LAW OF LIFE: ARTICLE: "THEY WANT ME DEAD" - ACTIVE KILLING - AN OPTION IN MODERN HEALTH CARE DECISION MAKING

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Text

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Introduction

"Thousands of medical ethicists and bioethicists, as they are called, professionally guide the unthinkable on its passage through the debatable on its way to becoming the justifiable until it is finally established as the unexceptional." [1]

According to the published statements of British medical practitioners in June of 2012, more than 100,000 patients each year are put on a "death pathway" protocol by their doctors, thereby hastening their deaths. [2] The death pathway is invoked for a variety of reasons, including the difficulty of the treatment involved, or to free up additional beds in overcrowded health care facilities. The protocol can include withdrawal of treatment - including water and nourishment - and usually results in death within thirty-three hours. Observers were not slow to equate the use of this protocol to euthanasia, which although legal in some jurisdictions, [3] remains illegal in the United Kingdom. [4]

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[1] Richard John Neuhaus, The Return of Eugenics, Commentary, April 1988, at 15, 19 (emphasis added).

[2] Steve Doughty, Top Doctors' Chilling Claim: The NHS Kills off 130,000 Elderly Patients Every Year, Mail Online (June 19, 2012), http://www.dailymail.co.uk/news/article-2161869/Top-doctors-chilling-claim-The-NHS-kills-130-000-elderly-patients-year.html#ixzz1yK7gbr7D; see also Stephen Adams, Hospitals "Letting Patients Die to Save Money," The Telegraph (July 8, 2012), http://www.telegraph.co.uk/health/healthnews/9385674/Hospitals-letting-patients-die-to-save-money.html.

[3] Physician assisted suicide is legal by statute in the Netherlands, Luxembourg, Belgium, and Switzerland; in the United States, it is legal by statute in Oregon and Washington. Marlisa Tiedemann et al., Euthanasia and Assisted Suicide: International Experiences, at i, 7, 10, 12 (2011) (Canada) (summarizing assisted suicide laws in the United States and Europe), available at http://www.parl.gc.ca/Content/LOP/ResearchPublications/2011-67-e.pdf.

[4] Id. at 4. See also Doughty, supra note 2; CNN Wire Staff, Paralyzed UK Man Dies After Losing Assisted-Suicide Case, CNN (Aug. 23, 2012), http://www.cnn.com/2012/08/22/world/europe/uk-locked-in-death/index.html.

[*228] Although the death pathway protocol occurs under a system of nationalized health care, this shocking revelation serves as a reminder of a deadly threat facing those who are most vulnerable - namely, the elderly, sick, and disabled. Cases in the United States demonstrate that similar practices that hasten death are widely accepted, albeit not as a result of an official government protocol, and affirmative legal steps may be necessary to protect a life threatened by such practices. This hastening of death, while distinguishable in social consciousness from actions generally considered to constitute homicide, will be referred to as "active killing." [5]

Modern healthcare has embraced practices leading to letting people die and even helping people die in certain circumstances. The medical, ethical, and legal issues involved with these life and death decisions should be re-examined. Such a re-examination must consider the legal landscape that enables these practices and the cultural forces that encourage them. Accordingly, Part I explores the underlying theories that propel these practices. Part II discusses the public policies that either protect or advance active killing in practice. Lastly, Part III lays out practical responses available when facing a threat of active killing. While all citizens have a direct interest in preserving life and promoting justice for those who cannot speak for themselves, this Article specifically focuses on the essential role of the attorney and the legal system in the defense of life.

I. The Theory

Undergirding Western law is a morality that holds killing the innocent to be unequivocally wrong. This is the principle that humans are equal in value by virtue of their very humanness. This has been called the "sanctity of life ethic," [6] and is akin to the "equality of human life" ethic. This affirmation of the value of the individual underlies much of American social policy, [7] and the nation's law traces this principle to its founding documents. The Declaration of Independence proclaimed the self-evident truth that "all men are created equal," endowed with "life," among other inalienable rights. [8] **[*229]** Principles of individual equality are further enshrined in the Constitution. [9] Extending its reach beyond the law, this principle has been called the "keystone of Western medicine," [10] providing the moral impetus for physicians as healers and helpers of the human family.

It is at this intersection of morality and medicine that this traditional ethical principal is being eroded, leaving some observers to predict its eventual abandonment. [11] Acceptance of an alternative ethic in modern medical practice has led, by degrees, to a serious threat of unnaturally hastened death for the elderly, seriously ill, and disabled. Examples abound of these vulnerable individuals being dispatched into the next life without their consent, [12] and cases arise involving loved ones fighting to achieve continued treatment for disabled patients. [13] The erosion of the traditional ethic that recognizes the value of all human life has many causes, including perceived social burdens

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[5] See infra Part I.B. for further definition of "active killing."

[6] See Editorial, A New Ethic for Medicine and Society, 113 Cal. Med. 67, 67-68 (Sept. 1970).

[7] Id. at 67.

[8] The Declaration of Independence para. 2 (U.S. 1776).

[9] See *U.S. Const. amend. V*; U.S. Const. amend. XIV, § 1.

[10] A New Ethic for Medicine and Society, supra note 6, at 67; see also *In re Quinlan, 355 A.2d 647, 667 (1976)* (referencing the Judeo-Christian tradition of regard to human life, and moral matrix of medicine "to heal").

[11] A New Ethic for Medicine and Society, supra note 6, at 67-68 ("Hard choices will have to be made … that … will of necessity violate and ultimately destroy the traditional Western ethic with all that [it] portends. It will become necessary and acceptable to place relative rather than absolute values on such things as human lives … .").

[12] See, e.g., Doughty, supra note 2; Deborah Sontag, Virginia: Judge Orders Nutrition for Immigrant in Nursing Home, N. Y. Times, Mar. 11, 2011, http://www.nytimes.com/2011/03/12/us/12brfs-JUDGEORDERSN_BRF.html?_r=1&partner=rss&emc=rss.

[13] See infra Part II.

and needs, but one of the greatest is the belief that cognitive ability and quality of life - at least a sense of self-awareness - should be elevated above the right to live itself. [14]

The loss of the sanctity of human life ethic has coincided with the acceptance of other ethical principles and the adoption of the "futile care theory." Futile care, as defined by medical texts, is care that in medical judgment "will not have a reasonable chance of benefiting [the] patient." [15] Thus, if a particular treatment will not, in best medical judgment, benefit the patient, the physician has no obligation to administer it. [16] However, as the sanctity of human life ethic erodes, a new, more dangerous, ethic arises that not only views some treatments as futile, but also views some patients as futile - as worthless and therefore unworthy - of further existence. If **[*230]** something more than merely being human is required for a human life to have value, such as possessing an undefined level of cognitive ability, sustaining the life of a cognitively damaged individual may be viewed as an act of futility. Thus a medically effective treatment would be considered futile when a patient's life is viewed as futile. Such a result goes beyond patient choice or the rejection of unwanted medical treatment; it leads to the health care provider's refusal to provide wanted care and life-sustaining treatment, such as foods and fluids, precisely because that treatment would be effective in prolonging life.

A. Societal Acceptance

Historically, state laws regarding the withdrawal of nutrition and hydration were grounded in the common law theory of battery and the concept of informed consent - the right to refuse medical treatment. [17] Less than fifty years ago, providing food and fluids through a feeding tube was considered standard humane care. [18] Through a gradual process of elimination, this type of care has been redefined to mean "medical treatment." This is the result of a deliberate campaign that has followed an identifiable trajectory. It began with the rejection, at least in some academic circles, of the traditional ethic that all human life is of equal worth. A new field emerged, bioethics, in which philosophers - bioethicists - worried about the cost of caring for the dependent and elderly within an increasingly aging society. [19] Many factors contributed to a widespread rejection of the traditional ethic, such as the cultural upheaval combined with technological advances of the past fifty years. [20]

As the traditional ethic continued to erode, factors such as autonomy, quality of life, cost, and convenience tended to predominate decision-making. Finding a way to hasten death became a solution to these shortfalls. Values such as privacy and autonomy became driving forces in medical ethics. [21] Arguments for, and suggestions regarding,

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[14] See, e.g., Neale Duckworth, Living and Dying with Peter Singer, Psychology Today, Jan. 1999, available at *http://www.psychologytoday.com/articles/199901/living-and-dying-peter-singer* (reproducing an interview by Jill Neimark with Peter Singer).

[15] AMA Code of Med. Ethics, Op. 2.035 (1994), available at *http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-* medical-ethics/opinion2035.page?.

[16] See id.

[17] Jessica J. Sage, Preserving Human Dignity at the End of Life: A Survey of Federal and State Laws, in Americans United for Life, Defending Life 2010: Proven Strategies for a Pro-Life America 415, 416 (2010).

