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MICHAEL MARTIN AND ROBERT WENDLAND: BEYOND THE VEGETATIVE STATE

*Lawrence J. Nelson**
*Ronald E. Cranford***

INTRODUCTION

Over twenty years ago, the parents of Karen Quinlan wished to discontinue the ventilator that was supporting the life of their unconscious daughter. They were forced to litigate against the physicians who refused to carry out this wish. Karen was in the persistent vegetative state (PVS), a wakeful condition in which awareness of self and others is absent, and there is no ability to interact with others or the environment. Under criteria established by the Multi-Society Task Force Report on the Persistent Vegetative State, her condition was considered permanent.¹ In the intervening years, nearly fifty cases involving patients in the persistent vegetative state have been reviewed by appellate courts around the country.² Overwhelmingly, the courts have permitted family members to refuse medical treatment on behalf of these patients, including medically provided nutrition and hydration.³

In the last few years, several courts⁴ have delved into controversies

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1. See generally The Multi-Society Task Force on PVS, *Medical Aspects of the Persistent Vegetative State*, 330 NEW ENG. J. MED. 1499, 1499 (1994). For purposes of this Article, we will use the much more common term "persistent vegetative state" as equivalent to "permanent vegetative state" as defined by the Multi-Society Task Force. See *id.*

2. See ALAN MEISEL, *THE RIGHT TO DIE* 634-45 (2d ed. 1999).

3. "Medically provided nutrition and hydration" means food and fluids provided under the supervision of a physician to a patient by means of a tube manually or surgically inserted into the patient's body, viz., nasogastric tube, gastrostomy, jejunostomy, or central venous line (hyperalimentation). See Lawrence Nelson et al., *Forgoing Medically Provided Nutrition and Hydration in Pediatric Patients*, 23 J. L. MED. & ETHICS 33, 33 (1995).

4. See generally, e.g., *In re Martin*, 538 N.W.2d 399 (Mich. 1995), *cert. de-*

about stopping medical treatment on patients in a different, but related, medical category: the minimally conscious state (MCS). Generally speaking, persons in the minimally conscious state have severely impaired consciousness, demonstrate limited and inconsistent signs of cognitive awareness, and thus are not in the persistent vegetative state. A leading published medical article on this subject characterizes this syndrome as a "distinct clinical entity that may occur as a transitional condition for patients evolving to or from [the vegetative state], or a clinical end point for those with very severe brain damage."⁵

A consensus statement by professionals in the fields of rehabilitation and neurological sciences defines this state as "a condition of severely altered consciousness in which minimal but definite behavioral evidence of self or environmental awareness is demonstrated."⁶ This consensus statement proposes that:

One or more of the following clinical features must be clearly discernible and occur on a reproducible or sustained basis to make the diagnosis of the minimally conscious state:

- 1) follows simple commands;
- 2) gestural or verbal "yes/no" responses (regardless of accuracy);
- 3) intelligible verbalization; and
- 4) movements or affective behaviors that occur in contingent relation to relevant environmental stimuli and are not attributable to reflexive activity. Any of the following behavioral examples provide sufficient evidence for criterion 4, although this list is not meant to be exhaustive:

- a) smiling or crying in response to the linguistic or visual

nied, 516 U.S. 113 (1996); *In re Conservatorship of Wendland*, Probate Case No. 65669 (Cal. Sup. Ct., Jan. 21, 1997 & Mar. 9, 1998), *appeal pend'g*, No. C029439 (Cal. Ct. App., 3d App. Dist. 1998); *In re Edna M.F.*, 563 N.W.2d 485 (1997).

5. Joseph Giacino et al., *Development of Practice Guidelines for Assessment and Management of the Vegetative and Minimally Conscious States*, 12 J. HEAD TRAUMA & REHABILITATION 79, 83 (1997). This article, written by participants in the 1994 Aspen Neurobehavioral Conference and members of the Aspen Working Group on the Vegetative and Minimally Conscious States, is a preliminary report on the consensus-based conclusions of this group. The more definitive report from this group is referred to in note 6, *infra*.

6. THE ASPEN NEUROBEHAVIORAL CONFERENCE WORK GROUP, ASSESSMENT, PROGNOSIS AND TREATMENT OF THE VEGETATIVE AND MINIMALLY CONSCIOUS STATES: THE ASPEN NEUROBEHAVIORAL CONFERENCE CONSENSUS STATEMENT 12-13 (forthcoming 1999) (unpublished manuscript on file with authors) [hereinafter ASPEN CONSENSUS STATEMENT].

content of emotional but not neutral topics or stimuli;

b) vocalizations or gestures that occur in direct response to the linguistic content of questions;

c) reaching for objects that demonstrates a clear relationship between object location and direction of reach;

d) touching or holding objects in a manner that accommodates the size and shape of the object;

e) pursuit eye movement or sustained fixation that occurs in direct response to moving or salient stimuli; and

f) ambulation or wheelchair propulsion with avoidance of environmental obstacles.⁷

This consensus statement also describes two other noteworthy aspects of the minimally conscious state. One, the presence of these four key clinical features may vary widely among minimally conscious patients; therefore, patients in MCS may appear quite different in certain areas of function that indicate consciousness — yet all such patients have only minimal consciousness. The statement notes:

While it is not uncommon for individuals in MCS to demonstrate more than one of the above criteria, in some cases the evidence for MCS will be limited to only one behavior that provides sufficient evidence for consciousness. For example, some individuals do not demonstrate discernible evidence of command-following, object use or communication ability but are able to ambulate or even climb stairs with minimal assistance.⁸

Second, while the establishment of behavioral criteria for demarcating the boundary between unconsciousness and consciousness has certain practical advantages, this approach is limited in its underlying conceptual justification. The statement continues:

[The establishment of these criteria] presumes that [the vegetative state] and MCS have distinct borders when they may actually represent points along the same continuum of consciousness. Additionally, the process by which specific behaviors are designated as evidence of consciousness is relatively arbitrary . . . These diagnostic criteria for MCS will require validation from subsequent research.⁹

Consequently, the line between the vegetative state and MCS may not be distinct.

7. *Id.* at 13.

8. *Id.*

9. *Id.*

Two recent court cases, *In re Martin*¹⁰ and *Conservatorship of Wendland*,¹¹ contain strikingly similar facts and result in strikingly similar judicial resolutions. Both involved middle-aged males who were left with severe and irreversible brain damage as a result of auto accidents. Both men were unable to communicate in any meaningful way, incontinent of bowel and bladder, unable to eat by mouth and dependent on medically provided nutrition and hydration, and completely dependent on the care of others. All medical experts involved agreed that the patients were outside the vegetative state, even though neither could perform meaningful daily activities. Both were severely brain damaged, yet conscious to some degree and in the minimally conscious state because they demonstrated one or more of the clinical features mentioned above.

Their wives, with the support of their children, acted on what they perceived to be the previously expressed wishes of their husbands and directed termination of all life-sustaining medical treatment — including medically provided nutrition and hydration. However, other family members were adamantly opposed to stopping treatment on their relatives in both cases. Mr. Martin's mother and sister both disagreed with his wife's decision, and Mr. Wendland's mother and half-sister opposed his wife's choice. When physicians were unable to reach any resolution, both cases went into litigation in order to settle the dispute.

