REGARDING *CONSERVATORSHIP OF WENDLAND*

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OPENING REMARKS:

Thank you, Professor Winslade. I appreciate the opportunity to attend this very interesting and important symposium, and I thank you for inviting me. The appropriate care of the minimally conscious patient is certainly an area where medicine and law intersect, and one that evades definitive answers. I found Dr. Fins' presentation this morning fascinating.

As Professor Winslade mentioned, my purpose here today is to share with you some of the background and implications of the California Supreme Court case of *Conservatorship of Wendland,* decided in 2001.[1] My plan is first to discuss the factual background of the case and its legal history as it wound its way through the courts. I'll next discuss the proceedings in the trial court, including the evidence presented to the court of Robert's condition and of his wishes, and I'll share with you some of the

* Associate Justice, California Supreme Court, 1994–2017. Remarks delivered at the symposium, "Minimally Conscious: Grey Matters in Medicine, Law and Ethics," presented by the University of Houston Law Alumni Association Moot Court Committee and the Blakely Advocacy Institute, Houston, January 28, 2010 (with William J. Winslade, Ph.D., J.D.; and Joseph J. Fins, M.D., F.A.C.P.).

[1] Conservatorship of Wendland, 26 Cal.4th 519 (2001).

trial court's written opinion. After that I'll talk about the case in our court, why we took it, the background of the law concerning treatment decisions, and what we held. Finally, I'll mention some of the criticisms of our opinion. I anticipate my remarks will take about 30 to 40 minutes and then, as Professor Winslade indicated, he and I will entertain questions.

Wendland was the first case in California to concern end of life decisions for a minimally conscious patient, and only the second case in the United States. (The first was *In re Martin,* in Michigan, decided in 1995.[2]) Courts are often called upon to decide issues that challenge our society and divide us as a people. We don't necessarily welcome this, but it's our responsibility, and so it was with the *Wendland* case.

THE CASE:

As mentioned, *Wendland* involved a minimally conscious, severely disabled patient. He was not terminally ill, nor was he comatose or in a persistent vegetative state, and he had not left instructions for health care. His wife petitioned the court to be his conservator and asked the court for permission to authorize the hospital to withhold life-sustaining hydration and nutrition from him. His mother and sister objected. California, like most states, has a statute authorizing a conservator to make medical decisions for an incompetent conservatee.

The legal question for the court was what showing, under the California Health Care Decisions Law,[3] must the conservator of a minimally conscious individual make, to convince a court that her decision to withhold life-sustaining treatment is in accordance with the conservatee's own wishes or, failing that, is in his best interests.

Now let me turn to the factual background and the history of the case.

FACTS AND HISTORY OF THE CASE:

On September 29, 1993, 42-year-old Robert Wendland rolled his truck at high speed in a solo accident while driving under the influence of alcohol. The accident injured Robert's brain, leaving him severely disabled. For

[2] 450 Mich. 204.

[3] Cal. Prob. Code § 2355.

several months he lay in a coma, totally unresponsive. During this time, his wife, Rose, visited him daily and authorized treatment as necessary to maintain his health.

Approximately 16 months later (in January 1995) Robert regained consciousness and intensive physical therapy was initiated. But despite some improvements made in therapy, Robert remained severely disabled, both mentally and physically, and dependent on artificial nutrition and hydration. After Robert regained consciousness and while he was undergoing therapy, Rose authorized surgery three times to replace dislodged feeding tubes, which were inserted through his abdominal wall and stapled or sewn to the inside of his small intestine. When physicians sought her permission a fourth time, in July 1995, she refused. She concluded that Robert would not want to go through the procedure again, even if necessary to sustain his life, nor would he want to continue living in his current state. With the agreement of Robert's daughter, his brother, and the hospital, she decided to withhold treatment. Learning of this decision, Robert's mother Florence obtained a temporary restraining order. (In the meantime, Robert's doctor had inserted a nasogastric feeding tube to maintain the status quo.) Rose immediately petitioned the court for appointment as Robert's conservator and requested authority to withdraw his life-sustaining treatment. Florence and Robert's sister opposed the petition.

So here you have a clear family conflict: wife, child and brother in opposition to mother and sister.

California's Health Care Decisions Law authorizes the court to appoint a conservator for an incompetent conservatee, and authorizes the conservator to require or to withhold treatment, as she in good faith, based on medical advice, decides is in the conservatee's best interests.