[18] See Wesley J. Smith, Forced Exit: Euthanasia, Assisted Suicide, and the New Duty to Die 43-44 (3d ed. 2006) [hereinafter Forced Exit].

[19] See Wesley J. Smith, Culture of Death: The Assault on Medical Ethics in America 21 (2000) [hereinafter Culture of Death].

[20] See id.

[21] Forced Exit, supra note 18, at 44.

hastening death were **[*231]** originally made within a framework of supposedly strict medical guidelines - which largely control medical treatment options. [22]

Following the promulgation of the academic theories, a campaign commenced to test the theories in court and, if necessary, to stretch the bounds of the law. Convincing the courts proved to be an achievable goal. The courts accepted that the ethical issues had been carefully worked out, and that the power to remove sustenance would be exercised within the strictest guidelines. [23] However, legally, there had already been a rejection of the ethical principal of the equality of human life regarding certain members of the human family through the legalization of abortion. [24]

Today, the impetus for limiting care has never been stronger. Spiraling healthcare costs have led to measures aimed at curbing costs and providing more people with insurance coverage, such as the Patient Protection and Affordable Care Act (popularly dubbed "Obamacare"). [25] As cost-saving elements of this law are implemented, additional pressure may be brought to bear in favor of terminating treatment for a broader range of individuals. [26] Interestingly, the increasing acceptance of early termination of life-sustaining treatment has not led to a corresponding decrease in nation-wide health care costs. [27] Studies indicate that the actual cost savings of replacing curative treatment until death with a palliative model appear to be small when compared to national health care expenditure. [28] In a discussion of the economics associated with care at the end of life, Michael Ash and Stephen Arons estimated that a very small percentage of total national health care expenditure might be saved by a less-aggressive treatment paradigm:

3.3% of total national health care expenditure might be saved by a conversion away from aggressive curative treatment, [but] … the growth rate of health care expenditure would be unaffected. Furthermore, end-of-life care has not been a site of disproportionate growth of health care **[*232]** expenditure, so changes only to this component of health care cannot reduce the rapid growth that has been the focus of cost-control efforts. [29]

Thus, the pressure to decrease national health care costs by forgoing care appears to be ill-founded when considering the actual monetary benefits this strategy has achieved, not to mention the danger it presents disabled individuals. As the debate evolves from refusing to provide food and fluids, to openly assisting suicide, to downright euthanasia, it becomes clearer that the rejection of the human equality ethic has opened the door for increasingly intrusive measures to end human life. [30]

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[22] Kathryn L. Tucker, When Dying Takes Too Long: Activism for Social Change to Protect and Expand Choice at the End of Life, *33 Whittier L. Rev. 109, 150 (2011)* (arguing that physicians should have greater latitude to aid patients in dying).

[23] See Forced Exit, supra note 18, at 44-45.

[24] See A New Ethic for Medicine and Society, supra note 6, at 68. A lengthy discussion of abortion is beyond the scope of this Article.

[25] Patient Protection and Affordable Care Act, *42 U.S.C. § 18001* (2010).

[26] See Robert Powell Cent. for Med. Ethics, Life at Risk: How the Obama Health Care Plan Will Ration Your Family's Medical Treatment - A Factsheet (2012), available at *http://www.nrlc.org/HealthCareRationing/LifeatRiskLongform.pdf*.

[27] See Michael Ash & Stephen Arons, Economic Parameters of End-of-Life Care: Some Policy Implications in an Era of Health Care Reform, *31 W. New Eng. L. Rev. 305, 316-17 (2009)*.

[28] Id. at 317.

[29] Id. Ash and Arons further stated: "Although end-of-life care represents approximately a quarter of Medicare spending and overall Medicare spending has grown sharply over time, the end-of-life share of Medicare spending has been remarkably stable. New developments or applications of expensive interventions have not been disproportionately focused on end-of-life care." Id. at 318 (footnote omitted).

[30] See generally Culture of Death, supra note 19, at 11 (discussing Joseph Fletcher).

B. Terminology

Throughout this Article, "active killing" refers to the situation where caregivers, decision makers, or both, take affirmative steps to withdraw life-sustaining medical care from a patient with the intent to shorten a patient's life or hasten her death. While this is often the result of some seemingly altruistic motive, it too often occurs when it is unclear whether the patient would have opted to refuse such treatment. There is a passiveness in "letting the patient die" that belies the term "active killing." Nonetheless, the term "active" is appropriate since volitional deprivation of care is involved in hastening death. The word "killing" is used deliberately, because although a motive might be considered acceptable by society (e.g., to end suffering, conserve scarce resources, etc.), the decision results in the patient's death. In addition, the terms "life-sustaining treatment" and "life-sustaining medical care," as used in this Article, include not only medical intervention, but also the provision of the food and water necessary to sustain life - whether administered by tube or by the usual oral means. [31] Lastly, the term "health care provider" is used broadly to refer to physicians, hospitals, and other medical professionals in various other settings in which an incapacitated patient might receive treatment and care.

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C. Threats

Many may view the food and fluids cases as a primarily good trend in medicine - a necessary pushback against past practices in which some healthcare providers seemed to stray toward aggressive treatment whether a patient wanted it or not. Thoughtful observers, however, will realize that there is an essential distinction between allowing competent patients to refuse unwanted medical treatments and the denial of medical care to a patient because he is incapable of demanding it. [32] Looking at a patient's quality of life, rather than the fact that he or she is alive, as the basic litmus test for whether the patient ought to receive treatment opens a Pandora's Box of evils, including: a decrease in patient control over medical choice; increased devaluing of the disabled; increased practice of assisted suicide and euthanasia; increased risk of neglect and abuse of the elderly; and increased pressure on religious families to abandon their deeply held beliefs.

As mentioned, one of the dangers posed by the acceptance of active killing is that patients will face the removal of wanted medical care. Even twenty years ago, researchers studied the actions of physicians practicing in the area of adult intensive care, and looked at the impact, if any, that a patient's or surrogate's decision making had on the withdrawal of life-sustaining treatment, particularly where treatment was deemed to be medically futile. [33] Many physicians reported withholding life-sustaining treatment without the patient's or the patient's family's consent. [34] Some physicians reported doing so without a patient's or family's knowledge of the situation. [35] Some even withheld life-sustaining treatment over the objection of the patient or a family member. [36]

Patient wishes appear to be respected even less so in jurisdictions that have embraced physician assisted suicide. In 1998 in Belgium it was estimated that while 1.3 percent of all deaths were from physician assisted suicide, 3.3 percent of all deaths were from the administration of lethal drugs **[*234]** without the patient's explicit request. [37]

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[31] See Forced Exit, supra note 18, at 43-44 (discussing changes in the definition of "medical treatment").

[32] See id.

[33] The study included treatment through artificial nutrition and hydration. See Dorothy D. Nachman, Living Wills: Is It Time to Pull the Plug?, *18 Elder L.J. 289, 302 n.62 (2010-2011)* (citing David A. Asch et al., Decisions to Limit or Continue Life-Sustaining Treatment by Critical Care Physicians in the United States: Conflicts Between Physicians' Practices and Patients' Wishes, 151 Am. J. Respiratory & Critical Care Med. 288, 288-92 (1995)).

[34] Id. at 303 n.64 (citing Asch et al., supra note 33, at 291) (noting twenty-five percent reported doing so without patient or family consent).

[35] Id. (noting fourteen percent reported withholding treatment without a patient's or family's knowledge).

[36] Id. (noting three percent reported withholding treatment over objections).

Another Belgian study found that "in 2001, 1.5 percent of all deaths involved ending life without the patient's request." [38]

Recent experience indicates that health care providers in the United States tend to be closer to, not further from, a willingness to remove care. For example, in 2011, an immigrant woman diagnosed as being in a persistent vegetative state had her health care decisions relegated to a court-appointed guardian when the hospital that she was being treated at decided to end her treatment. [39] The guardian argued that the woman's feeding tube should be removed, despite the objection of the patient's family. [40] In e-mail correspondence with a reporter inquiring about the case, the guardian explained her reasoning: "Generically speaking, what gives any one family or person the right to control so many scarce health care resources in a situation where the prognosis is poor, and to the detriment of others who may actually benefit from them?" [41]

The medical profession itself is threatened by a standard of care that seeks to eliminate "futile" patients, rather than futile treatments. Traditions dating back to Hippocrates put physicians in the place of healer as opposed to harmer. As the Supreme Court pointed out in Washington v. Glucksberg, states have a legitimate interest in "protecting the integrity and ethics of the medical profession." [42] At the time of the Glucksberg decision, the American Medical Association had concluded that ""physician-assisted suicide is fundamentally incompatible with the physician's role as healer."' [43] But the acceptance of active killing logically leads to the incremental acceptance of physician assisted suicide (PAS). Although legal by statute in only two states, [44] there is an active lobby for legalizing PAS throughout the nation. Indeed, the practice receives active promotion in state legislatures nearly every legislative session. [45] Further, scholarly articles argue for the **[*235]** acceptance of assisted death, whether explicitly through legalization, through the refusal to prosecute a health care professional who assists a patient in dying, or through expanding practice guidelines to implicitly allow PAS. [46]

There is a short step between PAS and active euthanasia - the killing of those unable or unwilling to make the decision for themselves. Some assert that there is little practical difference between the acceptance of PAS for terminally ill patients and the acceptance of euthanasia, since jurisdictions that embrace PAS seldom prosecute doctors for practicing involuntary assisted suicide, which could rightly be called euthanasia. Further, PAS can

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[37] Raphael Cohen-Almagor, Euthanasia Policy and Practice in Belgium: Critical Observations and Suggestions for Improvement, *24 Issues L. & Med. 187, 200 (2009)*.