In the most recent and controlling ruling in each case, the judges reached similar resolutions based upon similar reasoning. In both cases, the courts denied the request of the wife to cease treatment and ruled that medically provided nutrition and hydration (in the case of Mr. Wendland)¹² and all medical treatment (in the case of Mr. Martin) should be continued indefinitely. These rulings largely rested on the courts' determinations that under the "clear and convincing" evidentiary

10. 538 N.W.2d 399, *cert. denied*, 516 U.S. 1113 (1996).

11. Probate Case No. 65669 (Cal. Sup. Ct. Jan. 17, 1997 & Mar. 9, 1998), *appeal pend'g.*, No. C029439 (Cal. Ct. App., 3d. App. Dist. 1998).

12. The court's final order only precludes Mrs. Wendland from stopping his medically provided nutrition and hydration. At present, as his legally appointed conservator with medical decision making authority, she has the authority to refuse to consent to all other forms of medical treatment for her husband. *See In re Wendland*, Probate No. 65669, slip. op. at 6 (Cal. Super. Ct. Jan. 17, 1997). For example, a physician's order not to attempt cardiopulmonary resuscitation on Mr. Wendland in the event of a cardiac or pulmonary arrest is presently in effect at Mrs. Wendland's direction.

standard laid out by the Supreme Court in *Cruzan v. Director*,¹³ the patients had not refused the treatment in question prior to incompetency. These rulings were also heavily influenced by the courts' perception that current state law could not be applied to the cases, despite the fact that both states had precedent relating to the cessation of treatment on patients in a persistent vegetative state.

These two decisions, in conjunction with a recent Wisconsin case,¹⁴ can be described as representing what appears to be an emerging judicial trend to distinguish the persistent vegetative state from other forms of permanent and profound neurological damage, such as the minimally conscious state. In addition, the decisions represent a trend not to treat minimally conscious patients like vegetative patients, despite the medical and practical connection between the two conditions and the similar response of spouses, and other family members, about the unacceptability of this condition to the patient. This Article, provides a preliminary legal and ethical assessment of the present controversy over discontinuing medical treatment of patients in the minimally conscious state.

First, this Article describes both the facts¹⁵ and the judicial resolution of the cases of Mr. Martin and Mr. Wendland in greater detail.¹⁶ Then, this Article comments on the legal, ethical, and medical implications of

13. 497 U.S. 261, 282 (1990). See generally *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988); *In re Westchester County Med. Ctr.*, 531 N.E.2d 607 (N.Y. 1988).

14. *In re Edna M.F.*, 563 N.W.2d 485 (Wisc. 1997). Although similar in some important respects to *Martin* and *Wendland* (e.g., the patient was not in the vegetative state but was minimally conscious as a result of advanced Alzheimer's disease), we are omitting any discussion of *Edna* in this article for purposes of focus and clarity.

15. Our presentation of the facts of these cases is based on several sources: The published decisions of *In re Martin*, 538 N.W.2d 399 (Mich. 1995), 504 N.W.2d 917 (Mich. Ct. App. 1993) and 517 N.W.2d 749 (Mich. Ct. App. 1994); Andrew Broder & Ronald Cranford, "Mary, Mary Quite Contrary, How was I to Know?" *Michael Martin, Absolute Prescience, and the Right to Die in Michigan*, 72 U. DET. MERCY L. REV. 787 (1995); and Dr. Cranford's personal knowledge of the facts gathered as an expert witness in both cases.

16. As it affects the authors' understanding of, and point of view on, these matters, it should be noted that Dr. Cranford served as a *pro bono* expert medical witness and advisor in both the *Martin* and *Wendland* cases. Dr. Nelson served as *pro bono* expert bioethics witness in the *Wendland* case. He is currently representing Mr. Wendland's wife of 20 years, Rose, on a *pro bono* basis in her appeal of the trial court's ruling. Mr. Wendland is separately represented by court appointed counsel.

foregoing medical treatment, as well as requiring continued treatment, of minimally conscious patients. The judicial resolution in those cases manifests an ignorance of, or an intentional disregard of, the many factual similarities between persons in both the vegetative and minimally conscious states. They also assume that any degree of consciousness in a person makes a decision to forego life-sustaining treatment much more legally and ethically problematic, if not outright impermissible, than a parallel decision for a patient in the vegetative state. As ethical continuity exists between the manner in which patients in these states ought to be treated, there is a question as to the validity and coherence of this assumption. For these reasons, although this trend in judicial resolution is not surprising, it remains troubling and worthy of critical scrutiny.

I. OVERVIEW OF *MARTIN* AND *WENDLAND*

On January 16, 1987, Michael Martin, his wife, and three children were all severely injured in an automobile accident when the family's car was hit by a train near their home in Moline, Michigan. Michael's seven-year-old daughter, Melanie, died instantly as a result of the crash. His wife and two other children suffered multiple injuries from which they eventually recovered. Michael, who was thirty-six at the time of the accident, sustained severe and permanent neurological injuries.

Over the last eleven years, and up to the time of the judicial proceedings in the early 1990s, Michael has not improved in any significant way. His left side is completely paralyzed. His right side shows minimal movements of the fingers and leg, and he can move muscles in his throat, lips, and tongue. Michael is unable to eat, walk, talk, or control his bladder and bowel. He is dependent on medically provided nutrition and hydration. He is conscious to some extent, but unable to communicate in any meaningful, consistent manner.

He is aware to some extent that questions are being addressed to him by others, and he can, and does, respond with "yes" and "no" answers by head movements. Unfortunately, the "yes" and "no" responses are "consistently inconsistent."¹⁷ This means that at times he may answer a question correctly, but most of the time his answers are incorrect and indicate, for example, that he has little or no ability to recognize familiar words, faces, names, or places. When Michael was questioned in detail by Dr. Cranford prior to trial, he nodded "yes" when he was asked if he could eat, walk, and talk. He repeatedly nodded "yes" when asked if he

17. Broden & Cranford, *supra* note 15, at 799.

was taking food and water by mouth, and also denied that he was wearing a diaper, that he had a feeding tube, that he was paralyzed, and that he could not go to the bathroom by himself. These answers were all factually incorrect.

Prior to this accident, Michael was a sportsman who loved the outdoors. He was physically strong, active, and independent. He also had an almost pathological fear of illness, weakness, helplessness, and dependency. He often denied illness even when he was sick. When he would go hunting, he would often talk to his wife about his fear of being accidentally shot and disabled, or being rendered helpless and dependent. He was also fearful of being in a hospital and dealing with doctors.

Michael's wife, Mary, felt very strongly that his prior lifestyle, conduct, and explicit statements indicated that Michael would not want to continue living in a dependent state. One specific comment that Mary said her husband had made in the past was that if she permitted him to endure an existence of helplessness and hopelessness after an injury or illness, he would "haunt her until the day she died." Based on the previously expressed wishes of the patient and his lifestyle, Mary, her two children, and Michael's brother, requested that all treatment, including medically provided nutrition and hydration, be terminated and that Michael be allowed to die. However, Michael's mother and sister strongly opposed this action, which resulted in extensive court proceedings in Michigan over a three year period.