Pursuant to the statute, the court appointed Rose as conservator and granted her permission to authorize a "Do Not Resuscitate Order" for Robert, but it reserved judgment on her request for authority to remove Robert's reinstated feeding tube. The court ordered Rose to continue the program of physical therapy for 60 days and then report back to the court. During this 60-day period the court itself visited Robert in the hospital.

After the 60 days elapsed with no significant improvement on Robert's part, Rose renewed her request for authority to remove Robert's feeding tube.

Then came a nine-month hiatus during which Florence asked the trial court for appointment of independent counsel for Robert; the trial court refused, reasoning that both sides of the question — whether to maintain life or allow death — were already represented by Florence and Rose; the Court of Appeal summarily denied Florence's petition for writ of mandate; our court granted review and transferred the case back to the Court of Appeal to reconsider its denial; and the Court of Appeal, on reconsideration, directed the trial court to appoint counsel for Robert. In its opinion, the Court of Appeal stated: "The trial court said independent counsel would not be helpful or necessary because Robert's interests were adequately represented by his mother and sister. However, a person facing the final accounting of death should not be required to rely on the uncertain beneficence of relatives. . . . Because Robert's very life is at stake, he is entitled to counsel to represent his interests, *whatever* those interests might be."[4]

Back in the trial court, appointed counsel supported Rose's decision. The trial court, however, denied Rose's request. The court first determined that Rose bore the burden of producing evidence and the burden of persuasion concerning Robert's wishes. Rose would be required to show by clear and convincing evidence that Robert would wish to have his treatment terminated. "'[F]inding itself in uncharted territory,'" the court reasoned that "'[w]hen a situation arises where it is proposed to terminate the life of a conscious but severely cognitively impaired person, it seems more rational . . . to ask *"why?"* of the party proposing the act rather than *"why not?"* of the party challenging it.'"[5]

The court then heard evidence concerning Robert's condition and his previous expressions of his wishes. On conclusion of the trial, the court held that, although Rose had acted in good faith, she had not met her burden to show by clear and convincing evidence that Robert would under the circumstances want to die.

EVIDENCE BEFORE THE COURT:

As indicated, the court had before it evidence of Robert's condition and evidence of his wishes.

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[4] Wendland v. Superior Court, 49 Cal. App. 4th 44, 52 (1996).

[5] 26 Cal.4th at 527 (emphasis added) (quoting from the trial court decision).

(1) *The evidence of Robert's condition* included video recordings of Robert in therapy over a period of approximately two years (from 1995 to 1997), as well as contemporaneous medical reports and the testimony of treating physicians. The medical reports stated that after several months of therapy, Robert improved to where he was inconsistently interacting with his environment in response to simple commands. At his highest level of function between February and July 1995, the videos showed he was able to do such things as throw and catch a ball, operate an electric wheelchair with assistance, choose a requested color block, and set a peg in a pegboard. However, no consistent means of communication had been established, either by eye blinking or by use of an augmented communication device — a so-called "yes/no board."

Despite improvements made in therapy, Robert remained severely disabled, both mentally and physically. A medical report summarized his continuing impairments, in part, as follows: " 'severe cognitive impairment with concurrent motor and communication impairments . . .'; 'maladaptive behavior characterized by agitation, aggressiveness and non-compliance'; 'severe paralysis on the right and moderate paralysis on the left'; . . . 'severe swallowing dysfunction, . . .'; 'incontinence . . .'; 'moderate spasticity'; . . . 'general dysphoria'; [and] 'recurrent medical illnesses . . . .' "[6] The testifying physicians agreed that Robert would never be able to make medical treatment decisions, walk, talk, feed himself, eat, drink, or control his bodily functions.

Also in evidence was the testimony of Robert's physician concerning an exchange he had with Robert on April 29, 1997, eight months before the trial court's decision. The physician asked Robert a series of questions, which Robert, using the "yes/no board," appeared to answer correctly most of the time. " 'Do you have pain? Yes. Do your legs hurt? No. . . . Do you want us to leave you alone? Yes. Do you want more therapy? No. Do you want to get into the chair? Yes. Do you want to go back to bed? No. Do you want to die? No answer. Are you angry? Yes. At somebody? No.' "[7] However, Robert's physician testified he did not think Robert understood

[6] *Id*. at 525.

