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LET HIM DIE WITH DIGNITY OR HOPE FOR A CURE: THE CONSEQUENCES OF MODERN MEDICINE

Andrew P. Lannon*

I. A SHARK ATTACK AND A FAMILY LEFT WITH LITTLE HOPE AND FEW CHOICES

On July 6, 2001, a 200 pound bull shark bit and nearly killed eight-year-old Jessie Arbogast at the Gulf Islands National Seashore in Pensacola, Florida. Jessie was rushed to Baptist Hospital and was later transferred to Sacred Heart Children's Hospital in critical, yet stable, condition. He lost a significant amount of blood after the shark's firm bite entirely severed his right arm. He arrived at the hospital without a pulse or blood pressure. Due to the trauma, doctors were uncertain as to what would happen should he regain consciousness. Would his brain continue to function at a healthy level for a child his age, or would it be so irreparably

1. Not long ago the realms of life and death were delineated by a bright line. Now this line is blurred by wondrous advances in medical technology -- advances that until recent years were only ideas conceivable by such science-fiction visionaries as Jules Verne and H.G. Wells. Medical technology has effectively created a twilight zone of suspended animation where death commences while life, in some form, continues. Some patients, however, want no part of a life sustained only by medical technology. Instead, they prefer a plan of medical treatment that allows nature to take its course and permits them to die with dignity. As more individuals assert their right to refuse medical treatment, more frequently do the disciplines of medicine, law, philosophy, technology and religion collide. This interdisciplinary interplay raises many questions to which no single person or profession has all the answers.


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I would like to thank my wife, Cora, my friends and my family for their help and support over the countless hours I have spent researching and writing on this issue.


3. Id.

4. Id.


6. Nation in Brief, supra note 2, at A16.
damaged by the massive blood loss that whatever sapient functions it used to perform would be completely destroyed?"7

This dilemma left the Arbogast family with many unanswered questions. What if Jessie's brain is so severely damaged that he may never return to the child he once was? What if modern life-sustaining medical procedures could keep Jessie alive for another sixty-five years? How much will this medical treatment cost and who will pay the bills?8 Would his family want to see him lie in bed or in a wheelchair: (1) unable to feed himself, living on the nourishment provided through a nasogastric tube9 that has been painfully10 inserted through his nose; (2) unable to breath on his own, requiring the assistance of an MA-1 respirator;11 or (3) unable to remove the mucus in his throat, needing an endotracheal tube12 to prevent him from drowning in his own bodily fluids? Would they wish to visit his crippled body covered in bed sores,13 atrophying at such an incredible rate that he will weigh only sixty-five to seventy pounds when he reaches adulthood,14 requiring constant care from a team of nurses in order to feed,

8. See John B. Oldershaw, Jeff Atkinson, and Louis D. Boshes, Persistent Vegetative State: Medical, Ethical, Religious, Economic, and Legal Perspectives, 1 DePaul J. Health Care L. 495, 515-16 (1997). Oldershaw went on to say:
   In another study, twenty-three patients in PVS were reviewed, all requiring at least one type of mechanical assistance such as respirators, nasogastric or gastrostomy tubes, or intravenous lines. Each case was complicated by incontinence and, in a majority or [sic] cases, by decubitus ulcers, pneumonia, and urinary tract infections. The bills for thirteen patients averaged $170,000, and the length of stay for all patients averaged almost two-hundred days with the total number of “bed days” averaging twelve and a half bed years. Survival of patients in PVS may extend for many years depending heavily upon the level of supportive care. A Hastings Center report in 1998 estimated the annual cost for PVS patients as high as $1 billion.

Id.
9. See In re Conroy, 486 A.2d 1209, 1216 (N.J. 1985) (defining a ‘nasogastric tube’ as a feeding tube that is inserted through the nose and runs from the esophagus to the stomach where it delivers nutrients to the patient).
10. Id.
11. See In re Quinlan, 355 A.2d 647, 655 (N.J. 1976) (“an MA-1 respirator, a sophisticated machine which delivers a given volume of air at a certain rate and periodically provides a ‘sigh’ volume, a relatively large measured volume of air designed to purge the lungs of excretions”).
13. See Conroy, 486 A.2d at 1217.
wash, clean, turn and help him with elimination of urine and fecal matter? Would they wish to visit him periodically, lie down on the bed with his meager frame and wonder what he might have accomplished in his life had that horrible, man-eating creature decided not to swim near the Gulf shore on that fateful afternoon?

All of these daunting questions loom over any family presented with such a crisis. Sadly, although modern medicine is now "capable of sustaining life well past the point where natural forces would have brought certain death in earlier times," a cure has yet to be found for the damage

15. Id.

16. Cruzan v. Missouri Dep't of Health, 497 U.S. 261, 270 (1990). This language also treads into the area of debate between actively hastening death, such as through euthanasia, and passively causing death, such as by removing the patient's respirator or nasogastric tubes. Cf. DeGrella v. Elston, 858 S.W.2d 698, 707 (Ky. 1993). The court elaborated:

'Mercy killing' and 'euthanasia' or any other 'affirmative or deliberate act to end life' are fundamental violations of the common law. The key phrase is the last phrase, 'other than to permit the natural process of dying,' and this phrase explains, clarifies and limits what is meant by an 'affirmative or deliberate act to end life.' This phrase recognizes that the advances of medical technology have made it possible to sustain existence when life has ended except for the 'natural process of dying.' This is not an objective inquiry into the quality of life, but a subjective inquiry into whether the patient wishes the continuation of medical procedures to interdict 'the natural process of dying.' The withdrawal of nutrition and hydration from a person in Sue DeGrella's state, irreversible brain damage and a prolonged period in a persistent vegetative state, is medically recognized as fitting the definition of 'permitting the natural process of dying' as documented by the evidence in the record before us.

Id.


Other courts have distinguished the right to refuse life-sustaining treatment from the act of suicide by reasoning that patients who exercise their right to refuse life-sustaining treatment do not actually intend to die as does one who attempts suicide. The New Jersey Supreme Court reasoned that 'people who refuse life-sustaining medical treatment may not harbor a specific intent to die...rather, they may fervently wish to live, but to do so free of unwanted medical technology, surgery or drugs, and without protracted suffering.' Thus, the difference between the right to
that results from anoxia, a prolonged lack of oxygen in the bloodstream that causes irreversible damage in patients like Jessie. To compound the difficulty of these circumstances, adult patients who find themselves placed in a crisis similar to Jessie’s are unlikely to have executed a living will or designated any agent to make crucial healthcare decisions. Who would plan for such tragedies?

refuse medical treatment and suicide is that the first involves self-determination, whereas the latter involves self-destruction.

See also Roger S. Magnusson, The Sanctity of Life and the Right to Die: Social and Jurisprudential Aspects of the Euthanasia Debate in Australia and the United States, 6 PAC. RIM L. & POL’Y 1, 5 (1997). Magnusson stated:

In view of the changing legal and moral foundations of society, it is inevitable - whether in the short or medium term - that courts and legislatures in western democracies will progressively legalize PAS [physician-assisted suicide]/AVE [active voluntary euthanasia]. Within a generation, the suggestion that a terminally ill patient should be denied the right to die with medical assistance will appear primitive, if not absurd...In the United States and beyond, the development of a legal right to die with medical assistance, appears inevitable.