The trial court determined that there was clear and convincing evidence that before losing his mental capacity to decide, Michael expressed his preference to decline life-sustaining medical treatment under the circumstances he faced. Although the Michigan Court of Appeals affirmed, the Michigan Supreme Court reversed, and litigation in this matter has come to an end.

Robert Wendland was forty-two years old when he was involved in a motor vehicle accident near Stockton, California on September 29, 1993. This accident left him comatose due to severe head injuries. Although Robert remained unresponsive for many months after the accident, sometime in late 1994 or early 1995, his wife noticed that he began to develop signs of cognitive responsiveness. By the early summer of 1995, he was inconsistently but definitely interacting at a conscious level with his environment. For example, in therapy sessions he could pick up designated objects with his left hand with some regularity, but he consistently needed much cueing from the therapists to accomplish

this. With encouragement and direction, he could also maneuver an electric wheelchair by himself and go down a corridor and make a left-hand turn. However, he could not avoid objects in his way or move his chair if it hit a wall or other obstacle.¹⁸

He showed some degree of intermittent and inconsistent visual pursuit. His right side was completely paralyzed, and his left side was moderately weak. Robert sometimes showed other definite signs of voluntary movement on the left side, such as scratching his nose or making other apparently purposeful movements of the left arm toward his face. Not infrequently during physical therapy, he would manifest a definite snarl on his face and was observed to strike out at the therapist with his left hand. He became increasingly agitated during prolonged therapy sessions and at other times as well. He rarely responded to yes and no questions, and when he did, his answers were extremely inconsistent. Usually, he responded only with maximal cueing from another person.

Robert is married with three children. He is described by his wife, Rose, as a hard working man who carried three jobs when she first met him. He was very quiet, private, and rather taciturn. Some characterized him as a workaholic. To relax, he liked to read, the Bible in particular. When Robert's father-in-law died in the summer of 1993, he seemed to take this loss very hard and began drinking excessively. After experiencing difficulties with the quality of Rose's father's death, he spoke with his brother Mike, and indicated that if he were ever being kept alive by feeding tubes and life-support machines, he wouldn't want Mike to allow him to continue in that situation. Ironically and tragically, his wife and brother confronted him about his drinking and driving just five days prior to the accident, and he stated at this time that if he were in a "terrible accident" and lived, "you know what my feelings are. Don't let that happen to me. Just let me go. Leave me alone I wouldn't want my children to ever see me like that."

Since July of 1995, Robert has demonstrated little, if any, further neurologic recovery. His mother has reported being hugged by Robert and seeing other signs of responsiveness, but these have not been confirmed by any other observer. Some dispute has existed among some of Robert's health care providers and other outside medical experts concerning whether he might improve in cognitive function. However, two inde-

18. His ability to use the control of an electric wheelchair was personally witnessed twice by Dr. Nelson and once by Dr. Cranford. Mr. Wendland no longer engages in this activity.

pendent medical examiners retained by Robert's court appointed trial counsel concluded there was no evidence of further improvement in cognitive functions beyond early 1995. When the patient was examined by these two independent medical examiners in the latter half of 1997, he demonstrated minimal but definite signs of consciousness and followed some commands with significant prompting.

Both of these independent medical examiners concluded that Robert's prognosis for further recovery was poor and that further aggressive rehabilitation would prevent or minimize some medical complications but would not enhance his neurologic condition or significantly improve his functional status. Both doctors found that he clearly displays dysphoria¹⁹ and combativeness. However, this is understandable given the pain associated with the degree of his spasticity,²⁰ the presence of contractures,²¹ his ongoing dental problems, and the extent of his brain injury. These same experts reexamined him in December of 1998 and reaffirmed their prior conclusions.

Robert's wife, children (two of whom were in their teens at the time of the accident), and his brother, Mike, were convinced that Robert would not want to live in his present state. However, Robert's mother and half-sister, Rebecca, opposed this conclusion claiming that he would not want to go against God by committing suicide and ending up in hell. However, uncontradicted evidence presented at the trial showed that Robert was estranged from both his mother and Rebecca. Specifically, Rose testified that neither had even been in their home for the last ten years. Neither celebrated birthdays or holidays with them, and their children had never received cards or gifts from their grandmother. Robert refused to give Rebecca away at her wedding or to even attend the event, and when Rose and Robert had first met, he was afraid to introduce her to his family for fear that she would no longer love him if he did.

After several years of legal maneuvers, including several appeals by

19. That is, disquiet, restlessness, or malaise. Dysphoria is a state of emotional pain where one is unable to bring oneself to a state of calmness or relaxation. See RICHARD SLOANE, *THE SLOANE-DORLAND ANNOTATED MEDICAL-LEGAL DICTIONARY* 202 (1992 Supp.).

20. "[A] state of hypertonicity, or increase over the normal tone of a muscle, with heightened deep tendon reflexes." *Id.* at 480.

21. Contractures are, "[a] condition of fixed high resistance to passive stretch of a muscle, resulting from fibrosis of the tissues supporting the muscles or the joints, or from disorders of the muscle fibers." *Id.* at 164.

the mother and half-sister, the trial court held eight weeks of hearings in the Fall of 1997 and the early part of 1998. In March of 1998, the court ruled that Rose lacked the legal authority to discontinue Robert's medically provided nutrition and hydration, although it refused the mother's and half-sister's petition to be named Robert's conservator in place of Rose. At the time of this article's publication, Rose and Robert, through their court appointed appellate counsel, were appealing the judge's ruling. A ruling from the California Court of Appeal is not expected until the summer of 1999.

II. DECISIONS OF THE COURTS

Before looking more closely at each decision, several basic similarities in the judicial resolution of the disputes and the reasoning upon which they rest should be noted. First, in both cases the neurological consensus was that the patient was outside the vegetative state. In other words, both patients manifested some minimal degree of consciousness inconsistent with the vegetative state. This apparently led the courts to hold that previous law concerning the discontinuation of life-sustaining treatment in vegetative patients was inapplicable.²² In essence, these rulings distinguished the vegetative state from the minimally conscious state as a matter of law, divorcing existing case law from the judicial resolution of disputes arising in this new category of patients.

Second, neither court offered much justification for distinguishing the vegetative state from the minimally conscious state. At bottom, both simply assumed that the minimally conscious state is somehow radically different — medically, legally, and ethically — from the vegetative state. According to these courts, a minimally conscious person must be treated differently when questions arise concerning the maintenance of their lives with medical treatment. The courts also assume that the consequences of making termination of treatment decisions for non-vegetative patients and society are far more dangerous than similar decisions made for vegetative patients. These assumptions, which beg for justification, largely determined the outcome of these cases.