[7] *Id*. at 528.

all the questions, and his therapist testified that he had never used the yes/no board consistently.

(2) *As evidence of Robert's wishes,* Robert's wife, brother, and daughter recounted pre-accident statements Robert had made about his attitude toward life-sustaining health care. On one occasion, when Rose had to decide whether to turn off a respirator sustaining her father's life, Robert said: "'I would never want to live like that,' . . . 'wouldn't want to live like a vegetable' . . . [or] 'in a comatose state.'"[8] On another occasion, when his brother was warning him that his heavy drinking and driving would cause him to be in a terrible accident and end up in the hospital like a vegetable, he told his brother: "'[W]hatever you do[,] don't let that happen. Don't let them do that to me.'"[9]

Rose appealed to the Court of Appeal, which reversed. Contrary to the trial court, the Court of Appeal believed that under the statute, the trial court was required to determine only whether the conservator was acting in good faith, based on medical advice, and was not to determine whether there was clear and convincing evidence that the decision was what the conservatee would have wanted. The court observed that the statute had no such limitation, and it found no constitutionally significant difference between a PVS patient (as in *Drabick*[10]) and a minimally conscious one in this context.

Florence petitioned the California Supreme Court for review, and in June 2000, five years after Rose's first request to withdraw treatment, we granted review.

So, at that point, Robert had been alive five years after Rose first sought to withdraw treatment, seven years after his accident. The case started in the trial court in August 1995 with Rose's petition, went up to the Court of Appeal and then to our court and back to the Court of Appeal on Florence's request that an attorney be appointed to represent Robert, was returned to the trial court for decision on Rose's petition, was appealed by Rose to the Court of Appeal when her petition was denied, and finally came to us on Florence's petition for review of the Court of Appeal's decision.

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[8] *Id.*

[9] *Id.* at 529.

[10] Conservatorship of Drabick, 200 Cal. App. 3d 185 (1988).

The case, as you may know, attracted national media attention, both on television and in magazines and newspapers. It's been described as one of the top news stories of 2001. The parties before us were of course Florence, seeking to reverse the Court of Appeal, and Rose seeking to uphold it. But in cases of such importance we often get briefs from amicus curiae, that is "friends of the court," interested groups or individuals who weigh in on the issues. In this case we received numerous such briefs. *On behalf of Rose, arguing for deference to the conservator's decision,* were, among others, the Alliance of Catholic Health Care and other healthcare entities, the California Medical Association, the American Civil Liberties Union, and various Bioethics Committees and Associations; *On behalf of Florence, arguing in support of the trial court's clear and convincing evidence standard,* were the Coalition of Concerned Medical Professionals, the Ethics and Advocacy Task Force of the Nursing Home Action Group, the National Legal Center for the Medically Dependent and Disabled, the Brain Injury Association, the Disability Rights Center, the National Council on Independent Living, and more. As you can see, the amici were divided between those who were concerned that an individual's autonomy be respected and he be accorded his right to choose to die, and those who were seeking to protect the sanctity of life and the individual's right to choose to live.

In addition to all the briefs, the evidence before our court was the same as that before the trial court three years earlier, in 1997, including six hours of video tape. We took no additional evidence of Robert's condition. I watched an edited version of the videos and my staff attorney watched the entire six hours. Other members of the court and staff may have done the same.

Now to our decision.

(1) We first recognized that the common law and the California constitutional right to privacy gives a competent individual the right to consent or withhold consent to medical treatment, including the right to refuse treatment, even when necessary to sustain life.

(2) We next recognized that this right of a competent individual to choose survives incapacity, so long as the law of the jurisdiction gives such a choice lasting validity. The California Health Care Decisions Law (fashioned after the Uniform Health-Care Decisions Act of 1993) does give competent adults the power to leave formal directions or to authorize an agent

to speak for the individual when he or she is no longer able to make health care decisions. In thus giving lasting effect to the decision of a competent person, these laws foster self-determination and respect for an individual's autonomy.