[38] Id.

[39] See Sontag, supra note 12; see also Peter J. Smith, Feeding Tube Restored to Immigrant Woman Unable to Pay Jesuit Hospital, LifeSiteNews.com (Mar. 11, 2011), *http://www.lifesitenews.com/news/breaking-feeding-tube-restored-to-immigrant-woman-unable-to-pay-jesuit-hosp*.

[40] See Smith, supra note 39.

[41] Id.

[42] *521 U.S. 702, 731 (1997)*.

[43] Id. (alteration in original) (quoting American Medical Association, Code of Ethics § 2.211 (1994)).

[44] See Oregon Death with Dignity Act, *Or. Rev. Stat. §§127.800-897* (2009); Washington Death with Dignity Act, *Wash. Rev. Code §§70.245.010-904* (2012).

[45] See, e.g., Steven Ertelt, Vermont to Vote on Measure to Legalize Assisted Suicide, LifeNews.com (Apr. 11, 2012), *http://www.lifenews.com/2012/04/11/vermont-to-vote-on-measure-to-legalize-assisted-suicide/* (pressure was being asserted on the Vermont legislature to legalize assisted suicide in April, 2011. At time of publication the Vermont legislature had passed a bill legalizing assisted suicide, which awaited the Governor's signature. See Dave Gram, Vermont House Passes Aid-In-Dying Bill, Associated Press, May 14, 2013, *http://bigstory.ap.org/article/vermont-house-passes-aid-dying-bill*).

[46] See, e.g.,Tucker, supra note 22, at 157-59.

increase suicide among persons who are not terminally ill. For example, studies of the PAS law in Belgium reveal the very real fear that the law has opened the door for physically healthy persons to request their lives be ended because they are tired of life. [47]

Once law and medical practice accept a procedure, such as PAS, the actions of practitioners tend to go further. For instance, Belgium enacted an assisted suicide law that included practice guidelines. [48] In the very first case following this law (one week after its passage), a physician did not adhere to the guidelines. Thirty-nine year old Mario Verstraete, who suffered from multiple sclerosis, was dead within a week of the law's passage, despite the requirement that at least one month must elapse between a written death request and the euthanasia. [49] Moreover, Mr. Verstraete was not in the final stages of a terminal illness. [50] In another case, an eighty-seven year old dementia patient was killed by her physician who gave her a drink containing barbiturates. [51] Although this killing violated numerous aspects of the applicable law, including the requirement of informed consent, prosecutors decided not to prosecute the physician. [52] Even the most innocent and helpless members of society, newborn infants, are directly impacted by the acceptance of active killing. In Flanders, a 2005 study revealed that three out of four doctors were willing to shorten the life of critically ill babies through the withdrawal of treatment or - in some cases - the administration of drugs. [53]

[*236] When death is considered a treatment option, its abuse is not limited to medical practitioners that believe they have altruistic motives such as relieving their patients of a painful life. It also becomes an option for those who seek to benefit from the patient's death outside of the doctor-patient relationship. In other words, a greedy decision maker (who may be in line to inherit upon the patient's death) can save thousands of dollars by shortening the patient's life. Indeed, inexplicable changes of heart by decision makers in notable cases leave the bitter taste of greed. For example, in the aftermath of the infamous Terri Schiavo case, it was pointed out that Michael Schiavo stood to benefit financially from his wife's death when he brought the petition for removal of her feeding tube. [54]

A recent and particularly chilling trend in active killing cases affects those who are strong adherents to particular religious values, such as the belief that human life is a sacred gift from God. Bioethicists have suggested that ""fundamentalist Christian' parents" cause "unnecessary" suffering to their children when refusing to remove life support. [55] Indeed, the argument was floated that strict adherence to life-affirming religious values should be grounds for disqualifying parents from choosing continued care for their minor children. [56] Thus, the targeting of religious beliefs is yet another danger posed by the acceptance of active killing.

While a balanced view of patient care would reduce unwanted and intrusive treatment, the enormous shift in theory of the past four decades overreaches and effectively devalues individual patients, particularly when they have a diminished capacity to make their own decisions.

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[47] See Cohen-Almagor, supra note 37, at 207-08.

[48] See id.

[49] Id. at 207.

[50] Id. at 208.

[51] Id.

[52] Id.

[53] Id. at 210.

[54] Discussed infra Part II.A.3. See Forced Exit, supra note 18, at 71.

[55] Wesley J. Smith, Opinion, Ethicists Attack Religious Parents for Refusing to Pull the Plug, The Daily Caller (Aug. 16, 2012), *http://dailycaller.com/2012/08/16/ethicists-attack-religious-parents-for-refusing-to-pull-the-plug/* (noting a study in the Journal of Medical Ethics and various news reports that followed).

[56] See id.

II. Public Policy

The past forty years have seen much growth in policy and law regarding heath care decision-making, particularly in the area of making decisions on behalf of the incapacitated. The following sections focus on some of the groundbreaking cases in this area, as well as on the general statutory approach.

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A. Case Law

To illustrate the evolution of the law in the area of life-sustaining treatment for incapacitated individuals, this section focuses on four significant and groundbreaking cases. The first three cases deserve attention for their high-profile nature and long-term impact as well as the policies underlying their rulings. The fourth will receive closer treatment so that the practical aspects of this type of case can be referenced and highlighted. [57]

1. In re Quinlan [58]

The parents of Karen Ann Quinlan, a young woman who had been unconscious for several years, sued her hospital to obtain the right to remove their daughter's life support, including her respirator, without which she would die. [59] The case eventually went to the New Jersey Supreme Court, which ruled that Karen's father would be appointed her guardian, and would have the right to determine her care. [60] This included the power to refuse treatment, even if it meant Karen would die, if there was consensus from the doctor and hospital ethics committee that there was no possibility of the patient ever recovering or regaining sentient function. [61]

This case is mostly famous for the proposition that since a patient can refuse unwanted medical treatment, it is logical for a decision maker, such as a parent or guardian, to exercise the ability to refuse such treatment on behalf of the incapacitated patient. However, this case took the proposition one step further by ruling that this refusal could be exercised even when the result would be, almost certainly, the death of the patient. Nevertheless, surprising everyone, Karen ended up living ten years after her respirator was removed (the removal of her nutrition and hydration was never a consideration). [62]

2. Cruzan v. Director, Missouri Department of Health [63]

In 1983, Nancy Cruzan was injured in a car accident that left her with profound cognitive dysfunction, although authorities dispute the actual level **[*238]** of her abilities. [64] She recovered to the extent that she was neither in critical care, nor on a ventilator, [65] although she did require nutrition and hydration to be administered through a feeding tube. [66] Her parents sought to have the feeding tube removed, but the hospital refused. [67] The parents

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[57] See infra Part II.A.4.

[58] *355 A.2d 647 (1976)*.

[59] *Id. at 655*.

[60] *Id. at 671*.

[61] Id.

[62] Culture of Death, supra note 19, at 92.

[63] *497 U.S. 261 (1990)*.

[64] Forced Exit, supra note 18, at 46-47 (stating that there was evidence she could see and hear; she smiled at amusing stories and sometimes cried when visitors left).