22. The patient in *Rosebush v. Oakland County Prosecutor*, 491 N.W.2d 633, 635 (Mich. Ct. App. 1992), was vegetative, as were the patients in *Barber v. Superior Court*, 195 Cal. Rptr. 484, 486 (Cal. Ct. App. 1983); *In re Conservatorship of Drabick*, 245 Cal. Rptr. 840, 842 (Cal. Ct. App. 1988), *reh'g denied*, 488 U.S. 1024 (1989); and *In re Conservatorship of Morrison*, 253 Cal. Rptr. 530, 531 (Cal. Ct. App. 1988).

In fact, these two courts were far more concerned about projected social consequences to anonymous persons than the interests and rights of the particular injured individuals and their close family members. As interpreted by their spouses and other family members, both Michael and Robert expressed their wishes about continued existence in a profoundly disabled state quite clearly and directly. Both have some capacity for experiencing pain and suffering, and yet their continued existence is assumed to be benign to them in this regard. This assumption is plainly unwarranted in Robert's case due to his general dysphoria and other signs of negative affect and is questionable in Michael's case. In addition, the wives' pain and frustration of being unable to effectuate their husbands' wishes in the face of a dismal prognosis for recovery was overlooked or discounted.

Third, using slightly different reasoning, both courts came to the same conclusions that the patients must make non-treatment decisions themselves in advance, and that the clear and convincing evidence standard should apply to establish that they have made these decisions. However, despite strong and persuasive evidence of each patients' previously expressed wishes about living in a severely impaired state,²³ the courts

23. Mr. Wendland's brother and wife confronted him about his driving after drinking alcohol and warned him of the chance that he could be in a terrible accident and badly injure himself or another. Mr. Wendland responded, "If that ever happened [sic] to me, you know what my feelings are. Don't let that happen to me. Just let me go. Leave me alone." Reporter's Transcript at 54, *In re Conservatorship of Wendland*, Probate Case No. 65669 (Cal. Sup. Ct., Jan. 21, 1997 & Mar. 9, 1998). When asked about his children, Robert responded, "You know how I feel about that Rose. We talked about that with your father. I wouldn't want my children to ever see me like that." *Id.* In reacting to the last days of Rose's father's life, when he was unresponsive and on life-support, Rose recounted that Robert stated:

Basically that is no way of living. And was I keeping him alive for myself or was I keeping him alive for my father. And he told me at that point 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.

Id. at 49.

According to Mr. Martin's wife, Mr. Martin:

Made a lot of comments to me about never wanting to live 'like a vegetable.' He said that if anyone had to live like a vegetable, 'their families and doctors should be shot for forcing someone to live like that.' He would say, 'I'd be pissed if I had to live that way.' He also told me that he believed it was unfair to the person who had to be kept alive on machines because that person would always be in pain. He also told me that 'no one should have to be kept alive if they would never get well again.'

ruled that this evidentiary standard was not met in either case. Again, these conclusions are ultimately driven by the assumption that the minimally conscious state should be sharply distinguished from the vegetative state for fear of the “slippery slope” effect on the lives of other minimally conscious patients should Michael’s and Robert’s spouses be permitted to discontinue life-sustaining medical treatment.

A. Martin

In *Martin* the majority opinion correctly acknowledged that competent persons have a common law right to refuse life-sustaining medical treatment, that this right survives incompetence, and that the right may be discharged by a surrogate decision maker.²⁴ However, the court cast this right in narrow terms: The right to decide “to refuse medical treatment under the particular circumstances, made while [the patient is] competent” must be honored when the patient is incompetent.²⁵ The court stated:

We wish to make clear that we are deciding only that to the extent the right to refuse medical treatment ‘refers to decisions already made and communicated by the patient before losing the

In re Martin, 538 N.W.2d 399, 412 (Mich. 1995). He also told his wife that he would “always haunt” her if she put him on machines to keep him alive if there was no hope of getting better. *See id.*

24. *See In re Martin*, 538 N.W.2d at 405-06. For unknown reasons, the court expressly declined to rule on whether constitutional and statutory grounds existed for recognizing this right. *See id.* This judicial maneuver unfortunately permits the court to dodge the question of whether the constitutional right to refuse treatment, as expressed in *Cruzan v. Director*, 497 U.S. 261, 279 (1990), requires that the State permit a legally appointed surrogate to make medical decisions on behalf of a mentally incapacitated patient. For the arguments that the State should not require clear and convincing evidence of a person’s own statements refusing medical treatment in advance, see *In re Conservatorship of Drabick*, 245 Cal. Rptr 840, 856-57 (1988). There the court wrote:

This approach presents several serious problems. First we have found no authority – other than cases on the subject of life-sustaining treatment – to support the idea that a person can exercise (or waive) a fundamental constitutional and common law right unintentionally through informal statements years in advance. Second, if one bases the treatment of persistently vegetative patients not on the statutory delegation of rights to a conservator but on the theory that an evidentiary hearing can reveal the patient’s own hypothetical choice, one is left with no consistent basis for a decision when a patient has been silent on the matter.

Id.

25. *In re Martin*, 538 N.W.2d at 406.

capacity to make further choices, . . . it is true that the patient's interest in having those choices honored must survive incapacity.²⁶

In other words, the patient possesses the right to have his own decisions enforced, and not to have the right to refuse treatment exercised by another on his behalf, even if his values and interests suggest the exercise to be a correct one. Accordingly, the surrogate merely is the conduit of the patient's own decision and does not have any role in the creation of a decision after the patient becomes incompetent.

By interpreting the right to refuse in this manner, the court precluded the possibility of approving a standard of surrogate decision making that would grant the surrogate personal discretion in making the treatment decision on the patient's behalf. Consequently, it rejected the "substituted judgment" standard²⁷ as a legal fiction which simply supplants a patient's decision to withdraw treatment with that of a surrogate.²⁸ It also rejected the "best interests" standard²⁹ because it is both inconsistent with the common law right to refuse,³⁰ and it permits another to "make a determination of a patient's quality of life, thereby undermining the foundation of self-determination and inviolability of the person upon which the right to refuse medical treatment stands."³¹

The court asserted that a purely subjective analysis of one's right to refuse is most appropriate in cases of this nature³² because it allows a surrogate to withhold life-sustaining treatment when it is clear that the patient would have refused such treatment given the circumstances.³³ In

26. *Id.* (citing James Bopp, Jr. & Daniel Avila, *Perspectives on Cruzan: The Sirens' Lure of Invented Consent: A Critique of Autonomy-Based Surrogate Decisionmaking for Legally-Incapacitated Older Persons*, 42 HASTINGS L. J. 779, 806 (1991)).

27. "Through this standard, the surrogate attempts to ascertain, with as much specificity as possible, the decision the incompetent patient would make if he were competent to do so." *In re Martin*, 538 N.W.2d at 407.

28. *See id.* (citations omitted).

29. "The best interest standard is an objective analysis under which the benefits and burdens to the patient of treatment are assessed by the surrogate in conjunction with any statements made by the patient if such statements are available." *Id.* (footnote and citation omitted).

30. This is so largely because the right to refuse is personal in nature, whereas the best interests standard is inherently impersonal and objective.