(3) We then noted that decisions made by a conservator, in contrast, derive their authority not from the patient, but from the *parens patriae* power of the state to protect incompetent persons, that is, the state's power to care for those who cannot care for themselves. As the United States Supreme Court said in the *Cruzan* case: "[A]n incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right. Such a 'right' must be exercised for her, if at all, by some sort of surrogate."[11]

With this background, we turned to the California Health Care Decisions Law. This is what it says:

> If the conservatee has been adjudicated to lack the capacity to make health care decisions, the conservator has the exclusive authority to make health care decisions for the conservatee that the conservator in good faith based on medical advice determines to be necessary. The conservator shall make health care decisions for the conservatee in accordance with the conservatee's individual health care instructions, if any, and other wishes to the extent known to the conservator. Otherwise, the conservator shall make the decision in accordance with the conservator's determination of the conservatee's best interest. In determining the conservatee's best interest, the conservator shall consider the conservatee's personal values to the extent known to the conservator. The conservator may require the conservatee to receive the health care, whether or not the conservatee objects.[12]

In *Drabick*, the Court of Appeal had before them the 1981 version, but the statute was later amended to include the part about abiding by the conservatee's wishes, if known, and that's the statute we construed. The statute makes no mention of any burden of proof. The Law Review Commission comment to the statute suggested that preponderance of the evidence

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[11] Cruzan v. Director, Missouri Department of Health, 497 U.S. 261, 280 (1990).

[12] Cal. Prob. Code § 2355 subd. (a).

would suffice; but they did not put that in the actual statute. We rejected that standard. In a unanimous opinion, we held that a conservator may not withhold artificial nutrition and hydration from a conscious conservatee absent *clear and convincing evidence* that the conservator's decision is in accordance with either the conservatee's own wishes or his or her best interest.

Now what is "clear and convincing evidence?" There are three levels of evidence — preponderance, clear and convincing, and proof beyond a reasonable doubt. Proof beyond a reasonable doubt is the highest standard and applies only in criminal cases. The preponderance of evidence standard — the weight of evidence — is the lowest standard and the one that applies to most civil cases. But when the interests at stake in a civil case are particularly significant and the consequences grave, the courts will require the intermediate standard of clear and convincing evidence to support the decision. California courts have done so in cases involving sterilization of a developmentally disabled conservatee, termination of parental rights, and administering electroconvulsive therapy to an individual incompetent to consent. The clear and convincing evidence test requires — I quote — "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.'"'"[13]

Although we did not say what *would* constitute clear and convincing evidence, we agreed with the trial court that Rose's evidence did not meet that standard. We also agreed that the evidence did not support a finding that termination of life support would be in Robert's best interests.

It bears repeating that we were interpreting a statute, Probate Code section 2355, a statute that speaks to the powers of a conservator to authorize or withhold medical treatment for a conservatee, but makes no mention of a burden or standard of proof. Our task, then, was to supply a standard that would be appropriate to justify withdrawing life support from a conscious individual who well might perceive the consequences of the decision, and whose wishes were not known and could not be known. A lower standard, we believed, could infringe on the conscious individual's constitutional right to life.

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[13] 26 Cal.4th at 552 (citations omitted).

LIMITATIONS OF OUR HOLDING:

(1) If a conservatorship is not involved, *Wendland* and its burden of proof do not govern the case. Even if a conservatorship *is* involved, the conservator does not have to petition the court for permission to make a life-terminating decision. The issue comes to court only if there is a conflict, or if the conservator seeks guidance. Otherwise, the law does not require judicial involvement in a decision to forgo medical treatment.

(2) Our decision does not affect any other health care decisions a conservator might need to make, only the decision to withhold life-sustaining treatment.

(3) The decision speaks only to a minimally conscious individual who is not terminally ill, and again, only one for whom a conservator has been appointed. It says nothing about decisions concerning patients who are terminally ill, or in a vegetative or comatose state.

I quote from our opinion: "[O]ur decision today affects only a narrow class of persons: conscious conservatees who have not left formal directions for health care and whose conservators propose to withhold lifesustaining treatment for the purpose of causing their conservatees' deaths. Our conclusion does not affect permanently unconscious patients, including those who are comatose and in a persistent vegetative state, persons who have left legally cognizable instructions for health care, persons who have designated agents or other surrogates for health care, or conservatees for whom conservators have made medical decisions other than those intended to bring about the death of a conscious conservatee."[14]

HOW TO AVOID JUDICIAL INVOLVEMENT:

The hope, of course, is that these difficult and sensitive decisions never come to the court. The courts do not want these cases, they are not well equipped to decide them, and the issues are not best decided by way of litigation. Think of the years of agony for Robert Wendland's family.