17. Quinlan, 355 A.2d at 655.
18. In re L.W., 482 N.W.2d 60, 67-68 (Wis. 1992) (“Relatively few individuals provide explicit written or oral instructions concerning their treatment preferences should they become incompetent. The reasons for this are undoubtedly myriad: ignorance, superstition, carelessness, sloth, procrastination or the simple refusal to believe it could happen to oneself.”); See also Barber v. Superior Court, 195 Cal.Rptr. 484, 489 (1983) (“The lack of generalized public awareness of the statutory scheme and the typically human characteristics of procrastination and reluctance to contemplate the need for such arrangements however makes this [living will] a tool which all too often go unused by those who might desire it.”); It is important to note that just because Jessie is a minor that does not mean he is not entitled to make his own medical decisions. Cf. In re Swan, 569 A.2d 1202, 1205 (Me. 1990) (“It is well recognized that in all facets of life, ‘a minor acquires capacity to consent to different kinds of invasions and conduct at different stages of his development. Capacity exists when the minor has the ability of the average person to understand and weigh the risks and benefits.’”) (quoting Prosser and Keaton on Torts, § 18 at 115 (5th ed. 1984)).

19. Neal F. Splaine, The Incompetent Individual’s Right to Refuse Life-Sustaining Medical Treatment: Legislating, Not Litigating, A Profoundly Private Decision, 27 SUFFOLK U. L.REV. 905 (1993) (“Very few people are willing to anticipate the possibility of incompetence and to make provisions for abating life-sustaining medical care in such an event. Yet once an individual becomes incompetent, the opportunity to execute advance directives has passed.”).
Jessie’s family is now forced to make a heart-wrenching decision. Should they order the hospital to remove all life-sustaining equipment,20 or should they hold out hope for a cure? They will understandably look for guidance from family members, friends, doctors, lawyers and members of their local parish21 for answers to this ethical, moral, social, legal, medical and spiritual dilemma.22 However, there is no answer that will lift the burden from their shoulders, as the decision is theirs and theirs alone.

20. "Ceasing the nutrition and hydration will cause no pain, although, likewise, continuing treatment causes no pain." Degrella, 858 S.W.2d at 702.

21. See Oldershaw, supra note 8, at 509-13. Oldershaw continued:

In fact, Catholic moral theology mandates a duty to reject burdensome medical treatment and proclaims individuals must take responsibility for the manner of their dying...Judaism forbids the hastening of death but allows removing impediments to death...Islam believes that illness is a result of God’s or Allah’s trial of the people. Physical illness may be cured by recitation of the Koran or prayers. Under Islamic belief, Allah is the creator of life, and no individual ‘owns’ his or her life. Therefore, no person can actively terminate such life. Lutherans accept medical judgment on the best course of action. They focus on the reality of the situation while affirming the resurrection of the body in immortality after death. Pentecostal religions invoke the New Testament gifts of healing. Believers turn to healing through prayer and maintain a belief in miracles. Therefore, Pentecostal believers generally will not terminate the PVS. Afro-Caribbean religions, including some religious groups involving Haitians, Cubans, Jamaicans, Puerto Ricans and African Americans, consider healing as the work of religion...In these religions, physicians play a lesser role in healing and decision-making. Indigenous groups in Mexico believe in traditional curing practices performed by a healer, or ‘Curandero.’...The traditional Irish view reveals that life is full of suffering, and it must be accepted with stoic resignation. If the person is to recover, then he shall independent of any efforts that are made.

Id.

22. See Conroy, 486 A.2d at 1221 ("...raises moral, social, technological, philosophical, and legal questions involving the interplay of many disciplines. No one person or profession has all the answers."); Quinlan, 355 A.2d at 659 ("The right to a natural death is one outstanding area in which the disciplines of theology, medicine and law overlap; or, to put it another way, it is an area in which these three disciplines converge."); and Thor v. Superior Court, 855 P.2d 375, 378 (Cal. 1993). The court in Thor stated:

Although seemingly categorical, these pronouncements predate the recent rapid advancements in medical technology with their attendant ethical, moral and social implications. Illnesses and injuries that once brought the clergy to the bedside of the afflicted now may bring a team of
Or is it? What if a family chooses to remove the life-sustaining equipment from their child, and someone who opposes their decision seeks court intervention? What should the court in their local jurisdiction do? Should a court honor their wishes or refute their decision? What tests will the court apply? Could the family be forced to live the rest of their lives knowing that their relative is lying in a hospital ward without any hope of a return to cognitive existence? Are they expected to move on with their lives and forget? How could they possibly do so?

This Comment will explore all of these questions and provide some surprising answers. First, it will discuss the judicial history and the competing social policies surrounding this issue since the 1976 decision of In re Quinlan to the most recent holding in Conservatorship of Wendland. Second, it will present the often adversarial interests of the state and family in the life-sustaining treatment of the patient. Third, this Comment will analyze the beneficial and detrimental aspects of the various tests and standards that have been supplied by the courts, academics and various litigants throughout the past several decades. Lastly, it will conclude with a proposed five-part model test, compiled from the strongest aspects of tests already applied by courts.

highly skilled medical personnel fully equipped with sophisticated, life-preserving machinery. Increasingly, the courts are drawn into the wake of this technological process to mediate among the myriad concerns it has generated.

Id.

23. See DeGrella, 858 S.W.2d at 705. The court said:
Indeed, every state that has considered the matter has upheld the right of patients in a persistent vegetative state, through surrogates, to elect to withdraw such medical care: some courts based their decision on common law rights and some on common law viewed as constitutionally protected. These seventeen states are Arizona, California, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Maine, Massachusetts, Minnesota, Missouri, New Jersey, New York, Ohio, Rhode Island and Washington.

Id.

24. Rasmussen, 741 P.2d at 691 ("The consequences of a decision to terminate medical treatment will often be irreversible. Therefore, the court in any dispute will assume that the patient wishes to continue receiving medical treatment, and the burden to prove otherwise will rest on the party or parties desiring to terminate the treatment.").

25. Quinlan, 355 A.2d at 647.
II. FROM QUINLAN TO WENDLAND: DEVELOPMENT OF THE
JUDICIAL DETERMINATION OF WHEN THE STATE’S PARENS PATRIAE
INTEREST IS OUTWEIGHTED BY THE PATIENT’S INTEREST IN REFUSING
MEDICAL TREATMENT

On the evening of April 15th, 1975, Karen Quinlan’s respiratory
functions completely ceased for two fifteen-minute periods. 27 Her
temperature rose to 100 degrees, 28 her pupils dilated and she became
unresponsive. 29 After she was rushed to the hospital and a series of
neurological tests were performed, her physician, Dr. Morse, concluded
that she was suffering from anoxia and that her brain had been severely
impaired. 30 He determined she was in a coma 31 - a complete lack of
consciousness.

Dr. Morse and other physicians at the hospital eventually determined
that Karen was in a chronic “persistent vegetative state” (or PVS). 33

27. Quinlan, 355 A.2d at 654.
28. Id.
29. Id.
30. Id.
31. But see Oldershaw, supra note 8, at 501. Oldershaw elaborated:
   “Therefore, the difference between coma and PVS is that coma is a closed-
   eye state of unresponsiveness, whereas PVS is an open-eyed condition
   with no evidence of conscious awareness. A recent study found that
   approximately 37 percent of patients after more than one month post
   injury were diagnosed with coma or PVS inaccurately. The errors in
diagnosis were believed to be the result of confusion in terminology, lack
of extended observation of patients and lack of skill or training in the
assessment of neurologically devastated patients.