31. *In re Martin*, 538 N.W.2d at 407 (citation omitted).

32. *See id.*

33. *See id.* (citation omitted).

other words, a purely subjective standard makes the surrogate merely the messenger of the patient's previous decision. The court affirmed that, out of respect for the patient's common law right to self-determination, the decision made by the patient while competent should continue to be honored regardless of the patient's current condition.³⁴ It added that this right does not justify or support the exercise of a surrogate's discretion in medical decision making for an incompetent person by means of a substituted judgment or best interests standard. Instead, objective standards — ones not personally exercised by the rights bearer — are grounded in the State's *parens patriae* power and therefore may be controlled by the State.³⁵

Specifically, the *Martin* court ruled that the State can control the use of a surrogate's own discretion and judgment in making treatment decisions on behalf of an incompetent person by requiring that the patient be in a certain medical condition before permitting the surrogate to make any decision at all. The court stated that, "[N]othing . . . prevents the state from grounding any objective analysis on a threshold requirement of pain, terminal illness, foreseeable death, a persistent vegetative state, or affliction of a similar genre."³⁶ The court was fully aware that certain circumstances have led other courts to apply tests which are based on more objective criteria, and noted that patients in such cases have generally been in a comatose or persistent vegetative state.³⁷ However, the facts of the case did not present the *Martin* court with the same situation.³⁸ The court was directly led to reject permitting the surrogate to use

34. *See id.* at 408.

35. *See id.* at 408 (citation omitted). Even though the majority opinion sharply distinguishes the vegetative and minimally conscious states, it nevertheless indiscriminately mixes these supposedly very different kinds of cases when it discusses the various decision making standards. For example, the court extensively cites not only *In re Conroy*, 486 A.2d 1209 (N.J. 1985) in this regard, a case involving a profoundly demented yet conscious patient, but also *Cruzan v. Director*, 497 U.S. 261 (1990); *In re Westchester County Med. Ctr.*, 531 N.E.2d 206 (N.Y. 1988); *In re Jobes*, 529 A.2d 434 (N.J.), *reh'g denied*, 531 A.2d 1360 (N.J. 1987); *Lincoln Park Nursing & Convalescent Home v. Kahn*, 483 U.S. 1036 (1987); and *Browning v. Herbert*, 568 So.2d 4 (Fla. 1990). All these involve vegetative patients. Throughout its discussion of these various other cases and the various decision making standards, the *Martin* court fails to note the possible distinctions and similarities among the neurologic condition of the patients involved. *See id.*

36. *In re Martin*, 538 N.W.2d at 408.

37. *See id.* (citations omitted).

38. *See id.*

an objective standard by the fact that Michael Martin had some consciousness and was not vegetative.

In one of the most startling, yet telling, passages in the decision, the majority opinion reaches the following conclusion: "In this case, Michael's life and health are not threatened by infirmities of [the] nature [of his condition]."³⁹ In reality, being permanently comatose or vegetative poses no more "threat" to a person's life than being minimally conscious like Michael and Robert; all three conditions shorten life expectancy markedly. Moreover, as demonstrated above, it is largely illusory to assert that the "health" of minimally conscious patients is better than that of the comatose or vegetative patients. The two conditions are much more descriptively alike than different. To further illustrate that the majority did not grasp the actual neurologic condition of Michael Martin, the court stated that "[b]y all accounts, Michael is not experiencing any type of pain that would outweigh any enjoyment or pleasure he is experiencing."⁴⁰

The *Martin* court also held that the purely subjective standard for refusal of treatment on an incompetent patient must be proven by clear and convincing evidence.⁴¹ In other words, when a surrogate claims that an incompetent individual's statements express a decision by that individual to refuse life-sustaining treatment, such statements must be proved by clear and convincing evidence "before the surrogate is allowed to effectuate them."⁴² While preferring written directives as evidence of a person's wishes, the court observed that oral statements might be relevant if they are made under appropriate circumstances. In their own words, the court concluded that the weight accorded such oral statements "depends on the remoteness, consistency, specificity, and solemnity of the prior statement."⁴³

In any event, the combination of the "purely subjective standard" for

39. *Id.*

40. *Id.* at 409 n.16.

41. See *In re Martin*, 538 N.W.2d at 401, 406 n.12, 410.

Evidence is clear and convincing when it 'produce[s] in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, evidence so clear, direct and weighty and convincing as to enable [the factfinder] [sic] to come to a clear conviction, without hesitancy, of the truth of the precise facts in issue.'

Id. at 410 (citing *In re Jobs*, 529 A.2d 434, 441).

42. *Id.* at 409.

43. *Id.* at 411.

surrogate decision making for the incompetent with the “clear and convincing” standard of proof places a very heavy burden on the surrogate. The burden may, for all practical purposes, be literally impossible to satisfy. As the court held:

Only when the patient’s prior statements clearly illustrate a serious, well thought out, consistent decision to refuse treatment under [the] exact circumstances, or circumstances highly similar to the current situation, should treatment be refused or withdrawn. In all events, the proofs in sum must meet the exacting standard of clear and convincing evidence.⁴⁴

The court recognized the criticism of this assertion as “possibly creating too stringent a standard, inhumanely condemning a patient to a ‘prolonged and painful death,’” but dismissed it because “the facts of this case do not dictate that we progress beyond a purely subjective standard, and we refuse to do so.”⁴⁵

The court was also acutely aware of the dilemma posed by the choice between allowing the minimally conscious patient to die and requiring him to live. “To err either way has incalculable ramifications. To end the life of a patient who still derives meaning and enjoyment from life or to condemn persons to lives from which they cry out for release is nothing short of barbaric.”⁴⁶ But when the choice must be made, the value of maintaining even minimally conscious life trumps: “If we are to err, however, we must err in preserving life.”⁴⁷

The central “fact” the court implicitly claimed dominated its decision was Michael Martin’s neurological status of being minimally conscious and not permanently unconscious. The court was afraid to “progress beyond a purely subjective standard” because of the potential legal, social, and ethical ramifications of a surrogate making decisions about the quality of life of another. In short, the court was worried about the “slippery slope.”⁴⁸

44. *Id.*

45. *Id.* at 409 (citation omitted).

46. *In re Martin*, 538 N.W.2d at 401.

47. *Id.* at 402.

48. *Id.* at 409 (“We cannot stress too strongly that the complexity and ramifications of any decision in this area caution against moving too swiftly or adopting controversial decision making standards in cases that do not present facts compelling such decision. . . . As we noted at the outset, if we are to err, we must err in preserving life. Our first step in this area must be a careful one.”).