[65] See id. at 47.

sued, requesting a court order directing the withdrawal of Nancy's nutrition and hydration equipment. Initially, the parents won. [68] The Missouri Supreme Court, however, reversed by holding, inter alia, that the court lacked authority to effectuate the request because of the lack of clear and convincing evidence that Nancy desired to have life-sustaining treatment withdrawn as required under Missouri's Living Will statute. [69] Eventually, the case was appealed to the United States Supreme Court, which affirmed and held that the Due Process Clause [70] did not require the state to repose judgment on matters concerning the right to refuse treatment in anyone other than the patient herself. [71] The Court further held that a state could choose to defer only to the patient's wishes rather than entrust the decision to close family members. [72] Finally, the state could require clear and convincing evidence of the patient's desires and wishes. [73]

On remand to the original Missouri trial court, new evidence was presented, including testimony by some of Nancy's former co-workers regarding statements Nancy made in casual conversations. [74] The court ruled that based on this new - albeit slim - evidence, the Cruzans were indeed able to meet the clear and convincing evidence standard. [75] Upon removal of her food and fluids, Nancy died of starvation and dehydration in December of 1990. [76]

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3. In re Schiavo [77]

Because of the widespread familiarity with the Schiavo case, this overview will seek only to highlight those aspects that are particularly relevant to this discussion. Terri Schiavo became severely cognitively disabled following an unexplained collapse in 1990. [78] Eventually, she was diagnosed as being in a persistent vegetative state ("PVS"), although this designation was controversial. [79] Eventually, Terri improved to the point that the only treatment she required was a feeding tube. [80] Terri's husband Michael worked with her parents, the Schindlers, for the first several years to provide for her care. [81] When the three experienced a falling out, years of court battles ensued. In

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[66] *Cruzan, 497 U.S. at 266*.

[67] *Id. at 267-68*.

[68] *Id. at 268*.

[69] *Id. at 268-69* (construing *Mo. Rev. Stat. § 459.010* (1986)).

[70] U.S. Const. amend. XIV, § 1.

[71] *Cruzan, 497 U.S. at 286*.

[72] *Id. at 286-87*.

[73] See *id. at 284-85* ("In sum, we conclude that a State may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state.").

[74] Forced Exit, supra note 18, at 48.

[75] Id.

[76] Id.

[77] *780 So.2d 176 (Fla. 2d DCA 2001)* (upholding decision to allow removal of Mrs. Schiavo's feeding tube). Note that court proceedings in this dispute spanned a number of years and resulted in numerous reported cases.

[78] See Forced Exit, supra note 18, at 67.

[79] Id. See also David Gibbs & Bob DeMoss, Fighting for Dear Life: The Untold Story of Terri Schiavo and What it Means for All of Us 64 (2006).

[80] Id. at 21-22.

1993, the Schindlers sought guardianship of their daughter following Michael's refusal to have her treated for an infection. [82] They clashed again in 1998 over Michael's attempt to remove Terri's feeding tube. [83] Up until Terri's death in March of 2005, they battled at all levels of the state and federal judiciaries, legislatures, and the court of public opinion. [84] At each stage of the conflict, the courts unanimously upheld the Pinellas County Circuit Court's order to remove Terri's nutrition and hydration. [85]

To this day, legal and cultural commentators continue to explain why Terri's death was such a profound injustice. [86] For instance, they point out that the court accepted evidence of statements purportedly made by Terri in various casual conversations that asserted she would not want "tubes" to sustain her in such a situation. These were ruled sufficiently "clear and convincing" evidence of her desires despite contrary testimony that Terri had disapproved of the death of Karen Ann Quinlan. [87]

[*240] Further, commentators note that Michael Schiavo, Terri's husband and guardian, had told different stories to different courts. In an earlier medical malpractice action brought on Terri's behalf, Michael presented evidence that Terri would likely live a normal lifespan. In addition, he stated that he would become a nurse, dedicate his life to Terri's care, and that monies awarded in the suit would be used for her care and rehabilitation. [88] The verdict of $ 1.3 million left ample money for Terri's care - money Michael would inherit if Terri died. [89] But when he was subsequently in court seeking the removal of care, Michael claimed his wife never wanted to live with such a disability.

For this and other reasons, Michael had serious conflicts of interest as Terri's guardian. Indeed, the financial conflict was coupled with the fact that he had fallen in love, moved in, and fathered children with another woman. These conflicts should have precluded him from acting as Terri's guardian, as was pointed out by Terri's initial guardian ad litum, Richard Pearse. [90]

Finally, in addition to the court's tenuous evidentiary findings, and Michael's inconsistent positions and conflicts of interest, commentators point out that many came forward disputing the diagnoses of PVS, Terri's cognitive abilities, and her potential for recovery with proper therapy (of which she was entirely deprived). [91] In the end, none of the arguments and efforts for Terri's life prevailed. Deprived of all forms of nutrition and hydration, Terri died in March of 2005. [92]

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[81] Forced Exit, supra note 18, at 67.

[82] Id.

[83] Id.

[84] Id.

[85] Id.

[86] See, e.g., Gibbs & DeMoss, supra note 79. In addition, the Schindler family has since set up a foundation in Terri's memory to assist families that find themselves in similar situations. See Terri Schiavo Life and Hope Network, *http://www.terrisfight.org/* (last visited Sept. 9, 2012).

[87] See Forced Exit, supra note 18, at 68.

[88] Id. at 69-70.

[89] Id. at 70. See *In re Schiavo, 780 So.2d. 176, 178 (Fla. 2d DCA)* (noting that Michael stood to inherit under Florida's intestacy laws).

[90] Forced Exit, supra note 18, at 70-73 (citing Report of Guardian ad Litem, In re Schiavo, Case No. 90-2908BGD-003).

[91] Gibbs & DeMoss, supra note 79, at 63-66.

[92] Id. at 170.

4. Wendland v. Wendland [93]

As the result of a single-car automobile accident, Robert Wendland was left in a coma for approximately sixteen months. [94] Contrary to his doctors' predictions, he awoke in January of 1995. [95] He regained voluntary reactions and became able to respond to directives and operate both a manual and a motorized wheelchair. [96] Additionally, he performed other neurologically complex tasks such as throwing and catching a ball, balancing in a standing **[*241]** frame, blinking his eyes in response to questions, turning pages, drawing circles, and writing the letter "R" with his left hand. [97]

Robert's wife, Rose, in consultation with Robert's doctor, initially agreed that he should undergo an extensive program of speech and physical therapy. [98] However, after Robert began the program, Rose determined that his feeding tube should not be replaced when it became dislodged - as it had on three prior occasions. [99] This decision would constitute a death sentence since he received all of his nutrition and hydration through that feeding tube. Robert had no written directive for health care. Rose, along with Robert's doctor, sought and obtained the endorsement of the hospital's ethics committee to remove his feeding tube. [100] Under their plan, Robert would be discharged and moved to a convalescent home where he would be starved and dehydrated to death. [101]

Before the plan could be executed, an anonymous caller notified Robert's sister, Rebekah Vinson, and his mother, Florence Wendland, about the plan to move Robert and discontinue his care. [102] Attorneys for Rebekah and Florence persuaded the court to grant injunctive relief, prohibiting the cessation of Robert's life-sustaining treatment and prohibiting his transfer from the hospital. [103]

Rose petitioned the court to be appointed as Robert's conservator, and was so appointed over the objections of Rebekah and Florence. [104] Whether Rose had the authority to terminate Robert's food and nutrition was litigated separately, [105] and included the foundational question of whether nutrition and hydration could legally be removed from a conscious patient who was neither terminally ill nor in a persistent vegetative state - an issue of first impression in California. [106] The court held that Rose would be allowed to withhold nutrition and hydration only if it

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[93] *Conservatorship of Wendland, 28 P.3d 151 (Cal. 2001)*.

[94] *Id. at 154*; *Conservatorship of Wendland, 93 Cal. Rptr. 2d 550, 554 (Cal. Ct. App. 2000)*.

[95] *Conservatorship of Wendland, 93 Cal. Rptr. 2d at 554*.

[96] Id. See also Forced Exit, supra note 18, at 61-62.

[97] Culture of Death, supra note 19, at 74-75; The Underlying Facts of Conservatorship of Wendland, *http://www.robertslegacy.com* (last visited Oct. 3, 2012).

[98] *The Underlying Facts of Conservatorship of Wendland, supra note 97*.

[99] Id.

[100] *Conservatorship of Wendland, 28 P.3d at 155*.

[101] Forced Exit, supra note 18, at 63.

[102] Id.; *Conservatorship of Wendland, 28 P.3d at 155*.

[103] *Conservatorship of Wendland, 28 P.3d at 155*.

[104] Id.

[105] Id.