Id.
32. Quinlan, 355 A.2d at 654. The court commented:
   “... there are basically two types of coma, sleep-like unresponsiveness and
awake unresponsiveness. Karen was originally in a sleep-like
unresponsive condition but soon developed “sleep-wake” cycles,
apparently a normal improvement for comatose patients occurring within
three to four weeks. In the awake cycle she blinks, cries out and does
things of that sort but is still totally unaware of anyone or anything around
her.

Id.
33. Id. at 654 (“a subject who remains with the capacity to maintain the
vegetative parts of neurological function but who no longer has any cognitive
Though not technically "brain dead," her prognosis was bleak since the sapient function of her brain had been completely destroyed. Essentially, the brain functions in two ways:

A body which is functioning entirely in terms of its internal controls. It maintains temperature. It maintains heart beat and pulmonary ventilation. It maintains digestive activity. It maintains reflexive activity of muscles and nerves for low level conditioned responses. But there is no behavioral evidence of either self-awareness or awareness of the surroundings in a learned manner.

Id.  
See also Romeo, 697 F.Supp. at 582. The court stated:  
PVS is a type of comatose state in which the cerebral functioning has ceased but in which the brain stem functioning is fully or partially intact. The brain stem controls primitive reflexes, including heart activity, breathing, the sleep/wake cycle, reflexive activity in upper and lower extremities, some swallowing motions and eye movements.

Id.  
Cf. Oldershaw, supra note 8, at 497-99. Oldershaw further commented:  
Both the American Academy of Neurology and the American Medical Association define patients in a persistent vegetative state as being chronically awake, or suffering diurnal sleep-wake cycles, but without consciousness of their surroundings...Because the cerebral cortex is not functioning, PVS patients essentially have 'amentia,' a lack of language function. It is believed patients in a persistent vegetative state do not experience pain and suffering, because both emotions are conscious attributes requiring an intact cerebrum...Depending on the etiology of the PVS, most patients are in a vegetative state for one month or more and do not recover to a level of independent function. The American Academy of Neurology recommends a waiting period of three months to establish the PVS diagnosis.

Id.  
34. Quinlan, 355 A.2d at 654. See also D. Walton, ETHICS OF WITHDRAWAL OF LIFE-SUPPORT SYSTEMS: CASE STUDIES ON DECISION MAKING IN INTENSIVE CARE 97 (1983) ("whole-brain death results in such irreversible fluctuations and disorganization of the human organism that irreversible destruction of the whole body by irreversible cardiac arrest will follow within a short period" – probably no more than a week); Id. at 76-80 (A person suffering from an irreversible coma as a result of partial brain death is not considered dead since he still has some brain functioning); and Oldershaw, supra note 8, at 499 ("The presently accepted standard definition of whole or global brain death, under the Uniform Determination of Death Act, specifies that an individual can be determined to be dead if the person has sustained irreversible cessation of all functions of the entire brain including the brain stem.").  
35. Quinlan, 355 A.2d at 655.
We have an internal vegetative regulation which controls body temperature which controls breathing, which controls to a considerable degree blood pressure, which controls to some degree heart rate, which controls chewing, swallowing and which controls sleeping and walking. We have a more highly developed brain which is uniquely human which controls our relation to the outside world, our capacity to talk, to see, to feel, to sing, to think. Brain death necessarily must mean the death of both of these functions of the brain, vegetative and the sapient. Therefore, the presence of any function which is regulated or governed or controlled by the deeper parts of the brain which in laymen’s terms might be considered purely vegetative would mean that the brain is not biologically dead.36

Immediately after this tragic, unexplainable sequence of events, Karen was placed on a respirator, and a nasogastric tube was inserted through her nose and into her stomach to provide nutrition.37 No treatment or procedure was known or available to treat her condition.38 The medical staff predicted that her brain would never regain its cognitive existence.39 Seemingly left with no other choice, Karen’s father and appointed guardian,40 Joseph Quinlan, sought to remove the life-sustaining medical equipment and let his daughter die with dignity.41 However, Dr. Morse refused, contending that his understanding of medical standards, practice and ethics prevented him from doing so.42

The case reached the New Jersey Supreme Court, which held that relief could be granted to Joseph Quinlan only if several conditions were satisfied.43 First, the physicians attending to Karen had to conclude that there was no reasonable possibility of her ever returning to a cognitive state.44 If the attending physicians so concluded, then all members of Karen’s family had to unanimously consent to withdraw the life-sustaining medical equipment.45 If unanimous consent was attained, both the attending physician and Karen’s family had to meet with a hospital “Ethics

36. Id. at 654.
37. Id. at 655.
38. Id.
39. Id.
40. Id. at 651.
41. Id. at 656.
42. Id.
43. Id. at 671.
44. Id.
45. Id.
Committee” or a similar consultative body.\textsuperscript{46} If that consultative body were to agree with both the doctors and the family, then life-sustaining medical procedures could be withdrawn, and Karen would be allowed to die with dignity from the underlying natural causes of her condition.\textsuperscript{47} Furthermore, the New Jersey Supreme Court eased Dr. Morse’s fears by providing that if this process were adhered to, no person involved could be held civilly or criminally liable.\textsuperscript{48}

Since Quinlan,\textsuperscript{49} a number of courts have addressed this issue. The most prominent case was Cruzan v. Missouri Department of Health\textsuperscript{50} in which the parents of a woman who suffered irreparable brain damage from an automobile accident sought to remove all life-sustaining medical equipment.\textsuperscript{51} The Supreme Court acknowledged that there is both a common law right\textsuperscript{52} and a constitutional right\textsuperscript{53} to refuse medical treatment\textsuperscript{54} which dates back to Union Pacific Railroad Company v. Botsford.\textsuperscript{55} The \textit{Botsford} court stated, “no right is held more sacred, or is more carefully guaranteed, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.”\textsuperscript{56} The Supreme Court noted that this principle was

\textsuperscript{46} Id.
\textsuperscript{47} Id.
\textsuperscript{48} Id.
\textsuperscript{49} “The New Jersey Supreme Court, in \textit{Quinlan}, was the first appellate court to uphold a patient’s refusal of medical care based on the federal constitutional right of privacy. Since \textit{Quinlan}, many jurisdictions have followed this constitutional analysis. Other courts, however, continue to rely solely upon the common-law right of self-determination to uphold a patient’s right to refuse treatment.” Splaine, \textit{supra} note 19, at 910.
\textsuperscript{50} 497 U.S. 261 (1990).
\textsuperscript{51} Id. at 261, 266.
\textsuperscript{52} Id. at 277.
\textsuperscript{53} Id. at 278.
\textsuperscript{54} Splaine, \textit{supra} note 19, at 911. The court stated:

A patient’s right to refuse unwanted medical care, whether it derives from common law or the Constitution, is not absolute. Courts must balance the patient’s right to refuse medical treatment against several state interests such as preserving life, protecting innocent third parties’ interests, preventing suicide and maintaining the medical profession’s ethical integrity.”