B. Wendland

The Superior Court judge hearing Mr. Wendland's case, Bob W. McNatt, made two central written rulings. In the first, Judge McNatt noted that Mr. Wendland was an "incompetent person whose cognitive abilities cannot be determined because of serious brain injuries, but who is neither terminally ill nor in a persistent vegetative state."⁴⁹ In his view, previous California case law on persons in the vegetative state did not provide adequate guidance or precedent.⁵⁰ In this decision, Judge McNatt placed the burden of proof upon the surrogate decision maker, namely, Wendland's wife. The standard for surrogate decision making was to be a best interest approach, but one "tempered with certain *subjective* considerations." He also established the "evidentiary standard in situations involving withdrawal of medical treatment from conscious but cognitively impaired persons [as] 'clear and convincing evidence.'"⁵¹

Like the *Martin* court, Judge McNatt was aware of the fundamental dilemma the case presented and the possible ramifications of his decision. In this regard, he echoed, but did not mimic, *Martin's* language. He even questioned *Martin's* reliance on the oft-heard but seldom carefully justified preference for the preservation of biological life over the respect for an individual's wishes to maintain his dignity, the quality of his life, and the integrity of his human relationships with loved ones and the world.

[T]he stakes are simply too high and the consequences too dire to determine an appropriate course of action on a less compelling showing [than clear and convincing evidence]. To bring about the death of an innocent person who still finds meaning and enjoyment in life would be barbaric. It would be equally cruel, however, to force someone who has lost all dignity and faces only an existence of constant pain or suffering and who would fervently seek death as a release to go on living merely on the presumption that life is always preferable to death.⁵²

Consequently, Judge McNatt wanted to act cautiously in this case. Just like the *Martin* court, he worried too much about the possible consequences to others in the minimally conscious state of permitting a surro-

49. *In re Wendland*, Probate No. 65669, slip op. at 1 (Cal. Super. Ct. Jan. 17, 1997).

50. *See id.*

51. *Id.* at 16, 17.

52. *Id.* at 6-7.

gate to refuse medical treatment, and too little about the specific consequences to Robert Wendland. The judge's caution led him to determine that treatment ought to continue.⁵³

His caution also led to concerns about his endorsement of the "tempered best interest" approach to surrogate decision making because it may start a slippery slope. Without reference to the present case, it would certainly provide the opportunity for unethical conservators of non-communicative incompetents to try to end the life of patients based on mere inconvenience, or for personal gain."⁵⁴ Later in his opinion, the judge noted that "there are many whose motives and morals are not equal to [Mrs. Wendland's]" and that permitting treatment to be stopped in this case "would allow the opening of a door that other families with less noble motives might follow through."⁵⁵

After making the above-mentioned basic legal rulings, Judge McNatt heard approximately eight weeks of testimony. At the conclusion of Mrs. Wendland's case, during which she attempted to meet the burdens placed on her, the attorney for the estranged mother and half-sister made a motion for summary judgment and contended that the court should rule in their favor as a matter of law even though they had put forward no evidence of their own. The judge granted this motion and, in a written opinion issued later, held that Mrs. Wendland "has not met her duty and burden to show by clear and convincing evidence that . . . Robert Wendland, who is not in a persistent vegetative state nor suffering from a terminal illness, would, under the circumstances, want to die."⁵⁶ She was also unable to meet "her burden of establishing that the withdrawal of artificially delivered nutrition and hydration is commensurate with conservatee's best interests . . ."⁵⁷

Like the Michigan Supreme Court, Judge McNatt found that the patient's previously expressed wishes were legally insufficient to prove the patient's decision to refuse treatment under the precise circumstances in

53. *See id.* at 9. "When a situation arises where it is proposed to terminate the life of a conscious but severely cognitively impaired person, it seems more rational for the court to ask 'why?' of the party proposing the act rather than 'why not?' of the party challenging it." *Id.*

54. *In re Wendland*, Probate No. 65669, slip op. at 16 (Cal. Super. Ct. Jan. 17, 1997).

55. *Id.* at 5.

56. *In re Wendland*, Probate No. 65669, slip. op. at 3 (Cal. Super. Ct. Mar. 9, 1998).

57. *Id.*

which he then existed. He held that:

The court finds that neither of these conversations [about refusing treatment that were testified to by several witnesses] reflect an exact 'on all fours' description of conservatee's present medical condition. More explicit direction than just 'I don't want to live like a vegetable' is required in order to justify terminating the life of someone who is not in a PVS.⁵⁸

Although these conversations convinced Robert Wendland's wife of twenty years, his teen-aged children, and his brother that he did not want to live in a vegetative state, the conversations did not convince Judge McNatt. His decision could quite easily lead one to believe that nothing Robert Wendland could have *ever* said in advance of being severely brain damaged would have satisfied Judge McNatt.

Similar to the *Martin* court, Judge McNatt concluded that in the case of a patient who was not in the vegetative state and who had not while competent clearly, directly, and definitively refused the treatment in question under the precise medical circumstances in question, the court "must err on the side of caution" and "choose life" for the patient.⁵⁹ Yet, unlike the *Martin* majority, Judge McNatt noted that despite his ruling "it still can be debated whether [Mr. Wendland's life] is being preserved or he is being sentenced to [a miserable] life."⁶⁰

III. LEGAL AND ETHICAL ASSESSMENT

Although the *Martin* and *Wendland* decisions both make a strong legal distinction between decisions to forego treatment for persons in the vegetative state and those in the minimally conscious state, neither explained the basis for this distinction. The following is an analysis of the assumptions and values that underlie the courts' positions.

Both courts seem to focus on the major descriptive differences between the two states: A vegetative patient has no consciousness whatsoever and experiences nothing, while a minimally conscious patient has some rudimentary degree of consciousness, suffers from severe to profound dementia, and therefore has conscious experiences of some type. This suggests a major ethical difference. A permanently vegetative patient really has no morally significant interests whatsoever,⁶¹ including

58. *Id.* at 4.

59. *See id.* at 5.

60. *Id.* at 6.

61. Except, perhaps, for an interest in the very small chance that he or she will truly emerge from the unconscious state.

an interest in remaining alive. This is because the overwhelming likelihood is that the patient will never be aware of anything.⁶²

In contrast, a minimally conscious patient, at the very least, has an interest in avoiding pain, suffering, the possible burdens of continued treatment, and other unpleasant or debilitating experiences and in having pleasant, happy, or personally satisfying experiences; this includes an interest in remaining alive. Like the vegetative patient, the minimally conscious patient has an interest in emerging from this state and going back to a more functional form of human existence, however unlikely this may be.

Despite these differences, the vegetative and minimally conscious states are actually quite similar in many respects. First, most persons in these conditions are unable to perform any of the typical activities of daily living such as walking or meaningfully communicating with others. Second, they are totally dependent upon others for care such as toileting, dressing, or feeding themselves. Third, as both groups of persons are profoundly physically and mentally limited and rendered largely inactive by their condition, both are subject to the medical complications of their inactivity, such as bedsores, infections, and contractures. Furthermore, the life expectancy of both groups is greatly shortened as a direct consequence of their medical conditions. The data supporting this claim, however, is much more extensive for vegetative patients than for the minimally conscious.⁶³ In sum, persons in the vegetative and minimally conscious states are profoundly dysfunctional.

62. Good recovery after one year in the vegetative state or in the minimally conscious state has never been documented in the medical literature. See ASPEN CONSENSUS STATEMENT, *supra* note 6, at 7-8; see also Multi-Society Task Force, *supra* note 1, at 1572.

