under which the conservator had been appointed to develop a standard for the surrogate decisionmaker. The *Drabick* court rejected the need for an initial evaluation of the patient's choice and held that the conservator should only be guided by the patient's best interest.¹⁴¹ The Probate Code requires a conservator to make a good faith determination regarding the conservatee's treatment based upon medical advice and the necessity of the treatment.¹⁴²

135. *Barber*, 195 Cal. Rptr. at 492.

136. *Id.* at 492-93.

137. *Id.* at 493 (citing President's Commission for Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment*, Report on Ethical, Medical and Legal Issues in Treatment Decisions at 132- 39 (March 1983) [hereinafter President's Commission]).

138. *Id.* (citing President's Commission at 132).

139. *Id.* at 493.

140. Cal. Prob. Code § 2355 (West 1991). *See supra* note 88.

141. *Conservatorship of Drabick*, 245 Cal. Rptr. 840, 855 (Ct. App. 1988). However, the court acknowledged that "[t]o delegate an incompetent person's right to choose inevitably runs the risk that the surrogate's choices will not be the same as the incompetent's hypothetical, subjective choices." *Id.*

142. Cal. Prob. Code § 2355 (West 1991). *See supra* note 88.

The *Drabick* court specifically stated that the patient's prior informal statements, alone, *cannot* compel either the continuance or cessation of treatment.¹⁴³ The probable reason the court held the conservator's decision to supersede the known desires of the patient, is that California Probate Code section 2355 gives the conservator exclusive authority to make decisions regarding medical treatment "whether or not the conservatee objects."¹⁴⁴

Thus, the different standards used by the two cases can be reconciled by focusing on the *Drabick* court's need to adhere to the Probate Code. Although the surrogate in *Drabick* is court appointed, the court states that "this opinion should not be read as suggesting that conservatorship proceedings are always necessary."¹⁴⁵ Similarly, the standard used by the conservator in *Drabick* should not be considered a general rule applicable to all situations involving the termination of an incompetent patient's life support system. If the conservatorship proceedings are not necessary, then the restrictions governing the conservator's behavior are not necessary either.

Therefore, the standard set in *Barber* should be the prevailing standard used by surrogates in California. This standard, which gives deference to the known opinion of the incompetent patient, insures that the rights and interest of the patient are adequately represented. As has been previously stated, the absolute right to refuse medical treatment belongs to the patient and not the surrogate. By determining that this right survives incompetence, the court did not take the right away from the patient and give it to his surrogate. Instead, the courts gave the surrogate the right to act on behalf of the patient. The consequence of an improperly considered decision by a surrogate to terminate the patient's life-sustaining treatment is irreversible. Therefore, it is only proper that the surrogate make the primary determination of the patient's preference regarding his own death.

In *Cruzan*, the United States Supreme Court upheld a standard advocating clear and convincing evidence of an

143. *Drabick*, 245 Cal. Rptr. at 856 (Ct. App. 1988). The court felt that the "conservator may consider the conservatee's known preferences together with all other information bearing on the conservatee's best interests." *Id.*

144. Cal. Prob. Code § 2355 (West 1991).

145. *Drabick*, 245 Cal. Rptr. at 848. See *supra* note 93 and accompanying text.

incompetent's desire to die.¹⁴⁶ In support of this high standard set by the Missouri Legislature, the Court cited the state's interest in guarding "against potential abuses in such situations."¹⁴⁷ The Court acknowledged that "an erroneous decision to withdraw life-sustaining treatment is not susceptible of correction," yet an erroneous decision to not withdraw life-support would retain the status quo.¹⁴⁸ In addition, the Court did not hold that the state must accept the substituted judgment of close family members because "there is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been had she been confronted with the prospect of her situation while competent."¹⁴⁹

The effect of *Cruzan* on California case law has yet to be determined. First, the United States Supreme Court clearly stated that it did not accept the right of privacy analysis used by California in the development of the right to refuse medical treatment.¹⁵⁰ Yet, it did find the same right to exist under a constitutionally recognized liberty interest. Second, the Court held that Missouri was not constitutionally obligated to accept the decisions made by surrogates, and yet, it did not hold that these decisions were unconstitutional.¹⁵¹ Third, although the Court held Missouri's clear and convincing evidence standard to be constitutional, it did not hold this standard to be the only constitutionally acceptable standard.¹⁵² In summary, the Court did not explicitly adopt or reject any of the standards presently existing in California.

In the *Cruzan* decision, the United States Supreme Court indicated its desire to minimize the interest in constitutional litigation in the area of death and dying, "so that states can continue to experiment and discern the best means for han-

146. *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2856 (1990). See *supra* notes 99-113 and accompanying text.

147. *Id.* at 2853.

148. *Id.* at 2854.

149. *Id.* at 2856.

150. *Id.* at 2851 n.7.

151. *Id.* at 2856. The Court stated that "there is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been had she been confronted with the prospect of her situation while competent." *Id.*

152. *Id.* at 2841.

ding decisions to terminate treatment for incompetent patients."¹⁵³ The California Legislature needs to respond to this challenge. There must be some sort of standard set to determine who can act as a surrogate. The legislature should adopt a test similar to the one articulated in *Barber*, specifying the standard to be used by a surrogate when deciding to terminate a patient's life-sustaining equipment.