\textit{Id.}
\textsuperscript{55} 141 U.S. 250, 251 (1891).
\textsuperscript{56} Id. at 251.
further expanded in Schloendorff v. Society of New York Hospital.\textsuperscript{57} Justice Benjamin Cardozo stated, “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”\textsuperscript{58} Nevertheless, the Supreme Court has emphasized that this right of refusal, a corollary to the patient’s right of informed consent before any medical treatment,\textsuperscript{59} must necessarily be balanced against the State’s firmly rooted parens patriae\textsuperscript{60} interest in preserving life.\textsuperscript{61} The Supreme Court avows that the State need not remain a bystander when the family of an incompetent ward decided to take her life.\textsuperscript{62} On the contrary, the Supreme Court asserted that the Due Process Clause of the Constitution\textsuperscript{63} explicitly directed Missouri to intervene.\textsuperscript{64} The Supreme Court explained the reasons for this protection: “Not all incompetent patients will have loved ones available to serve as surrogate decision-makers. And even where family members are present, [t]here will, of course, be some unfortunate situations in which family members will not act to protect a patient.”\textsuperscript{65} A state is entitled to guard against potential abuses in such situations.\textsuperscript{66}

Analyzing the factual background surrounding Ms. Cruzan, the Supreme Court determined that the Cruzan family had failed to prove by clear and convincing evidence that Ms. Cruzan would have wanted to withdraw life-sustaining treatment in her condition.\textsuperscript{67} Though the

\textsuperscript{57} 105 N.E. 92, 93 (N.Y. 1914), rev’d on other grounds, Bing v. Thunig, 143 N.E.2d 3 (N.Y. 1957).
\textsuperscript{58}  Schloendorff, 105 N.E. at 93.
\textsuperscript{59}  See Splaine, supra note 20, at 909.
\textsuperscript{60} See L.W., 482 N.W.2d at 76 n.9. The court declared: Parens patriae literally means 'parent of the country' and refers to the role of the state as guardian of persons under legal disabilities, such as juveniles or incompetent persons. Under the theory of parens patriae it is the right and duty of the state to step in and act in what appears to be the best interests of the ward.
\textsuperscript{61} Id.
\textsuperscript{62} Id. at 280-81.
\textsuperscript{63} U.S. CONST. amend. XIV.
\textsuperscript{64} Cruzan, 497 U.S. at 281.
\textsuperscript{65} Id. at 281-82 (quoting Jobes, 529 A.2d at 447).
\textsuperscript{66} Id. at 281.
\textsuperscript{67} Id. at 280.
Supreme Court conceded that there was evidence presented in the Missouri trial court that Ms. Cruzan had made statements to her housemate approximately one year before her accident that she would not wish to live as a vegetable, the Court stated that these statements had failed to satisfy the Court’s high evidentiary burden since the statements did not deal directly with the withdrawal of life-sustaining treatment. The Court emphasized that the clear and convincing evidence standard was appropriate because of the important state interest presented, namely the protection and preservation of human life.

Since Cruzan, most states have conformed their own tests and evidentiary standards to substantially replicate the Supreme Court’s holding, yet with significant differences. The most recent decision on the matter has come from the Supreme Court of California in Conservatorship of Wendland. Wendland is strikingly similar to Cruzan in that the source of the patient’s suffering was a tragic car accident. Significantly, the conservatee, Robert Wendland, was never in a comatose state, unlike Cruzan and Quinlan. Rather he was conscious, yet severely disabled both mentally and physically, unable to feed or care for himself. He was able to interact with his environment, albeit inconsistently. At his highest level of function after the accident, he was able to perform very menial

68. Id. at 285.

69. Id. at 280.


71. 28 P.3d 151 (Cal. 2001).

72. Wendland, 28 P.3d at 154.

73. Id.

74. Id.
Despite small improvements in his condition due to intensive therapy, his disabilities were severe. Once it became apparent that Robert's cognitive abilities would never return to their pre-accident status, Robert's wife, children, brother, the hospital's physicians and even the hospital's ombudsman collectively decided to end life-sustaining procedures. Nevertheless, Robert's mother and sister objected. They petitioned the California judiciary to prevent the cessation of life-sustaining treatment, as well as to remove Rose Wendland, Robert's wife, as Robert's "conservator."

Though the factual situation would seem to strongly favor California's parens patriae interest over Rose's decision to refuse life-sustaining treatment, the California Supreme Court refused to apply a higher standard than the clear and convincing standard set forth in Cruzan. The Court was satisfied with that standard, indicating that it was a sufficient evidentiary burden to protect important rights. The "'clear and convincing evidence' test requires a finding of high probability, based on evidence 'so clear as to leave no substantial doubt' [and] 'sufficiently strong to command the unhesitating assent of every reasonable mind.'"

Before the accident, Robert had twice expressed his wishes to refuse life-sustaining treatment. The first such incident occurred when Rose decided to turn off the respirator that was sustaining the life of her father.

75. Id. at 154-55 (reporting activities such as throwing a ball, operating an electric wheelchair with assistance, turning pages, drawing circles, drawing an 'R' and performing two-step commands. For example, he was able to respond appropriately to the command 'close your eyes and open them when I say the number 3'. He could choose a requested color block out of a four color blocks, etc.).

76. Id.

77. Id. A conservator is "a person appointed by the court to manage the estate or affairs of another who is incapable of doing so." BLACK'S LAW DICTIONARY 127 (Pocket ed. 1996).

78. Wendland, 28 P.3d at 168. See e.g., Santosky v. Kramer, 455 U.S. 745 (1982) (applying the clear and convincing standard of proof in proceedings involving the termination of parental rights); Addington v. Texas, 441 U.S. 418 (1979) (applying the clear and convincing standard in deciding whether to commit a person to a mental hospital); and Woodby v. Immigration & Naturalization Serv., 385 U.S. 276 (1966) (applying the clear and convincing standard in deciding whether to deport an immigrant).

79. Wendland, 28 P.3d at 173.

80. Id. at 157.

81. Id.
Robert stated, "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."  

The second occasion occurred shortly after the death of Rose's father when Robert developed a serious drinking problem. Robert's brother, Michael, stopped by to admonish Robert for consuming too much alcohol stating, "I'm going to get a call from Rosie one day, and you're going to be in a terrible accident." To which Robert replied, "If that ever happened to me, you know what my feelings are. Don't let that happen to me. Just let me go. Leave me alone." Even Robert's daughter, Kate, recalled him saying during his conversation with Michael that "if he could not be a provider for his family, if he could not do all the things that he enjoyed doing, just enjoying the outdoors, just basic things, feeding himself, talking, communicating, if he could not do those things, he would not want to live."  

Though the California Supreme Court acknowledged that statements from a conservatee prior to an accident would be a necessary guide for the conservator in deciding whether the conservatee would exercise his right to forego life-sustaining medical procedures, the Court was not satisfied that Robert's statements to his family satisfied the clear and convincing standard of proof. The Court reasoned that Robert was not thinking clearly in either instance. In the first instance, Robert was grief-stricken and angry at the loss of his father-in-law, and in the second instance Robert was intoxicated. Furthermore, none of these statements was an "'exact on all-fours' description" of his current medical condition. As a result, his statements were given little credibility.  

In its conclusion, the California Supreme Court held that Rose's position was supported by nothing more than a subjective viewpoint that

82. Id.
83. Id at 157.
84. Id.
85. Id.
86. Id.
87. Id. at 168 ("The only apparent purpose of requiring conservators to make decisions in accordance with the conservatee's wishes, when those wishes are known, is to enforce the fundamental principle of personal autonomy.").
88. Id. at 173.
89. Id.
90. Id.
91. Id.
92. Id.
Robert should be removed from life-sustaining treatment. As a result, the Court held that California's parens patriae interest significantly outweighed any competing interest, and ordered that Robert remain on life support.