63. Recent data has shown persuasively that life expectancy is substantially shortened for patients who are severely cognitively impaired, immobile, nonambulatory and feeding tube dependent. See Multi-Society Task Force, *supra* note 1, at 1499, 1576. These traits characterize both the vegetative state and minimally conscious state. See *id.* In the permanent vegetative state, for example, general life expectancy is two to five years, with survival beyond 10 years uncommon and survival beyond 15 years rare (one in 15,000 to one in 75,000 according to the Multi-Society Task Force Report on PVS). See *id.*; see also David Strauss et al., *Prognosis for Survival and Improvement in Function in Children with Severe Development Disabilities*, 31 J. PEDIATRICS 712, 715 (1997); Richard K. Eyman et al., *The Life Expectancy of Profoundly Handicapped People With Mental Retardation*, 323 NEW ENG. J. MED. 584, 588 (1990); Ashwal et al., *Life Expectancy of Children in a Persistent Vegetative State* 10 PEDIATRIC NEUROLOGY 27, 27 (1994).

Finally, we believe it fair to claim that no one would freely choose to enter into either state and that anyone who intentionally, or otherwise, culpably placed someone else in either state would have done the patient great harm and grave moral wrong. In neither condition, is an individual able to live a life of interaction with others, to achieve one's own vision of the good life, to fulfill one's goals, or to reach for one's dreams? Although persons in both states are alive biologically, in neither state are they more than minimally alive personally or biographically. For all intents and purposes, both states equally obliterate an individual's personal and sapient existence, leaving him profoundly neurologically impaired. None of this, however, is to say that persons who have been reliably diagnosed as being in either state permanently have lost their human value or their right to be treated with respect. The disagreement is about the meaning of valuing and respecting these individuals.

The factual differences between the two states has generated an assumption on the part of the courts that persons in these two supposedly distinct states ought to be treated radically different in terms of the ethical and legal obligations of others to continue to maintain their lives with medical treatment. Adopting this position is a serious mistake. The assumption that any degree of consciousness in a person — no matter how minimal — makes a decision to forego life-sustaining medical treatment much more ethically problematic, if not outright impermissible, is unjustifiable. In several important and fundamentally descriptive ways, persons in these states are more alike than different. But more importantly, the arguments for considering their ethical situations to be dissimilar are erroneous in several basic and crucial ways.

First, the assumption that ceasing treatment on a minimally conscious patient is highly ethically suspect or simply impermissible seems to rest in large part on the fact that the patient is conscious and therefore able to experience pain and suffering. This consideration militates against stopping treatment because such non-action will cause the patient to suffer, although it is irrelevant to vegetative patients because they do not experience pain. Because Robert Wendland or Michael Martin might experience pain or discomfort related to the cessation of medically provided nutrition and hydration, as this argument goes, it is morally wrong to undertake such an act in the first place — a factor that is not an issue for vegetative patients.

This argument is fatally flawed for two reasons. First, the pain or suffering associated with foregoing treatment of a minimally conscious

patient can be avoided by the careful professional administration of analgesic medications. If it is ethically right to forego treatment and allow any conscious patient to die, that patient need not pass from this world in pain because we have the means to avoid this plainly undesirable result. Second, and more compelling, the argument for requiring continued treatment of a minimally conscious patient ignores the pain and suffering the patient will have to undergo while his life is being prolonged. Vegetative patients experience nothing with or without life-sustaining treatment. In contrast, continued treatment of minimally conscious patients — precisely because they are conscious — may result in them suffering for years, or even decades, and probably being wholly unable to express adequately to anyone the depth of their pain, not to mention their elemental sense of frustration and loss.

In other words, being kept alive in the minimally conscious state may be far worse for the individual than being maintained in the vegetative state. Judge McNatt was painfully aware of this aspect of his ruling: “[I]t still can be debated whether [Mr. Wendland’s] life is being preserved or he is being sentenced to life [by my order].”⁶⁴ In Mr. Wendland’s case, the “life sentence” is to an indefinite term in a prison of solitary confinement, unable to reach out to other persons, unable to express himself, unable to even move, possibly deeply frustrated by being stranded in a diminished life he never wanted, yet able to suffer to an extent ultimately known only by him. With the minimal degree of awareness that gives him the capacity for pain and suffering — the precise extent or nature of which is unknown to others — the minimally conscious patient potentially poses a much stronger case for allowing death than the vegetative patient does due to the principle of mercy.⁶⁵

We hypothesize that the courts’ great reluctance to approve of discontinuing medically provided nutrition and hydration in minimally conscious patients also rests on the perception that stopping such treatment and providing “terminal pain relief” is much closer to nonvoluntary active euthanasia and is, therefore, legally and morally objectionable. This perception, we contend, is grounded in the fact that the patient

64. *In re Wendland*, Probate No. 65669, slip. op. at 6 (Cal. Super. Ct. Mar. 9, 1998).

65. See Nancy L. Childs & Ronald E. Cranford, *Termination of Nutrition and Hydration in the Minimally Conscious State: Contrasting Clinical Views*, 12 *J. HEAD TRAUMA REHABILITATION* 70, 70 (Aug. 1997); Ronald Cranford, *Misdiagnosing the Persistent Vegetative State*, 313 *B.M.J.* 5, 6 (1996).

is conscious to some extent, cannot refuse the treatment himself, and is in need of analgesia and sedation. It therefore appears as if the patient's life is being intentionally and directly terminated — and he is being “drugged” in order to spare him the suffering that cessation of treatment will generate for him.

This perception, however, possesses only superficial moral plausibility. With the possible exception of the provision of analgesia and sedation (which is not necessary to avoid pain in the vegetative patient, but is sometimes provided nonetheless), withdrawing medically provided nutrition and hydration in a vegetative patient raises the identical concerns. Yet, it remains a well-established and accepted procedure in medicine, law, and ethics.⁶⁶

Neither the vegetative nor minimally conscious patient is terminally ill. The fundamental ethical reasons for withdrawing treatment apply to both states — the patient would not want to live in such a condition, and treatment offers no appreciable benefit to the patient other than being kept biologically alive. Furthermore, the patient has no reasonable chance of recovering,⁶⁷ and the patient would likely want to be released from such a state, relieving his family of the heartache of watching him merely exist but not live. The desire not to kill the patient but to let nature take its course by removing unwanted and nonbeneficial treatment is the same for persons in both states. In fact, precisely because the minimally conscious patient might suffer greatly if his life is prolonged, the ethical case for stopping treatment and letting him die is even stronger than if he were vegetative. While delving into the philosophical distinction between the ethics of “killing” versus “allowing to die” is beyond the scope of this Article, suffice it to say that if stopping treatment on a minimally conscious patient is wrongful killing, the same would hold true for the vegetative patient.

Third, both the *Martin* and *Wendland* courts were explicitly concerned with the possibly pernicious consequences of permitting treatment to be stopped in a minimally conscious patient. As discussed in detail above, both courts were very worried about the implications for other persons in similar situations if the wives of Michael Martin and Robert Wend-

66. See *Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State*, 39 *NEUROLOGY* 125, 125-26 (1989).

67. At least six physicians in the *Wendland* case opined that he would never recover from his present state.

land were to be permitted to refuse life-sustaining treatment, an action that would surely lead to their husbands' deaths.