V. PROPOSAL

As stated earlier, legislation in California regarding an individual's ability to express his right to die is severely limited in its application. The present legislation needs to be updated and expanded to include the guidelines advocated in current case law.

A. *Competent, Non-Terminally Ill, Patients*

The current legislation allows a competent, terminally-ill person to write a Natural Death Act and have his life-sustaining treatment terminated. Case law has stated that it is possible for a non-terminally ill, competent person to also have his life support legally terminated. However, there is no legislation regulating the right of the non-terminally ill person. Although a competent adult patient deciding to forego treatment is presumptively rational, this presumption should be rebuttable if the patient is deciding to forego the possibility of a potentially productive life.

The courts have hindered the state's ability to prevent irrational self-destruction by effectively eliminating all requirements that the patient's decision meet a test of rationality. The potential now exists for the ill-considered, hastily-made decisions that the rationality test was implemented to prevent. Without some type of safeguard there are many patients likely to become victims of their own irrationality. Therefore, a mandatory waiting period should be instituted.

If a non-terminally ill patient expresses the desire to have his life-support removed, he should be required to wait a specified period of time before his desire is granted. The irre-

153. *The Supreme Court, 1989 Term: Leading Cases*, 104 Harv. L. Rev. 257, 266 (1990).

versible nature of the decision that the patient is making warrants this requirement. A waiting period would give the patient time to reconsider his options. Additionally, the patient's physicians and relatives could use this time to provide counseling for the patient. However, if the patient still wishes to die after the waiting period has expired, then his wishes should be granted.

In justification of the waiting period, the slight indignity suffered by some patients would be compensated for by the number of lives saved. In addition, the time that these patients would have to wait will ultimately be far less than the amount of time it would take to have the court's adjudicate the case of every potentially suicidal patient. At the end of the waiting period, the state's interest no longer justifies further intervention and the patient will have his wishes respected.

The legislators could protect the state's interest in the prevention of irrational self-destruction by requiring that the patient's decision meet the standards of legally effective informed consent.¹⁵⁴ An evaluation could be made during the mandatory waiting period to determine whether the patient was making an informed decision. The law generally requires a patient's informed consent in the process of all health care decisionmaking.¹⁵⁵ A patient's decision to forego life-support should not be treated any differently. The consequences of a patient's decision to terminate his own life support system are especially compelling, because the decision to die is irreversible. Therefore, to ensure that this decision is not made irrationally, the legislation should mandate that the patient is adequately informed.

154. See Edward A. Lyon, Comment, *The Right to Die; An Exercise of Informed Consent, Not an Extension of the Constitutional Right of Privacy*, 58 U. Cin. L. Rev. 1367 (1990). In this article, the author argues that granting a right to die under the right to privacy could lead to involuntary euthanasia, suicide and diagnostic mistakes. *Id.* at 1389. The author states that the "decision to refuse life-sustaining medical treatment is soundly supported by the common law doctrine of informed consent. That decision involves medical, ethical, and philosophical questions which are better regulated by legislation than by judicial decree." *Id.* at 1395.

155. See George J. Annas & Joan E. Densberger, *Competence to Refuse Medical Treatment: Autonomy vs. Paternalism*, 15 U. Tol. L. Rev. 561, 561-62 (1984). The law presumes that every competent adult is capable of making decisions for himself unless adjudged otherwise. *Id.* at 565. In the medical context, the law requires legally effective informed consent. *Id.*

There are three elements of informed consent: the patient's capacity to decide, the voluntary nature of the decision and the physician's disclosure of information.¹⁵⁶ The capacity of determination should be guided by two considerations; (1) Whether the patient's decision was well thought out, consistent with his values, goals, and religious beliefs; or alternatively, whether the decision was hastily made, in reaction to severe depression, pain or personal catastrophe (2) Whether a reasonable person would determine that the patient's life was worth living.¹⁵⁷ The voluntariness requirement would minimize potentially negative influences, such as the views of relatives, doctors and society. Disclosure by the physician should provide the patient with sufficient information regarding his present medical status, any treatment that could possibly improve his condition and the expectations he could have for his future.

B. Comatose or Incompetent Patients Who Have Failed to Create a Living Will of Durable Power of Attorney for Health Care

Current case law in California grants non-terminally ill, incompetent patients the right to have a surrogate enforce their right to refuse life-sustaining treatment.¹⁵⁸ However, there is no existing legislation regarding who may act as a surrogate and by what standards the surrogate should make the decision. This proposal suggests that the irreversible nature of the decision mandates legislation requiring that the surrogate be court-appointed. The legislation should include a standard test to be used by the surrogate which would require an initial evaluation of the patient's desires regarding his condition. If the patient's wishes cannot be ascertained, the surrogate may make his decision in the best interest of the patient.

156. *Id.* at 568. The doctrine of informed consent was formulated in *Schloendorff v. Soc'y of New York Hosp.*, 105 N.E. 92 (N.Y. 1914).