[106] *Id. at 156*.

would be in Robert's best interest, taking into account any wishes he may have expressed before becoming incompetent. It also determined that Rose would have to prove the facts justifying her decision by clear and convincing evidence. [107]

[*242] In the second phase of litigation, the court adjudicated whether these standards had been met. The trial court found the evidence insufficient to prove that Rose's decision was in accordance with Robert's wishes or best interest, based on a clear and convincing evidence standard. [108] Essentially, the course of action Robert would have chosen if capable of making his own decision was in dispute. Rose argued that Robert had made pre-accident verbal statements of his intent. [109] However, at least one of these statements was made in a heated discussion while Robert was suffering from a hangover and at a time when he was abusing alcohol and grieving the death of a close family member. [110] Thus, the court determined the evidence insufficient to justify removal of Robert's nutrition and hydration. [111] Rose appealed this decision, and the California Court of Appeal reversed, holding that the court was required to defer to Rose's good faith decision as to Robert's best interest, and that there need not be proof of Robert's expressed desire. [112]

However, the California Supreme Court reversed the Court of Appeal, upholding the trial court's ruling. [113] It held that when applying the clear and convincing evidence standard, Rose was required to show either that Robert wished to refuse life-sustaining treatment under these circumstances, or that to withhold such treatment would have been in his best interest. [114] Since such evidence was ultimately lacking, the request for permission to withdraw artificial hydration and nutrition was unsuccessful. [115] Unfortunately, Robert died of pneumonia several weeks before this victory. [116]

B. Legislation

Health care decision making, particularly when the patient is facing a terminal condition, is statutorily regulated in all states. Each state incorporates unique elements in its statutes, but there is generally some consensus on the basic approach. Consistent with the traditional ethic of the value of individual persons, these statutes usually focus on protecting the patient. Further, in accord with the desire to promote individual rights and personal autonomy, these statutes seek to protect and enforce the patient's decisions.

[*243] As Professor Alan Meisel discusses, these statutes generally incorporate, in some form, the following principles:

1) competent individuals have a legal right to refuse treatment; [117]

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[107] Id.

[108] *Id. at 157*.

[109] Id.

[110] Id.

[111] Id.

[112] *Conservatorship of Wendland, 93 Cal. Rptr. 2d 550, 567, 579 (Cal. Ct. App. 2000)*, rev'd, *28 P.3d 151 (Cal. 2001)*.

[113] *Conservatorship of Wendland, 28 P.3d at 174* (construing *Cal. Prob. Code § 2355* (West 2000)).

[114] *Id. at 175*.

[115] Id.

[116] Forced Exit, supra note 18, at 65.

2) incompetent individuals have a right to have treatment refused for them;

3) end-of-life decisions should ordinarily be made in clinical settings and not courts;

4) close family members have the legal authority to act as surrogates and make medical decisions for patients who lack decisionmaking [sic] capacity;

5) in making end-of-life decisions, surrogates should apply the substituted judgment standard [meaning they should act as the patient would have under like circumstances];

6) surrogates may rely on advance directives to ascertain patients' wishes; [and]

7) artificial nutrition and hydration are medical treatments … . [118]

Meisel adds an eighth point: "actively hastening death is impermissible." Here, he is speaking about euthanasia, or assisting the death of another without their consent. [119] However, he does not recognize the fact that removal of nutrition and hydration may in and of itself actively hasten death. Further, in a notable exception to this eighth point, two states, Oregon and Washington, have enacted physician assisted suicide laws. [120]

All states have adopted procedures whereby patients can designate an individual to make health care decisions on their behalf, should they become incapacitated. These give competent patients the ability to make numerous health care decisions prior to incapacity - for instance, through a living will - and to designate an individual to make those decisions through power of attorney for health care. Not all states use the "living will" or "power of attorney for health care" terminology, but all states recognize the underlying right of patients to make their own informed decisions, and have adopted procedures to protect that right. [121]

Studies indicate that although these procedures are universally available and relatively simple to execute, few people actually have living wills or **[*244]** powers of attorney for health care. [122] A California study in February of 2012 indicated that although eighty percent of patients believe it is important to have their wishes in writing, seventy-six percent of them neglect such planning. [123] When patients fail to designate a decision maker, most states have statutes controlling who may make decisions. The most common hierarchy follows this basic outline: if the patient does not have an agent or guardian, the spouse (unless legally separated) will control decision making;

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[117] Conversely, patients also have the right to receive treatment - a principle under attack - but nonetheless assumed in most statutory schemes. Further, federal law requires most hospitals to provide emergency treatment to patients. See, e.g., *42 U.S.C. § 1395dd(b)* (2012).

[118] Alan Meisel, Suppose the Schindlers Had Won the Schiavo Case, *61 U. Miami L. Rev. 733, 738 (2007)*.

[119] Id.

[120] See Oregon's Death with Dignity Act, *Or. Rev. Stat. §§127.800-897* (2012); Washington's Death with Dignity Act, *Wash. Rev. Code §§70.245.010-904* (2009).

[121] See Appendix: Health Care Decisions Laws infra.

[122] Ruth F. Maron, Who Has A Will to Live?: Why State Requirements for Advance Directives Should be Uniform(ly Revised), *24 Regent U. L. Rev. 169, 172 (2011-2012)*.

[123] Kevin B. O'Reilly, 76% of Patients Neglect End-of-Life Care Planning, Am. Med. News, Feb. 27, 2012, *http://www.ama-assn.org/amednews/2012/02/27/prsb0227.htm*; Patricia Bomba, Landmark Legislation in New York Affirms Benefits of a Two-Step Approach to Advance Care Planning Including MOLST: A Model of Shared, Informed Medical Decision-Making and Honoring Patient Preferences for Care at the End of Life,*17 Widener L. Rev. 475, 483 (2011)* (stating although a 2005 poll showed ninety-five percent of people realized the need for an advance directive, only twenty-nine percent had completed a living will).

followed by an adult child; then a parent; adult sibling; adult grandchild; and finally, a niece, nephew, or some other close relative. [124] Further, most states have safeguards in place to protect the patient. For example, in many states, any interested person who feels that the patient is not receiving care in accordance with his or her wishes or best interests may challenge the decisions of a health care decision maker in court. [125]

C. Reforms

The reality that relatively few persons execute living wills, combined with the high-profile nature of the court cases involving end-of-life care, has prompted some to urge reforms - particularly to relieve caregivers of liability for exercising their own discretion in making decisions regarding the care of incapacitated persons. Suggestions for legislative reform in this area have included: (1) physician counseling of patients to participate in advance planning; [126] (2) increasing direct-physician involvement with decision-making through forms such as Physician's Orders for Life Sustaining Treatment (POLST) or Medical Orders for Life Sustaining Treatment **[*245]** (MOLST); [127] and (3) changing the paradigm for settling disputes from the courtroom to alternative dispute resolution or mediation. [128]

Although there is disagreement over whether advance directives, including the newer POLST and MOLST forms, are good for patients, the reality is that there is an increasing risk that health care providers will simply ignore patient instructions with regard to life-sustaining treatment.

Most states allow health care providers to refuse to comply with a health care decision if it would either violate the ethical or moral policies of the provider, or if it would require medically futile treatment. [129] The difficulty lies in the increasingly broad view of what constitutes medical futility. Providers are generally required to allow transfer of the patient to a different provider in a situation where they are no longer willing to provide requested care. [130] The difficulty arises when the provider claims that further treatment is medically futile, and no other provider is willing to take the patient. When this happens, the question becomes: Does the original health care provider have the duty to continue to provide life-sustaining care?

The answer is "not necessarily" under most state statutes. Thus, an increasing number of controversies arise when family members attempt to get the care required for a loved one and the provider refuses to comply with their requests. Research available from the Robert Powell Center for Medical Ethics indicates that in all but eleven states, doctors and hospitals may disregard advance directives when they call for certain treatment. [131] In Texas, for example, a hospital committee can decide to deny life support against the will of a patient or his family. [132] After

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[124] See, e.g., *Del. Code Ann. tit. 16, § 2507(2)* (2012). See Appendix infra for each state's approach.

[125] See, e.g., *Cal. Prob. Code § 4765* (West 2012) (stating that a challenge to a decision may be brought by a patient, spouse, relative, agent or surrogate, conservator, investigator, public guardian, health care provider, or "any other interested person or friend of patient"). In Indiana, a health care provider or any interested individual may petition the court to make a health care decision, order health care for an individual incapable of consenting, or appoint a representative to act for the individual. *Ind. Code § 16-36-1-8* (2012). See Appendix infra.

[126] O'Reilly, supra note 123.

[127] See Bomba, supra note 123, at 483-87.

[128] David M. Shelton, Keeping End-of-Life Decisions Away from Courts After Thirty Years of Failure: Bioethical Mediation as an Alternative for Resolving End-of-Life Disputes, *31 Hamline L. Rev. 103, 133 (2008)*.

[129] Robert Powell Ctr. for Med. Ethics, Nat'l Right to Life Comm., Will Your Advance Directive Be Followed? 8 (Rev. ed. 2012), available at *http://www.nrlc.org/euthanasia/AdvancedDirectives/* WillYourAdvanceDirectiveBeFollowed.pdf (last visited Oct. 4, 2012).

[130] Id.