As the Wendland court noted, to the extent it and its predecessor in interest, Conservatorship of Drabick, had relied on the rights of an incompetent conservatee to justify the decision of the competent conservator to end the conservatee's life, the federal courts have absolutely refused to adopt this position. Nevertheless, state courts have not hesitated, and in fact have gone even further, by developing various tests and criteria to determine when, and under what conditions, a conservator may end all medical procedures used to prolong a conservatee's life. These various tests, and their strengths and weaknesses, are discussed in the following section.

III. SIFTING THROUGH THE STANDARDS OF PROOF AND APPLIED TESTS

A. Standards of Proof

In confronting any controversy where competing interests are asserted, the judiciary's task is to determine the appropriate standard of proof, keeping in mind the nature and purpose of the proceeding, any possible intrusion or stigma involved and any potential deprivation of liberty. Furthermore, it is designed to allocate the risks of error between the

93. Id. at 174.
94. Id. The issue was moot by the time of the decision because Robert passed away prior to the California Supreme Court's hearing of this case. Nevertheless, the issue was adjudged to be so important that the Court chose to hear the case anyway.
95. 245 Cal. Rptr. 840 (1988).
96. Wendland, 28 P.3d at 162.
97. Lillian F., 206 Cal. Rptr. at 606. See also Addington, 441 U.S. at 423 (quoting In re Winship, 397 U.S. 358, 370 (1970) (Harlan, J., concurring)). J. Harlan went on to say:

The function of a standard of proof, as that concept is embodied in the Due Process Clause and in the realm of fact-finding, is to 'instruct the fact-finder concerning the degree of confidence our society thinks should have in the correctness of factual conclusions for a particular type of adjudication.

Id.
litigants and to demonstrate the relative importance attributed to the ultimate decision.\textsuperscript{98}

Generally speaking, there are three standards of proof: preponderance of the evidence, clear and convincing evidence, and proof beyond a reasonable doubt.\textsuperscript{99} At the least stringent end of the spectrum is preponderance of the evidence.\textsuperscript{100} Since the outcome of many civil actions will have little impact on anyone other than the parties involved, this burden of proof falls squarely on the plaintiff, and any risk of error is shared equally by the parties.\textsuperscript{101} The preponderance of the evidence standard merely requires the trier of fact "to believe that the existence of a fact is more probable than its nonexistence."\textsuperscript{102}

On the opposite end of the spectrum is a criminal trial where the consequence of error is extremely grave: the constriction of liberty of a possibly innocent citizen.\textsuperscript{103} Since society has an interest in protecting the innocent, the burden of proof is beyond a reasonable doubt and is crafted to prevent, as near as possible, the chance of an erroneous judgment.\textsuperscript{104} Furthermore, some courts have extended this standard of proof to non-criminal situations in which a person’s freedom collides with the state’s interest in confinement for the protection of the public.\textsuperscript{105}

Between these two standards is the clear and convincing evidence standard. Courts use this standard of proof when a person’s interests in a judicial proceeding are both “particularly important” and “more substantial than mere loss of money.”\textsuperscript{106} Courts have universally adopted this standard in cases involving the withdrawal of life-sustaining medical assistance from incompetent, severely-impaired conservatees. Adoption of this standard was necessary to most effectively balance the state’s interests in the preservation of life,\textsuperscript{107} the prevention of suicide,\textsuperscript{108} the

\textsuperscript{98} Lillian F., 206 Cal. Rptr. at 607 and Wendland, 28 P.3d at 169.
\textsuperscript{99} Lillian F., 206 Cal. Rptr. at 608.
\textsuperscript{100} Id.
\textsuperscript{101} Id.
\textsuperscript{102} Winship, 397 U.S. at 371.
\textsuperscript{103} Lillian F., 206 Cal. Rptr. at 608.
\textsuperscript{104} Id.
\textsuperscript{106} Santosky, 455 U.S. at 756.
\textsuperscript{107} See L.W., 482 N.W.2d at 90. See also Bartling, 209 Cal.Rptr. at 225; Spring, 405 N.E.2d at 119; Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 425 (Mass. 1977); Quinlan, 355 A.2d at 651-52; and Thor, 855 P.2d at 383.
Let Him Die with Dignity or Hope for a Cure

safeguarding of the medical profession\textsuperscript{109} and the protection of third parties\textsuperscript{110} against the conservatee’s interest in refusing medical treatment.\textsuperscript{111} As best explained by the Wendland court:

108. \textit{See Conroy}, 486 A.2d at 1224 (“In any event, declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury.”). \textit{See also} Satz v. Perimutter, 362 So.2d 160, 162 (Fla. 1978); Saikewicz, 370 N.E.2d at 426; Torres, 357 N.W.2d at 339; and Colyer, 660 P.2d at 742. \textit{But see Cruzan}, 497 U.S. at 296 (Scalia, J., concurring). J. Scalia continued:

Suicide, it is said, consists of an affirmative act to end one’s life; refusing treatment is not an affirmative act ‘causing’ death, but merely a passive acceptance of the natural process of dying... the cause of death in both cases is the suicide’s conscious decision to ‘put an end to his own existence.’

\textit{Id.}

109. \textit{See Morrison}, 253 Cal. Rptr. at 534 (“The prevailing viewpoint among medical ethicists appears to be that a physician has the right to refuse on personal moral grounds to follow a conservator’s direction to withhold life-sustaining treatment, but must be willing to transfer the patient to another physician who will follow the conservator’s direction.”) and \textit{Cobbs}, 502 P.2d at 10. The \textit{Cobbs} court explained:

except in rare cases, courts may safely assume the knowledge of patient and physician are not in parity... the patient has an abject dependence upon and trust in his physician for the information upon which he relies during the decisional process, thus raising an obligation in the physician that transcends arm-length transactions.

\textit{Id.}

\textit{But see Conroy}, 486 A.2d at 1224-25. The \textit{Conroy} court stated:

This interest, like the interest in preventing suicide, is not particularly threatened by permitting competent patients to refuse life-sustaining medical treatment... If the patient rejected the doctor’s advice, the onus of that decision would rest on the patient, not the doctor. Indeed, if the patient’s right to informed consent is to have any meaning at all, it must be accorded respect even when it conflicts with the advice of the doctor or the values of the medical profession as a whole.

\textit{Id.}

\textit{See also} Natanson v. Kline, 350 P.2d 1093, 1104 (Kan. 1960) (“A doctor might well believe that an operation of form of treatment is desirable or necessary, but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception.”); \textit{Thor}, 855 P.2d at 382 (“[W]e conclude as a general proposition that a physician has no duty to treat an individual who declines medical intervention after ‘reasonable disclosure of the available choices with
While it may be constitutionally permissible to assume that an agent freely designated by a formerly competent person to make all health care decisions, including life-ending ones, will resolve such questions "in accordance with the principal's ... wishes, one cannot apply the same assumption to conservators and conservatees. For this reason, when the legal premise of a conservator's decision to end a conservatee's life by withholding medical care is that the conservatee would refuse such care, to apply a high standard of proof will help to ensure the reliability of the decision.\(^{112}\)

Therefore, whenever a conservator asserts that a conservatee had made a statement, or series of statements, prior to her tragic accident that she would not desire life-sustaining medical procedures to be employed if it appeared that there was no foreseeable hope of her regaining any cognitive or sapient functions, the courts apply the clear and convincing evidence standard.\(^{113}\)

respect to proposed therapy [including non-treatment] and of the dangers inherently and potentially involved in each."); and L.W., 482 N.W.2d at 63 ("The existence of this right will prevent premature and rash decisions to allow a patient to die, and will remove the potential conflict for the medical profession between ordinary compassion and the Hippocratic Oath.").