Only Judge McNatt clearly expressed his concern about less honest and well-intentioned family members than Rose Wendland "allowing" their conscious loved ones to die in order to inherit some money, to relieve themselves of the burden of caring for the patient, or some other selfish, ignoble, or corrupt motive. However, persons in the minimally conscious state are not any more or less subject to having ethically suspect decisions made on their behalf by unscrupulous relatives than are other mentally incapacitated patients, be they terminally ill from cancer or heart disease, slowing dying from the ravages of Alzheimer's, or permanently unconscious after an auto accident. Improperly motivated acts to allow someone to die should be resisted in regard to any patient, and not simply the minimally conscious.

Judge McNatt and the *Martin* majority are most likely fearful that deliberately allowing the minimally conscious to die for want of life-sustaining medical treatment constitutes invidious discrimination against the mentally disabled. This very accusation appeared in the *Martin* case when the relatives opposing the wife's decision claimed that she and her supporting witnesses held an invidious "bias against" persons with disabilities "rooted in . . . stereotypes" and were motivated by a "better dead than disabled" viewpoint.⁶⁸

To be sure, persons in the minimally conscious state, like Michael Martin and Robert Wendland, are mentally and physically disabled. Society should be vigilant about respecting the disabled and treating them like other individuals. Medically beneficial treatment should never be denied to a disabled person as a direct consequence of his disability or as means of expressing invidious discrimination. Allowing a disabled person to die is not, however, necessarily invidious discrimination, nor does it necessarily demonstrate a homicidal or genocidal urge toward the disabled. If the disabled can choose for themselves, they ought to be given this choice like anyone else. If they cannot choose for themselves, this does not mean that they should receive all available medical treatment until they are swept away by death.

We concur with the analysis on this point offered by a California Court of Appeal in a case involving the family's wish to discontinue

68. Thomas J. Marzen & Daniel Avila, *Will the Real Michael Martin Please Speak Up! Medical Decisionmaking for Questionably Competent Persons*, 72 U. DET. MERCY L. REV. 833, 837 n.20 (1995).

medically provided nutrition and hydration in a vegetative patient, William Drabick.

[H]uman beings are not the passive subjects of medical technology [California case law] recognize[s] that medical care decisions must be guided by the individual patient's interests and values. Allowing persons to determine their own medical treatment is an important way in which society respects persons as individuals. Moreover, the respect due to persons as individuals does not diminish simply because they have become incapable of participating in treatment decisions. While William's coma precludes his participation, it is still possible for others to make a decision that reflects his interests more closely than would a purely technological decision to do whatever is possible. Lacking the ability to decide, he has a right to a decision that takes his interests into account.⁶⁹

When legitimate questions arise about the propriety of continuing medical treatment, all persons deserve to be treated as subjects and not objects. All persons deserve to have their individual interests and circumstances considered by a responsible and sensitive decision maker; no one deserves to be treated as an object and potentially infused, invaded, and accosted by whatever medical technology is available. Refusing medical treatment on behalf of a disabled person may be right or it may be wrong; the difference depends on the individual involved, his interests, his capacity for enjoyment and love, pain and suffering, the nature of his future life, not on whether he happens to be in the category of "disabled" or, for that matter, the category of the "minimally conscious state."

CONCLUSION

Decisions to withdraw or withhold life-sustaining treatment from very ill or injured patients are almost always difficult and heart-wrenching for the family and health care professionals involved. Particularly difficult are those decisions made in the presence of intra-familial disagreement about the propriety of this decision.⁷⁰ Strong opposition to the ces-

69. *In re Conservatorship of Drabick*, 200 Cal. App.3d 185, 208 (Cal. Ct. App. 1988).

70. This Article deliberately does not address the possible significance of the intra-family disagreement in both the *Martin* and *Wendland* cases. In both, the court's resolution of the matter (requiring clear and convincing evidence of the patient's decision) rendered irrelevant the dispute between their wives and other

sation of treatment, even for persons in the permanent vegetative state, still exists. Witness, for example, the recent case involving Hugh Finn in Virginia, where that state's governor publicly tried to prevent Mr. Finn's wife from withdrawing his medically provided nutrition and hydration despite a state statute that permitted her to do so.⁷¹

The opinions of the *Martin* majority and Judge McNatt also demonstrate deep reservations about withholding life-sustaining treatment from persons in the minimally conscious state. They assume that a sharp distinction exists between patients permanently in the minimally conscious state and those who are permanently vegetative. As a direct result of making this distinction, the striking judicial consensus⁷² about foregoing treatment of patients in the vegetative state is rendered irrelevant in cases involving the minimally conscious patient.

We seriously question the underlying ethical and legal validity of this assumption primarily because it fails to recognize the considerable factual similarities and to acknowledge that the ethical rationale for foregoing life-sustaining treatment is at least equally applicable in both cases and probably even more compelling for the minimally conscious due to their capacity for further suffering. This Article is merely an introduction to the medical, legal, and ethical aspects of this relatively new diagnostic category. Surely more medical and ethical research needs to be done in order to better understand the minimally conscious state and to explicate our moral obligations to those who have this minimal amount of awareness and interaction with others.

Finally, we also question the assumption of a distinction between the vegetative and minimally conscious states because it unreflectively places the value of an individual's biological life over the value of his or

family members. However, we note that in Mr. Wendland's case, he was profoundly estranged from both his mother and half-sister, while Robert's close family members, his wife, his children, and his brother were all in agreement that he would not want to live as he is and that all treatment should be stopped.

71. See Brooke A. Masters, *Virginia is Faulted in Finn Case: State to Pay Widow for Part of Legal Costs*, WASH. POST, Nov. 26, 1998, at D1; R. Melton & Brooke A. Masters, *Court Rejects Gilmore's Bid to Overturn Finn Ruling: Family Decision Stands to Let Newscaster Die*, WASH. POST, Oct. 3, 1998, at B1; Irvin Molotsky, *Wife Wins Right-to-Die Case - Then a Governor Challenges It*, N.Y. TIMES, Oct. 2, 1998, at A26; *Amid Legal Battle, Feeding Tube Removed*, MINNEAPOLIS SUN TRIB., Oct. 2, 1998, at A4.

72. See MEISEL, *supra* note 2, at 634-35.

her biographical and personal life.⁷³ For individuals reliably diagnosed as being permanently in the vegetative state, as well as those in the minimally conscious state, their biographical and personal life is over. Many people would consider their lives over if they could no longer communicate with others even in simple ways, create or maintain relationships with others, or act in the world in simple ways. The value and the sacredness of human life is grounded in the personal, at least as much as in the biological.

73. See RONALD DWORKIN, *LIFE'S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM* 89-94 (1993); JAMES RACHELS, *THE END OF LIFE: EUTHANASIA AND MORALITY* 24-27, 60-77 (1986).