157. See Martha Alys Matthews, Comment, *Suicidal Competence and the Patient's Right to Refuse Lifesaving Treatment*, 75 Cal. L. Rev. 707, 754 (1987). Matthews advocates a test to be used by the courts to determine the competency of the patient. This test is based solely upon the capacity of the patient to make the decision and involves evaluation of the circumstances surrounding the patient's decision and the type of future the patient might have. *Id.* at 754-56.

158. *Conservatorship of Drabick*, 245 Cal. Rptr. 840 (Ct. App. 1988). See *supra* notes 86-98 and accompanying text.

Persons who wish to act as a patient's surrogate should be required to petition the court. Preference should be given to family members and close relatives because of their presumed familiarity with the patient. Other persons petitioning to become a surrogate should be required to submit a document to the court explaining their relationship with the patient and their reasons for wanting to be the surrogate decisionmaker.

In its determination of who will act as surrogate, the court should consider the petitioner's familiarity with the patient, as well as the ability to view the patient's situation objectively. With close relatives there is always the potential that they may be overly influenced by the patient's pain and suffering. In addition, the court should not ignore the possibility that a surrogate could benefit from the death of the patient and thus, wish to hasten its occurrence. Although it is impossible for the court to ascertain the motives of every petitioner requesting the termination of a patient's life-sustaining treatment, it should make a concerted effort through the use of its investigative officers to protect the patient.

The standards to be used by the surrogates should be incorporated into the Probate Code. The new statute should resemble the sections governing the powers and duties of guardians¹⁵⁹ and conservators.¹⁶⁰ The reason that the legislature needs to create a new set of standards for surrogate decisionmakers is that California Probate Code section 2355, which discusses the medical treatment of conservatees and wards adjudicated to lack capacity to give informed consent, gives the conservator and guardian exclusive authority to make decisions regardless of the patient's preference.¹⁶¹ Thus, these statutes give the guardian and conservator the ability to ignore the desires of the patient.

In contrast, the surrogate deciding to terminate the life-sustaining treatment of an incompetent patient must give

159. Cal. Prob. Code §§ 1500-1601 (West 1991).

160. *Id.* §§ 1800-1910.

161. *Id.* at § 2355 (a). This code states:

[T]he 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.

evidence of the patient's desires regarding his condition the utmost priority. The court held in *Drabick* that the right to refuse treatment survives incompetency and that the patient can have a surrogate enforce this right.¹⁶² The court did not transfer the patient's right to the surrogate. Instead, the court gave the surrogate the right to act on behalf of the patient. Therefore, it is the patient's right and the surrogate should make every effort to ascertain and enforce the patient's opinions and desires.

There is a wide variety of sources from which the surrogate could discern the patient's opinion of the prolongation of his life due to medical technology. An ineffective Natural Death Act directive may not be legally binding, but that does not affect the validity of the patient's intent when creating the document. In fact, if a directive is available it should be considered the primary source of information. Comments made by the patient regarding his desire to be kept alive or to not be kept alive must be analyzed with regard to the circumstances under which they were spoken. It is possible that these comments do not reflect the patient's true desires and were merely a reaction to a particular event.

If there is no reliable source of the patient's intent, the surrogate must make the decision in the best interest of the patient. The surrogate should base his evaluation on his familiarity with the patient; his knowledge of the patient's values and goals, religious and philosophical convictions, and general way of life. The surrogate should also evaluate the patient's medical situation. Such factors as the relief of suffering, the possibility of preservation or restoration of functioning and the quality, as well as the extent, of life sustained should be considered. In addition, the surrogate may take into account the impact of the decision on the people closest to the patient.

By advocating judicial approval of the surrogate, the proposed legislation would ensure that a sufficient evaluation would be made of the surrogate's familiarity with the patient. In addition, the rights of the patient would be protected by the enactment of the suggested standard to be used by the surrogate in his decision.

162. *Drabick*, 245 Cal. Rptr. at 855. See also *supra* notes 86- 98 and accompanying text.

VI. CONCLUSION

Modern medical technology has made possible the artificial prolongation of life beyond natural limits. Although the California Legislature has stated its awareness of this fact, its enactments have proved to be limited in their application. In the absence of applicable litigation, the California courts have been forced to decide several cases involving the termination of life-sustaining measures. The case law that has been developed has created rights for competent and incompetent patients without establishing the guidelines on how to implement these rights.

The legislation proposed in this comment attempts to remedy the current lack of guidance in the area of death and dying. Regarding the judicially-created right of a competent patient to forego life-sustaining treatment, the state should reassert its interest in the prevention of irrational self-destruction, and institute a mandatory waiting period for all non-terminally ill, competent patients who want to forego life support. Additionally, the patient's decision must meet the standards of legally effective informed consent. The courts have also granted incompetent patients the right to have a surrogate act on his or her behalf. In order to protect this right, the proposed legislation requires that the surrogate be court appointed. In addition, the surrogate must make every effort to determine the desires of the patient and, if this is not possible, must act in the patient's best interest.

Kathleen M. Malone