110. See Conroy, 486 A.2d at 1225 ("When the patient's exercise of his free choice could adversely and directly affect the health, safety or security of others, the patient's right of self-determination must frequently give way. Thus, for example, courts have required competent adults to undergo medical procedures against their will if necessary to protect the public health.") and Jacobson v. Massachusetts, 197 U.S. 11 (1905) (recognizing enforceability of compulsory smallpox vaccination law). See also Bartling, 229 Cal. Rptr. at 226 ("This interest has been invoked, for example, where the patient attempting to refuse treatment has minor children who would be left without a parent should the treatment not proceed.").

111. See, e.g., Drabick, 245 Cal. Rptr. 840; Cruzan, 497 U.S. 261; Santosky, 455 U.S. 745; L.W., 482 N.W.2d 60; Lillian F., 206 Cal. Rptr. 603; and Wendland, 28 P.3d 151.

112. Wendland, 28 P.3d at 433.

113. Cf. Splaine, supra note 19, at 939. Splaine explained:

A heightened burden of proof such as requiring clear and convincing evidence, however, may preclude effectuation of patients' rights and wishes. Courts have almost invariably rejected formerly competent patient's prior statements to family members and friends under the clear and convincing evidence standard. ... courts are imposing a burden that is virtually impossible to overcome. This burden is entirely unnecessary since less restrictive procedural safeguards adequately protect against
B. Applied Tests

Due to the complexity of this area of law, courts have struggled to devise a particular test that satisfies the competing interests of the state and the conservatee. Of course, different states have different perspectives of which rights are superior. As a direct result, many different tests exist.

I. Good Faith Basis Test

The first and perhaps simplest test is known as either the Good Faith Basis Test, the Best Interests Standard or the Substituted Judgment Doctrine. Under this test, the conservator need only demonstrate that all medical decisions concerning the fate of the incompetent are being made on a good faith basis and with the conservatee’s best interests in mind. In essence, the conservator is substituting his judgment for the conservatee’s.

In making any decision under this test, courts have presented a twelve-factor test as a helpful guide for the conservator. Following the factors, abuse. A heightened burden of proof also disregards the patient’s family members’ unique decision making position. Because of a family’s close association with incompetent patients, they may understandably ‘just know’ what a patient’s preferences would be, despite the likelihood that such intuitiveness is not provable in court. A heightened evidentiary standard, therefore, would not only neutralize the advantages created by having patients’ family members make medical decisions, it would produce poor legal decision making.

Id.

114. See generally Drabick, 245 Cal. Rptr. 840.
115. See L.W., 482 N.W.2d 60.
116. Id. at 77-78.
117. Drabick, 245 Cal. Rptr. at 861.
118. L.W., 482 N.W.2d at 65-66 (The courts twelve factors are as follows:
2. The wishes of the family.
3. An independent medical opinion.
4. The recommendation, if any, of a bioethics committee.
5. The chances of physical recovery.
6. The chances of mental recovery.
7. The likelihood of physical, psychological or emotional injury as a result of providing or not providing treatment.
8. The likelihood and duration of survival without treatment.
the conservator should determine that life-sustaining treatment is unnecessary if it will offer "no reasonable possibility of returning the conservatee to cognitive life and if it is not otherwise in the conservatee's best interests."\textsuperscript{119}

The advantage of this test is its simplicity and expediency. However, in this advantage lies an inherent and fatal flaw: extreme subjectivity\textsuperscript{120} and a lack of checks and balances. It would be quite easy for a conservator to assert that he is operating under a good faith basis and thereby gain the support of the conservatee's family, convincing them that death would be in the conservatee's best interest.\textsuperscript{121} Meanwhile, the conservator may have

\begin{itemize}
\item[10.] The benefits of continued life with and without treatment.
\item[11.] The motives of those supporting withdrawal.
\item[12.] Any other factors bearing on the best interests of the ward.
\end{itemize}

\textsuperscript{119.} Drabick, 245 Cal. Rptr. at 861.

\textsuperscript{120.} See Oldershaw, \textit{supra} note 8, at 504-05 ("The concept of futility may be quite variable and have different meanings to different people depending on whose 'quality of life' is in question...Therefore, quality of life and futility depends greatly on the patient's individual outlook on life and the outlook of a patient's family.").

\textsuperscript{121.} Generally, the conservator is a member of the conservatee's family. See Noonig, \textit{supra} note 16, at 871. Noonig continued:

All nineteen of the jurisdictions have provided by statute a list of persons who may act as surrogate for an incompetent patient. Those persons authorized by statute to make a health care decision (if no guardian has been appointed) generally include the patient's spouse, adult child, parent, adult sibling, grandparent and/or adult grandchild. Several jurisdictions additionally provide that either a competent relative of the patient or the patient's nearest living relative may make the health care decision.

\textit{Id.}

However, in these situations where a family member of the conservatee is the conservator, it is important to heed the warning presented by Splaine, \textit{supra} note 19, at 934-35. Splaine commented:

Ironically, the very intimacy that makes family members the most logical surrogate decisionmakers also raises the possibility of abuse and conflicts of interest. Family members may suffer more pain from patients' conditions than the patients themselves. Similarly, family members may derive their own emotional satisfaction from caring for incompetent patients. Consequently, the concern arises that family members as surrogates may impose their own self-interests and values when deciding patients' best interests. For instance, family members may reflect their own fear of dying or, conversely, their own desire not to remain on life-sustaining systems. In addition, a conflict of interest may arise where it is in the family's financial interests to discontinue life-sustaining treatment.
ulterior undisclosed motives, such as a substantial life insurance policy on
the conservatee.\textsuperscript{122}

2. Ordinary v. Extraordinary Test

Another test is the "Ordinary v. Extraordinary" or "Benefits v. Burdens" test.\textsuperscript{123} Under this test, medical treatment that is considered to
be ordinary should always be required, while extraordinary medical
treatment is considered optional.\textsuperscript{124} Extraordinary medical treatment is
defined as "all procedures, operations or other interventions which are
excessively expensive, burdensome or inconvenient or which offer no hope
of benefit to a patient."\textsuperscript{125} Therefore, anytime the treatment's benefits
outweigh its burdens, the treatment would be characterized as ordinary
and, therefore, ethically required.\textsuperscript{126} Otherwise, the treatment would be
considered extraordinary and, therefore, optional.\textsuperscript{127} Nevertheless,
consider that

While these are legitimate concerns, the greater likelihood is that patients'
families will have the same interests of the patients and, therefore, will act
on behalf of patients' best interests.

\textit{Id.}

122. \textit{Cf. Drabick,} 245 Cal. Rptr. at 861 (David Drabick, the conservator, had a
\$40,000 life insurance policy on the life of his brother, the conservatee, the
proceeds of which he planned to use to send his children to college). The court
further said:

While it is hard to avoid the conclusion that this financial interest is
logically relevant to the conservator's good faith, it does not follow that
this interest would compel the superior court to disapprove the petition
or, more appropriately, to appoint a new conservator. Conservators will
often be chosen from the conservatee's immediate family, since family
members are most likely to appreciate the conservatee's personal values.
Indeed, designated family members are entitled preference...Since
immediate family members are likely to have some testamentary or
beneficial interest, an inflexible rule in this area would often eliminate
those persons most qualified to serve as conservators...a financial interest
need not disqualify a potential conservator in all cases.