The whole body of law concerning end-of-life decisions involves *avoiding* conflicts and *resolving* conflicts when they arise. If there is no conflict, there is no problem.

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[14] *Id*. at 555 (internal citations omitted).

Most cases, happily, do not end up in court. In the absence of a conflict, either between family members or between a family member and the hospital, these cases are resolved informally, based on the good faith judgment of close family members together with the advice of the treating physician and the approval of the hospital's ethics committee. Had Florence not objected, Robert's treatment would have been withdrawn in July 1995.

To be sure no conflict will arise and that your wishes are honored, an individual can do several things: leave a written health care directive, appoint a surrogate or agent, or execute a medical power of attorney.

The Health Care Decisions Law in California is very flexible. A person can leave a formal health care directive, which can be as specific or as general as the individual wishes, and can say what should happen if the instructions given don't cover the situation that arises. Instead of a directive, or in addition to one, you can appoint an attorney for medical care or a surrogate. You can also make an oral appointment or give oral instructions, although these last only so long as you are in the hospital or being treated for the precipitating condition.

There have been some criticisms of the *Wendland* opinion. Happily, I'm not aware of all of them!

Most of the criticisms I do know of relate to the high burden of proof we imposed to show that a minimally conscious conservatee would want to die. It's argued that in imposing such a high standard, the court gave more weight to the state's interest in preserving life than to the conservatee's autonomy and right to choose to die. *Response:* The short answer is that the patient's autonomy is not in issue in these cases. We don't know what the patient wants. With Robert, a minimally conscious patient, we could be fairly sure he did have a preference, but we couldn't tell what it was. Had he left directions or named a surrogate, his autonomy would be honored by following the directive or allowing the surrogate to decide. Since he did not, the interest of the state, in its role as *parens patriae,* was that an *appropriate* decision be made; thus, the trial court required clear and convincing evidence that Robert would want treatment terminated, before it would authorize withdrawal of life support.

Secondly, it's argued that although we stated our decision affected only a narrow class of persons — conscious conservatees — it will actually have a wide impact; this is because a persistent vegetative state — to which the

opinion does not apply — is rare, and most patients in these situations are minimally conscious. In addition, it's argued, many patients with dementia, as to whom questions of life-sustaining treatment have arisen, retain some level of cognitive functioning before they are deemed terminally ill. *Response:* In those cases, as in *Wendland,* I submit the higher standard of proof concerning their wishes is appropriate. It is not a *given* that such individuals would want to die.

Finally, it's argued that the young and the poor are not likely to have appointed a surrogate or executed a directive. Hence, by imposing such a high standard of proof, the opinion deprives these individuals of their fundamental right to refuse life-sustaining treatment. *Response:* But if there is no conservator, *Wendland* has no application. The family of such persons and the hospital together can reach an appropriate decision.

In closing, I'll say that since some burden of proof had to be chosen, it was thought better to choose one that weighs in favor of life, which is the status quo, rather than one that would allow an irreversible decision to end life. Every court that I'm aware of has imposed the same burden of clear and convincing evidence in the circumstances. As the United States Supreme Court stated in the *Cruzan* case, responding to the equal protection argument that a high standard of proof deprives an incompetent individual of equal protection since no such burden is required to effectuate the choice of competent persons, "the differences between the choice made *by* a competent person to refuse medical treatment and the choice made *for* an incompetent person by someone else to refuse medical treatment are so obviously different that the State is warranted in establishing rigorous procedures for the latter class of cases which do not apply to the former class."[15]

Let me read from our *Wendland* opinion: "In this case the importance of the ultimate decision and the risk of error are manifest. . . . But the decision to treat is reversible. The decision to withdraw treatment is not. The role of a high evidentiary standard in such a case is to adjust the risk of error to favor the less perilous result."[16]

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15 497 U.S. at 287 n.12 (emphasis added).

16 26 Cal.4th at 547.

SUBSEQUENT DECISIONS:

Kentucky in 2004 issued an opinion that purported to rely on *Wendland*,[17] but it extended the requirement of clear and convincing evidence to withdrawal of treatment from a patient in a persistent vegetative state or permanently unconscious. I believe that only Kentucky and Missouri (*Cruzan*) have gone so far.

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[17] Woods v. Commonwealth of Kentucky, 142 S.W.3d 24 (Ky. 2004).