[131] Id. at 10.

such a refusal, the family has ten days to try to find another hospital willing to give the patient life-sustaining treatment. [133]

This is precisely the situation faced by the mother of a twelve-year old boy in Fort Worth, Texas. [134] He underwent trauma from a bullet wound, **[*246]** causing an indeterminate amount of damage to the brain. [135] Unbeknownst to his mother, the treating physician removed food and water, and inserted a do-not-resuscitate order into his medical chart. [136] Although the child was improving to the point of breathing on his own, the doctor made it clear that the hospital would no longer treat him - and all they needed was the affirmation of the hospital's ethics committee to achieve that very result. [137] If the hospital deemed his care "futile," the mother would have ten days to transfer her son, or they would discontinue the requested care. [138]

Indeed, over the last fifteen years, the trend has reversed from most cases involving patients seeking to end unwanted care, to patients or their decision-makers seeking continued or more aggressive treatment, with their health care providers refusing to honor their wishes. [139] Reports indicate physicians are willing to withdraw or withhold treatment they consider futile without informing the patient or his or her family. In one study, more than eighty percent had withdrawn treatment over the family's objections. [140]

A legislative solution to the threat facing patients in refusal of care situations is available: the law could be modified to require life-sustaining care to be provided until transfer can be completed. [141] The Oklahoma rule provides a model:

If the physician or other health care provider refuses to comply with a medical treatment decision made by or on behalf of the patient … and if the refusal would in reasonable medical judgment be likely to result in the death of the patient, then the physician or other health care provider must comply with the medical treatment decision pending the completion of the transfer of the patient to a physician or health care provider willing to comply with the decision. [142]

[*247] If the legislative advances of the past forty years are to continue to be effective in achieving the patient's wishes, it is necessary that health care providers continue to be required to honor those wishes - not circumvent them by advancing notions of futility.

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[132] Id. at 9.

[133] Id.

[134] Martin Barillas, Mother Pleads to Doctor to Restore Son's Food and Water, Spero News (Aug. 20, 2012), *http://www.speroforum.com/a/RQGKOIONJQ15/73038-Mother-pleads-to-doctor-to-restore-sons-food-and-water*.

[135] Id.

[136] Id.

[137] Id.

[138] Id. In a happy epilogue to this story, a new hospital was found and the child, instead of being left to die, is now conscious, able to talk, and is receiving therapy. Rachel Bohannon, Boy Who Doctor Claimed Was in PVS State Makes Miraculous Recovery, Life News (Oct. 8, 2012), *http://www.lifenews.com/2012/10/08/boy-who-doctor-claimed-was-in-pvs-state-makes-miraculous-recovery/*.

[139] Robert Powell Ctr. for Med. Ethics, supra note 129, at 3 (citing Pam Belluck, Even as Doctors Say Enough, Families Fight to Prolong Life, N.Y. Times (Mar. 27, 2005)).

[140] Id. at 6 (citing Patricia O'Donnell, Ethical Issues in End-of-Life Care: Social Work Facilitation and Practice Intervention, in Living with Dying: A Handbook for End-of-Life Healthcare Practitioners (Joan Berzoff & Phyllis Silverman eds., 2004)).

[141] See id. at 9-10.

[142] *Okla. Stat. tit. 63, § 3101.9* (2012).

III. Defending Against Active Killing

The current cultural and legal landscapes create a serious need for patients who find themselves deprived of life-sustaining care. These patients need advocates to quickly and forcefully invoke their right to continued treatment. Persons entangled in a medical crisis are not in the best position to defend their own interests. Into this void have stepped a variety of public policy and advocacy organizations, as well as individuals who often provide support for families and contribute legal aid where needed. These organizations are often the voices for change in legislation and are the vanguard of those standing in opposition to continuing trends such as legalization of assisted suicide. Practical steps are available to protect against the involuntary removal of life-sustaining treatment, and attorneys play a paramount role in executing these steps.

A. Advance Planning

As has been hammered into the American consciousness over the last decade, pre-incapacity decision-making is an essential element of planning for the future, [143] especially for the elderly. While the methods of advance planning vary from state to state and from individual to individual, an attorney plays the essential role in assisting the client in thinking through and properly executing advance directives and powers of attorney for health care. This is often a routine part of estate planning for clients, as it makes logical sense to incorporate all aspects of end-of-life planning.

The need for advance health care planning cannot be overemphasized in its importance in protecting the patient's wishes and values. It is not, however, the end of the equation. Many living wills and other advance planning documents hailed from an era when the primary concern of a patient was the ability to refuse unwanted medical treatment. As discussed above, today the most important issue is just as likely, or more likely, to be the patient's ability to obtain wanted medical treatment. Based on the recent trend in which hospitals sometimes ignore even clearly expressed wishes of **[*248]** patient surrogates, it is unrealistic to depend upon an advance directive alone for protection against active killing. [144]

Having a clearly designated agent for health care decisions is the best protection a patient has once they become incapacitated. Directives, such as the living will, provide general, static instructions for care; they often fail to offer the flexibility needed for specific situations. An agent, on the other hand, is a person who preferably knows the patient intimately. He or she can make decisions in gray areas not covered by a directive, and can ensure that the patient's wishes are being honored. In California, as in most states, a patient may designate a surrogate to make health care decisions, [145] and may execute a power of attorney for health care by following the same procedures and observing the same formalities as are required for an advance directive. [146] Encouraging patients to take the step of designating an agent for health care decisions is a large step toward protecting their interests should they become incapacitated.

B. Advocacy

When decision-making on behalf of a patient breaks down, such as when a family member or health care provider makes a treatment decision that does not appear to be in the best interests of the patient, the need to challenge the decision on behalf of the patient becomes apparent, and is usually urgent. Responding to a hospital's refusal to continue treating a patient may involve seeking an order to restore food and fluids, or to remove a do not resuscitate order from a patient's chart. The decision to end life-sustaining treatment in a hospital environment often goes through a recommendation process from the ethics committee. Since these committees are arms of the health

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[143] See supra Part II.C.

[144] See supra Part II.C.

[145] *Cal. Prob. Code § 4711* (West 2012).

[146] *Cal. Prob. Code § 4680* (West 2012).

care provider, the committee usually sanctions the removal of life-sustaining treatment when recommended by the treating physician. The findings made by the ethics committee, and facts upon which its decision is based, may be helpful (or harmful) to the patient. If possible, the interested person who disagrees with the decision to remove life-sustaining care should seek to participate in the ethics committee process. This may be accomplished by appearing at the meeting and expressing the patient's desires, or by having an attorney present to represent the patient's interests. When health care providers continue to refuse treatment, the remaining option is usually for the patient to be transferred to a different care provider. [147]

[*249] Termination of treatment controversies may involve relatives who dispute a decision to end life-sustaining treatment for the patient. Since each individual's circumstances are unique, this may involve a variety of parties, potential claims, and problems.

As to the parties, in most states, almost anyone may challenge a decision made on behalf of an incapacitated patient. Some statutes provide for a direct challenge to the health care decision; others use the vehicle of a guardianship proceeding. For example, in California, a treatment decision may be challenged under *California Probate Code § 4765*:

[A] petition may be filed under this part by any of the following persons:

(a) The patient.

(b) The patient's spouse, unless legally separated.

(c) A relative of the patient.

(d) The patient's agent or surrogate.

(e) The conservator of the person of the patient.

(f) The court investigator, described in Section 1454, of the county where the patient resides.

(g) The public guardian of the county where the patient resides.

(h) The supervising health care provider or health care institution involved with the patient's care.

(i) Any other interested person or friend of the patient. [148]

Thus, anyone interested in the welfare of a patient is a potential party to an action on behalf of the patient in California.

In cases involving the removal of life-sustaining treatment, the potential claims center on efforts to resume treatment. In California, if efforts to convince caregivers to continue treatment are ineffective, a petition for an order authorizing medical treatment may be filed in the Superior Court. [149] It may be necessary to include a petition for an emergency ex parte order requiring the requested health care of the patient in the short term, such as an injunction prohibiting removal of a feeding tube.

The unique problems raised in litigating this type of case deserve detailed attention. The following discussion seeks to highlight a few of the more unique issues raised in litigating these cases - particularly some of the unique

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[147] See, e.g., supra Part II.C.

[148] *Cal. Prob. Code § 4765* (West 2012) (emphasis added). See also Appendix infra.

[149] *Cal. Prob. Code §§4765*-*4767* (West 2012).

evidentiary hurdles, the use of expert testimony, the use of evidence **[*250]** of the patient's condition, and specific arguments that persuade and educate throughout the trial process. [150]

1. Evidentiary Hurdles

There may be unique evidentiary hurdles involved at a hearing on a petition for removal of life-sustaining treatment. For instance, in the Wendland case, witnesses testified at pretrial hearings that the ethics committee sanctioned the requested removal of the feeding tube. [151] Later, during depositions, when questions were asked about those same ethics committee proceedings, the witnesses who had previously testified about the ethics committee hearing objected to questions on the grounds of privilege. [152] During trial, legal counsel for the hospital brought a motion to quash a subpoena requesting hospital documents from the ethics committee proceedings, also on the basis of privilege. [153] Since the ethics committee recommendation would carry weight in the final analysis, it was important for the court to be fully aware of the issues the committee considered. Eventually, the court ruled that the ethics committee proceedings were privileged, but the privilege had been waived due to the witnesses' testimony at the pretrial hearing. [154] Thus, questions regarding the hospital committee's decision process were appropriate and were within the scope of the previous testimony. Notably, this further underscores the importance of the surrogate's participation in ethics committee proceedings.