\textit{Id.}

123. \textit{See Barber,} 195 Cal. Rptr. at 491; \textit{Quinlan,} 355 A.2d at 659; and \textit{Conroy,
}486 A.2d at 1218.

124. \textit{Conroy,} 486 A.2d at 1234.

125. \textit{Id.} at 1218.

126. \textit{Id.} at 1235.

127. \textit{Id.}
even 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. On the other hand, a treatment course which is only minimally painful or intrusive may nonetheless be considered disproportionate to the potential benefits if the prognosis is virtually hopeless for any significant improvement in condition.  

The problematic part of this test is its extremely subjective nature, even for the medical profession. Considering that the majority of the members of the medical profession do not agree on such issues as the intrusiveness of a procedure, its intrinsic risk or the possibility of a favorable result, the risk of error for a court with no medical background applying this test is astronomical. Furthermore, the terms 'ordinary' and 'extraordinary' have assumed too many inconsistent connotations to remain useful. Depending upon which definitions are applied, any particular treatment for an incompetent conservatee could be considered both ordinary and extraordinary. What should a conservator do in that situation? Should one err on the side of preservation of life, even when the conservatee has

128. Barber, 195 Cal. Rptr. at 491.
129. Conroy, 486 A.2d at 1235.
130. Id.
131. See Cruzan, 497 U.S. at 283. The Supreme Court stated:

An erroneous decision not to terminate results in a maintenance of the status quo; the possibility of subsequent developments such as advancements in medical science, the discovery of new evidence regarding the patient's intent, changes in the law or simply the unexpected death of the patient despite the administration of life-sustaining treatment at least create the potential that a wrong decision will eventually be corrected or its impact mitigated. An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible of correction.

Id.

But see id. at 320 (Brennan, J., dissenting). J. Brennan argued:

An erroneous decision to terminate life support is irrevocable, says the majority, while an erroneous decision not to terminate 'results in the maintenance of the status quo.' But, from the point of view of the patient, an erroneous decision in either direction is irrevocable. An erroneous decision to terminate artificial nutrition and hydration, to be sure, will lead to failure of that last remnant of physiological life, the brain stem and result in complete brain death. An erroneous decision not to terminate life support, however, robs a patient of the very qualities protected by the right to avoid unwanted medical treatment. His own degraded existence
personally expressed that he or she would not desire to live like a vegetable? The only advantage this test offers is to provide the conservator with some guidance when making this solemn decision.

3. Subjective Test

A third test is the Subjective Test. This extremely popular test has been employed by many courts. The Subjective Test is summarized best by the New Jersey Supreme Court, which devised it in the case of In re Conroy, “[t]he question is not what a reasonable or average person would have chosen to do under the circumstances but what the particular patient would have done if able to choose for himself. The patient may have expressed, in one or more ways, an intent not to have life-sustaining medical intervention.”

Of all of the aforementioned tests, the Subjective Test is the most promising. It provides the conservatee with the greatest role in the decision-making process. It also allows the conservator and the conservatee’s family to testify as to what medical procedures the conservatee said she would, or would not, have consented to, and any decision will be fashioned around the conservatee’s pre-accident statements.
The main drawbacks of this test are that courts are required to accept that the conservator and conservatee's family are telling the truth and are operating both in good faith and with the conservatee's best interests in mind. Furthermore, "the probative value of such evidence may vary depending on the remoteness, consistency and thoughtfulness of the prior statements or actions, and the maturity of the person at the time of the statements or acts." For example, a casual statement about wanting to die under certain circumstances made by a conservatee when youthful, and in the crest of life, would not in itself represent clear corroboration twenty years later that the person would want life-sustaining treatment withheld.

The last and most troubling aspect of the Subjective Test would be the specificity of the conservatee's statements. Any detailed statements by the conservatee about the level of impaired functioning and the forms of medical treatment that one would find intolerable must be specific enough to encompass the conservatee's present situation in order to pass the clear and convincing evidence standard. This issue of specificity has presented the greatest problem for this test in recent case law.

4. Limited Objective Test

The next test, the Limited-Objective Test, is a hybrid of the Subjective Test and the Ordinary v. Extraordinary Test. Under this model, life-sustaining medical treatment may be withdrawn from a conservatee if the conservatee made statements, prior to the accident, that he or she would refuse life-sustaining treatment. Furthermore, the burdens of the life-sustaining treatment must outweigh the benefits. These statements need not unequivocally express that the conservatee would refuse medical treatment in his exact situation but rather must be found to be generally trustworthy. Under the Limited Objective Test, any statements considered too vague, casual or remote under the Subjective Test would likely be adequate. Lastly, any medical evidence about the conservatee's future is especially crucial, mainly the conservatee's "life expectancy,

136. Id. at 1230-31.
137. Id.
138. Id.
139. See, e.g., id.; Wendland, 28 P.3d 151; Quinlan, 355 A.2d 647; and Cruzan, 497 U.S. 261.
140. Conroy, 486 A.2d at 1232.
141. Id.
142. Id.
143. Id.
prognosis, level of functioning, degree of humiliation and dependency and treatment options.”

The advantages and disadvantages of this test are readily apparent. It is extremely subjective, and the potential for abuse by the conservator and the conservatee’s family is still present. Furthermore, the benefits and burdens of a proposed treatment or forecast of the conservatee’s improvements are nearly impossible to discern with any certainty. However, this test is flexible and will help the conservator make a calm, collected and rational decision.

5. Pure Objective Test

The final test is the Pure Objective Test. Under this test, only pre-accident statements in which the conservatee expressed a desire to live under the conditions she now finds herself are material. Anything to the contrary would be disregarded. This test, like the Limited-Objective Test, also incorporates the Ordinary v. Extraordinary Test. Hence, if the burden of the life-sustaining treatment outweighs the benefits, it should be withdrawn.

The advantages of the “Pure Objective” Test are that it eradicates the intrinsic disadvantages of the Subjective Test. The conservator’s decision is based primarily on medical advice. Yet, therein lies the problem. As already mentioned, in every medical decision, no matter how routine, there are always underlying hazards that may cause the computation of risk to be different for each physician. As a result, the fate of the conservatee is determined by whichever members of the medical profession the conservator chooses to solicit for advice.

IV. THE FIVE-PRONG MODEL TEST

A. THE JUDICIARY v. THE LEGISLATURE

In forming the appropriate test, the first issue to be addressed is the determination of which governmental body is best suited to balance the interests of the state, conservatee and conservator. Should the courts have any place in the decision-making process when a conservator must make a
life-or-death decision regarding an incompetent, severely disabled conservatee? The majority of courts hold that the judiciary, in the absence of a disagreement among the conservator, the conservatee’s family, the attending physicians or the hospital ethics committee, should never get involved. The majority deems a practice of having a conservatee apply to a court to confirm resolutions of any medical decisions generally unsuitable, not only because it would be a superfluous intrusion upon the medical profession’s field of competence but also because it would be impermissibly burdensome. Such a review by the judiciary should be undertaken only in areas where it is really needed. The adjudication and commitment of mental incompetents are two examples.

The majority of courts correctly assert that this kind of cumbersome decision is best served if placed firmly in the hands of the legislature. As an elected group that must respond to concerns voiced by the people, the legislature is best able to balance the competing values. Furthermore, it has the resources and capability to synthesize vast quantities of data and opinions from an array of subjects in order to formulate general guidelines that may be applicable to an extensive range of circumstances. Because of these factors, the legislature is the only body which can “address the moral, social, ethical, medical and legal issues raised by” issues such as these. If a test is to be fashioned, it should necessarily flow from the hands of the legislature.