2. Use of Experts

Expert testimony will be necessary to establish standard of care, appropriate medical guidelines, and the patient's condition. In Wendland, Dr. Ronald Cranford, [155] a neurologist, provided expert testimony as to recommended guidelines for termination of the treatment of the "minimally conscious." [156] Under the guidelines he described, the parameters used to gauge whether a "minimally conscious" person should be deprived of life-giving care consisted of the following factors: (1) patient well being; (2) **[*251]** patient autonomy; (3) integrity of the medical profession; and (4) social justice or a proper allocation of resources. [157]

Some of the expert testimony presented appeared to be aimed at minimizing Robert Wendland's status as a person. Experts opined that Robert's inability to conceptualize the significance of particular tasks he performed (such as combing his hair) likened him to a "trained animal." [158] The late Dr. Ronald Cranford, criticized efforts to help Robert improve and sustain his current condition as prolonging an existence he dubbed a "living death." [159] He concluded "Robert should be allowed to die so the family can grieve." [160]

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[150] These issues arose in *Conservatorship of Wendland, 28 P.3d 151 (Cal. 2001)* (discussed supra Part II.B.4).

[151] Life Legal Def. Found., Active Killing: What the Law Allows 12 (2012).

[152] Id. at 12-13.

[153] Id.

[154] Id.

[155] The late Dr. Cranford testified at other cases of this nature. Culture of Death, supra note 19, at 200.

[156] Life Legal Def. Found., supra note 151, at 10.

[157] Id.

[158] Id. See description of Robert Wendland's condition supra Part II.B.4; see also *The Underlying Facts of Conservatorship of Wendland, supra note 97*.

[159] Life Legal Def. Found., supra note 151, at 10.

[160] Id. See also *The Underlying Facts of Conservatorship of Wendland, supra note 97*.

In rebuttal to this testimony, medical experts testified that the guidelines Dr. Cranford advocated are valid neurological assessments only insofar as they categorize patients for the purposes of treatment, such as hospital placement and treatment plans. [161] Such categories are not, and should not be, guidelines for making life and death decisions for minimally conscious or incapacitated patients. This type of rebuttal testimony is obviously essential since many are unfamiliar with appropriate medical standards.

Medical testimony is also useful in describing the dying process. It is one thing to discuss removing medical treatment, it is quite another to understand the result of removing such treatment. Indeed, the process is often far from peaceful and easy. [162]

Further, medical experts in treatment termination cases are often personally acquainted with one another, which may present difficulty in obtaining an unbiased opinion, or even any alternative opinion. The field of bioethics, including the label "bioethicist," is relatively new and unregulated. There is no licensure and few credentials officially tied to the term, and the profession lacks an official regulatory agency to maintain quality control. [163] This means that there are no governing rules of conduct for bioethicists and no remedy for improper conduct from the profession. Therefore, it is appropriate to use direct questions as to the number of cases in which the expert has testified and been consulted, the similarity of the facts of those cases, and the bases of the opinions advanced - including the expert's professional memberships, organizations, and publications.

[*252] Proponents of terminating treatment can easily misrepresent the physical and mental condition of the patient, since it is rare for the incapacitated patient herself to be in court. For example, in Terri Schiavo's case, there was dispute over the issue of whether Terri was in a persistent vegetative state (a condition that is misdiagnosed an estimated forty-three percent of the time). [164] One of the difficulties in that case was the inability to overcome the initial diagnosis of PVS. The trial court continuously reverted to this diagnosis in ruling for removal of life-sustaining care, even though there were a number of experts who expressed the opinion (out of court) that Terri had been misdiagnosed. [165]

3. Use of Technology

Video recordings are a useful tool in overcoming mischaracterizations of a patient's condition. Recordings not only show the court, but also the public (via the media), the humanity and capacity of the patient. In Robert Wendland's case, it was only after a videotape was released to the press that anyone seriously questioned whether his life-sustaining treatment should be terminated. [166] Most were under the impression he was comatose, when in fact he was conscious and able to interact with his environment. The video conveyed his humanity. [167]

4. Educating the Court

As difficult as treatment termination cases are from an emotional perspective, as a matter of litigation, they present a unique opportunity to educate on issues of utmost importance, including reaffirming the traditional equality-of-life ethic. From the initial petition, to motions, to opening statements, to closing statements - and everything in between - there are unique opportunities not only to persuade the court, but also to educate. Some of the arguments that are useful in making the case for life and educating on the issues are discussed below.

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[161] Life Legal Def. Found., supra note 151, at 10.

[162] See Forced Exit, supra note 18, at 52 (describing the painful and horrific process of starvation).

[163] Life Legal Def. Found., supra note 151, at 15-16.

[164] See Gibbs & DeMoss, supra note 79, at 26, 64.

[165] Id. at 64-65.

[166] Life Legal Def. Found., supra note 151, at 14.

[167] Id.

The law itself is premised on the notion that people have value, and therefore rights, as individual humans - this is the traditional Western ethic. [168] Thus, historically and traditionally in the United States, public **[*253]** policy has protected the weakest and most vulnerable members of society. [169] Legislation such as the Americans with Disabilities Act reaffirms that policy, prohibiting discrimination on the basis of disability. [170] Society should value and protect those who are disabled, and not see their incapacity as a license to eliminate them. Although often asserted, there is no constitutional right to die. This has been confirmed by the United States Supreme Court, [171] and remains the law of the land - statutory rights to PAS in two states notwithstanding. Traditionally and socially, physicians and others in the medical profession have the role of healers, not harmers. [172]

A decision to end treatment may not be medically sound or in the patient's best interest. Regardless of whether the patient is terminally ill, there are other treatment options available besides death through dehydration and starvation, including treatment for depression, pain, and other symptoms. Unanswered questions about the patient's medical condition should lead decision makers to err on the side of preserving life. Any improvement in a patient's condition can create hope for continued improvement. Improvement, or the promise thereof, should not, however, be the sole test by which the decision to end life should be made - the life itself still has inherent value. Although a patient can refuse continued treatment for herself through a written directive, determining the patient's wishes absent a written statement is a serious undertaking when one considers the permanent nature of the consequences: death. If there is any doubt, the safest course is to preserve life. This option, at least, is not irrevocable. [173]

Cases often turn on evidence of the patient's wishes. It is important to note the inherent unreliability in much of the testimony put forward as to what the patient's wishes would be if they could be expressed. General statements should be viewed cautiously, especially if they are undocumented and uncorroborated. Most people have made general statements at one time or another such as, "I wouldn't want to live like that." It is one thing to make such a blanket statement in casual conversation, but quite another to realize the alternative: death by dehydration and starvation. Further, evidence of a patient's wishes usually comes through family members or close friends of the patient. This raises questions as to the continued beneficence of these relatives. Care for an incapacitated patient can be burdensome. Family **[*254]** members who find the care of an incapacitated loved one tedious or unbearable may have underlying motives in wanting to terminate life-sustaining treatment. These may include inheritance, collection of life insurance proceeds, the need to move on with relationships, or simply the emotional difficulty inherent in such a painful situation. [174]

Each case will present its own unique set of facts and opportunities to educate on the issue of active killing. Some cases will never reach the litigation stage and may be resolved through some form of mediation between the parties. Whether through advocacy, litigation, mediation, or any other means, strong efforts should be made to affirm, argue, and reestablish the value of the individual - no matter the age or disability.

Conclusion

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[168] See supra Part I.

[169] Id.

[170] See *42 U.S.C. § 12101* (2012).

[171] See *Washington v. Glucksberg, 521 U.S. 702, 703 (1997)*; *Vacco v. Quill, 521 U.S. 793 (1997)*.

[172] See, e.g., *Glucksberg, 521 U.S. 702, 703-04, 731*.

[173] An unwillingness to err on the side of life, even when there is reasonable doubt, has been acknowledged as one of the most puzzling features of some of these cases, as was present in the Schiavo case. See, e.g., Gibbs & DeMoss supra note 79, at 106-08.

[174] Most of these circumstances were present in the Terri Schiavo case, although none of them were satisfactorily addressed by the court. See Forced Exit, supra note 18, at 69-71.

Law and medicine have inherited a sure foundation in the ethic that human life is worth protecting. Although the equality of human life ethic has generally been undermined, modern health care within the United States is still administered by talented and dedicated medical professionals, who, on the whole, deliver the highest standards of care. But what was once unthinkable - depriving helpless individuals of nourishment to hasten their deaths - has indeed become the unexceptionable. [175] The increasing pressure to engage in active killing of "futile" patients cannot be ignored.