149. See generally L.W., 428 N.W.2d at 75; Quinlan, 355 A.2d at 669; Cruzan, 497 U.S. at 293 (Scalia, J., concurring); and Drabick, 245 Cal. Rptr. at 846.
150. Quinlan, 355 A.2d at 669.
151. Id.
152. See generally L.W., 428 N.W.2d at 101; Conroy, 486 A.2d at 1220; Barber, 195 Cal. Rptr. at 488; and Cruzan, 497 U.S. at 293 (Scalia, J., concurring).
153. Conroy, 486 A.2d at 1220. See also Splaine, supra note 19, at 929-30 (“Since abating life-sustaining treatment involves not only questions of law but also medical and ethical concerns, legislatures, as elected bodies, are better able to respond to the issue. Legislatures have more time to deliberate these issues fully, whereas courts must make decisions one at a time on specific facts without the opportunity of formulating an overall framework for decision making.”) and Nooning, supra note 16, at 875 (“...the legislature is elected by the people to represent them and therefore, is best suited for determining social policy.”).
154. Id.
155. Barber, 195 Cal. Rptr at 488.
156. See generally L.W., 482 N.W.2d at 101; Conroy, 486 A.2d at 1220; Barber, 195 Cal. Rptr. at 488; and Cruzan, 497 U.S. at 293 (Scalia, J., concurring).
B. THE FIVE-PRONG MODEL TEST

The first prong of the quintessential test that the legislature should develop is a series of medical questions that must be answered by the conservatee’s attending physicians. The questions should be neither subjective, nor objective, but based on sound medical expertise. They unavoidably must serve as the first prong because without a definitive answer the whole process fails, and irreversible error is inevitable. This series of questions is as follows: Does the current state of medical or scientific knowledge suggest that a cure for all or part of the conservatee’s disability will be found in the near future? If the cure will only be partial, will it return the conservatee to a mental or physical state that the conservatee would find acceptable? Or, in the case the conservatee had not expressed his wishes should an accident occur, will it return the conservatee to a mental or physical state that the conservator would find acceptable? If the answer to these questions is a positive one, the conservator can conclude that life-sustaining treatment should continue. If there is any negative answer, then the conservator must proceed to the analysis of the second prong.

The second prong of the test is modeled after the Subjective Test.\(^{157}\) Had the conservatee expressed a desire to have life-sustaining treatment withheld or withdrawn should a debilitating accident leave the person without the sapient functions of the brain? If the answer to this prong is negative, then the conservator should skip the third prong of the test and proceed directly to the fourth. On the other hand, if the answer is positive, the conservator should continue on to the third prong.

The third prong concerns the time and circumstances of the above statements. How long ago did the conservatee express these desires? Was the conservatee under the influence of drugs or alcohol? This is a subjective determination, but it is not to be made by the conservator. Rather, this is where judicial intervention would be compulsory. For example, if the court finds the time frame to be too excessive, then the conservatee’s wishes may be disregarded. Also, if the conservatee was under the influence of drugs or alcohol, her statement should be disregarded. Conversely, life-sustaining treatment shall be withheld if the conservatee was lucid and the time frame was quite recent. The conservatee’s desires should be scrutinized, using the clear and convincing

\(^{157}\) See supra notes 137-44 (and accompanying text).
evidence standard.\textsuperscript{158} This is the only way to balance the preservation of life and the right of the conservatee to decline medical treatment.\textsuperscript{159}

The fourth prong is a reasonable person test. It simply asks the question: Would a reasonable person in the conservatee's position desire to have life-sustaining treatment withheld?\textsuperscript{160} If the conservator, the conservatee's family, the attending physicians and the hospital's ethics committee or ombudsman determine that the answer to that question is positive, then the life-sustaining treatment must be removed. However if the answer by any of the aforementioned parties is negative, then the conservatee should remain on life-sustaining treatment. An affirmative answer to this prong must be unanimous because the risk of error is too great. A decision to keep the conservatee alive can always be altered at a later date when more information is gathered.\textsuperscript{161} However, a decision to terminate all medical procedures and let the conservatee die of natural causes is, of course, irreversible.\textsuperscript{162}

The fifth and most crucial prong of this test is the good faith basis prong. The conservator must show that she or he is acting in good faith.\textsuperscript{163} The potential for abuse is far too great, and the conservator should not be

\begin{footnotesize}
\begin{enumerate}
\item See supra notes 110-17 (and accompanying text).
\item Cf. Wendland, 28 P 3d. at 165-66 (When dealing with a conservatee's life, it may be considered unconstitutional to have any standard lower than by clear and convincing evidence.).
\item See Oldershaw, supra note 8, at 507-08. Oldershaw stated:
A growing body of literature indicates the symptoms of death by starvation are not severe. Following cessation of fluid intake, hypernatremia [excess salt condition] develops slowly and induces confusion, weakness and lethargy which eventually progresses to impaired consciousness. The patient slowly progresses into unconsciousness over a period of days without complaining of pain or discomfort. In otherwise alert cancer patients, final hours of life are often marked by a sense of well-being following cessation of fluid therapy. One recurring physical complaint related to the absence or oral fluid intake is a dry mouth. This minimal discomfort can be alleviated by attending to oral hygiene such as providing ice chips, moistening cloths, and mildly irrigating. Total starvation is ironically associated with euphoria, in contrast to semi-starvation which produces intestine discomfort and depression. Rather than of [sic] inducing pain, food deprivation typically causes hypalgesia and/or analgesia.
\item Cruzan, 497 U.S. at 283.
\item Id.
\item Drabick, 245 Cal. Rptr. at 849.
\end{enumerate}
\end{footnotesize}
allowed to make a decision based upon his or her subjective view of the conservatee's personal worth. However, unlike the third prong, the judiciary is not the appropriate body to safeguard the conservatee's interests. As an alternative, the hospital's ethics committee would be the most appropriate body to supervise the conservator's decision. Since it is ultimately the party with the greatest power and the last cog in the decision-making process, it is able to determine if there are any external pressures or influences that might be tainting the conservator's decision.

CONCLUSION

Whenever a person suffers, it is a heart-wrenching, emotionally-draining time for all who love that person. This difficulty is compounded even further when a loved one is brutally injured in an unfortunate accident and enters a vegetative state. Though the person is still physically present, a significant part of that person has left forever and will never return. One must necessarily postulate whether that person is already in Heaven or is stuck in a dark, lonely cell to which only the conservator has the key.

The decisions that must be made in such a disastrous sequence of events are excessively burdensome and furnish no easy answers. Many tests have been formed and burdens of proof established to help the family members faced with these difficult decisions. They vary in complexity and have inherent advantages and disadvantages. The five-prong model test discussed in this Comment is designed to flush out these obscurities. Though it is neither intended to make this process any less distressing nor contains all the answers, it provides the least intrusive and most effective means to do what is best for the conservatee, and that is the ultimate concern.

164. L.W., 482 N.W.2d at 73 (quoting Rasmussen, 741 P.2d at 689 n. 23)("We emphasize at this point that the guardian must assess these factors from the standpoint of the patient and should not substitute his or her own view of the 'quality of life' of the ward.").
165. See generally Quinlan, 355 A.2d at 668-69.