All persons are equally entitled to the protection of the law and to the care of society. Those with intellectual or physical disabilities are not only included among those worthy of protection, they are especially worthy of protection. The time has come for members of the medical and legal professions, indeed all citizens, to stand up and defend this truth: all persons have inherent value, and therefore, all lives are worth protecting.

Appendix: Health Care Decisions Laws

State	Presumptive decision maker	Who may challenge treatment decision?
Alabama	Designated health care proxy, agent under power of attorney for healthcare, guardian or immediate family. Ala. Code§§22-1A-404, 8A-4, 8A-11 (2013).	Any person or health care provider who is directly involved in the care of the patient. Ala. Code § 22-8A-11(j) (2013).
Alaska	Health care agent, under durable power of attorney; guardian; surrogate decision maker-spouse, adult children, parents, and adult siblings, etc. Alaska Stat. §§13.52.010-040 (2013).	Agent, guardian, surrogate, health care provider, or the patient himself. Alaska Stat. §§13.26.090-320 (2013). Any person interested in patient's welfare may petition. §§13.26.125(a), .52.140.
Arizona	Agent under power of attorney; guardian; surrogate as follows spouse, adult child, parent, domestic partner, sibling,	Any interested person. Ariz. Rev. Stat. § 36-3206 (2012).

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[175] See Neuhaus, supra note 1.

	close friend. Ariz. Rev. Stat. §§36-3223(A)-(B), -3231(A), 14-5303(A)-(B) (2013). A surrogate who is not the patient's agent or guardian may not decide to withdraw food or fluid. §§36-3203, -3231.	
Arkansas	Health care surrogate under Durable Power of Attorney; Proxy for decisions re life sustaining treatment. Ark. Code Ann. § 20-17-201 (2012). If no designated proxy, guardian, parents of an unmarried patient under eighteen, spouse, adult child, etc. §§20-13-104, 17-214.	Any person may file petition for appointment as guardian of incapacitated person. Ark. Code Ann. § 28-65-205 (2012).
California	Agent under power of attorney for health care; designated surrogate; in conservatorship proceeding, priority of spouse, adult child, parent, sibling, other person. Cal. Prob. Code§§1812, 4643, 4685 (2012).	Patient, spouse, relative, agent or surrogate, conservator, investigator, public guardian, health care provider, or any other interested person or friend of patient. Cal. Prob. Code § 4765 (2012).
Colorado	Guardian, agent under medical durable power of attorney, proxy (spouse, parent, adult child, sibling, grandchild, or any close friend), decision-maker for medical treatment, or surrogate. Colo. Rev. Stat.§§15-18.5-103, -18.7-102 (2012).	Any of the interested persons-spouse, parent, adult child, sibling, grandchild, or any close friend. Colo. Rev. Stat. § 15-18-108 (2012).

Connecticut	Health care representative, under living will; physician to notify prior to termination of life-support: health care representative, next-of-kin (spouse, child, etc.), guardian, conservator. Conn. Gen. Stat.§§19a-575a, -580 (2012).	Person whose appointment as health care representative has been revoked. Conn. Gen. Stat. § 19a-580c (2012).
Delaware	Agent under health care directive/power of attorney for health care; if no agent or guardian: spouse, adult child, parent, sibling, grandchild, niece, or nephew. Del. Code Ann. tit. 16,§§2501, 2507(2) (2012).	Anyone with reason to believe withholding of health care is against wishes may petition the Court of Chancery for appointment of a guardian. Del. Code Ann. tit. 16, § 2511 (2012).
State	Presumptive decision maker	Who may challenge treatment decision?
District of Columbia	In absence of power of attorney for health care: guardian, court-appointed advocate, spouse, adult child, parent, adult sibling, religious superior, close friend, nearest living relative. D.C. Code § 21-2210(a) (2012).	Any person listed at left. *D.C. Code § 21-2210(e)* (2012).
Florida	Surrogate, designated health care representative; proxy at request of care facility (guardian, spouse, child, parent, etc.). Fla. Stat. §§765.202, .304, .401 (2012).	Patient's family, health care facility, attending physician, or any other interested person reasonably expected to be affected Fla. Stat. § 765.105 (2012).
Georgia	Health care agent; if no	Any interested person or the

	agent or guardian named: spouse, child, parent, sibling, grandparent, grandchild; relative in first degree; or an adult friend. *Ga. Code Ann.§§31*-9-2, -32-7 (2012).	ward. *Ga. Code Ann. § 29-4*-20 (2012).
Hawaii	Designated surrogate; if no agent or guardian, surrogate appointed from interested persons: spouse, child, parent, sibling, grandchild, or adult who has exhibited special care and concern for patient. Haw. Rev. Stat. §§327E-2, -5 (2012).	Patient's agent, guardian, or surrogate, or a health-care provider or institution involved with the patient's care may petition for change in care. Haw. Rev. Stat. § 327E-14 (2012).
Idaho	Guardian; agent under durable power of attorney; spouse, adult child, parent, relative, etc. Idaho Code §§39-4504, -4510 (2012).	Ward or any person interested in his welfare may challenge guardianship. *Idaho Code § 15-5-307* (2012).
Illinois	Designated agent; surrogate for incapacitated person without agent: guardian, spouse, adult children, patient's parents. 755 Ill. Comp. Stat. 40/25 (2012).	Health care provider, or potential surrogate decision maker. 755 Ill. Comp. Stat. 40/25(a), 40/25(d) (2012).
Indiana	Appointed health care representative; if none surrogate in following order: guardian, spouse, parent, child, sibling, or religious superior (if patient is member of religious order). Ind. Code §§16-36-1-7, -5 (2012).	A health care provider or any interested individual. *Ind. Code § 16-36-1-8* (2012).

Iowa	When patient is in terminal condition, after consultation with physician, decisions to be made by: designated attorney in fact, guardian, spouse, child, parent, sibling (in that order). *Iowa Code § 144A.7* (2012).	The principal (§ 144B.6); any person may file for conservatorship. Iowa Code § 633.566 (2012).
Kansas	Agent under power of attorney for health care. For*Kan. Stat. Ann. § 58-632* (2012).	Any person may request the appointment of a guardian for an adult with an
State	Presumptive decision maker	Who may challenge treatment decision?
	medical research consent by spouse, child, parent, relative, see § 65-4974.	impairment. Kan. Stat. Ann. § 59-3058 (2012).
Kentucky	Guardian, attorney-in-fact, spouse, adult child, parents, nearest relative. *Ky. Rev. Stat. Ann. § 311.631* (2012).	Patient, guardian, conservator, or any other interested person may petition for removal/ replacement of guardian or conservator. Ky. Rev. Stat. Ann. § 387.530 (2012).
Louisiana	If no designation by patient, judicially appointed tutor or curator, anyone previously designated by patient, souse, child, parents, sibling, etc. La. Rev. Stat. Ann. § 40:1299.58.5 (2012).	Any person may file for interdiction. La. Civ. Code Ann. art. 4541, 389, 391 (2012).
Maine	Agent under power of attorney for health care, or surrogate in following order: spouse or adult in	Patient, the patient's agent, guardian or surrogate, a health-care or social services provider,

	such relationship, adult child, parent, sibling, grandchild, niece or nephew, etc. Me. Rev. Stat. tit. 18-A,§§5-801, -802, 5-8055-806 (2012).	adult protective services, or an adult relative or adult friend of the patient. Me. Rev. Stat. tit. 18-A, § 5-814 (2012).
Maryland	If no surrogate or agent available, guardian, spouse or domestic partner, adult child, parent, brother or sister, friend or relative. Md. Code Ann., Health-Gen. § 5-605 (2012).	Health care provider; spouse, domestic partner, parent, child, grandchild, sibling, friend or other relative who has qualified as a surrogate under Md. Code Ann., Health-Gen.§§5-605, 5-612 (2012).
Massachusetts	Designated agent under health care proxy; if no designation physician may rely on consent of "responsible parties." Mass. Gen. Laws Ann. ch. 201D,§§1-4, 16 (West 2012).	Health care provider, conservator, guardian, members of the principal's family, close friend, or commissioner of public health. Mass. Gen. Laws Ann. ch. 201D, § 17 (West 2012).
Michigan	Designated patient advocate; surrogate for end of life care, member of immediate family, next of kin, legal guardian. Mich. Comp. Laws §§333.5655(b), 700.550 (2012).	A person interested in the welfare of declarant, Mich. Comp. Laws § 333.1059 (2012); interested person regarding guardianship, § 700.5303.
Minnesota	Agent under directive, or proxy, Minn. Stat. Ann. §§145B.03, 145C.07 (West 2012); guardian: order of priority of appointment includes agent, spouse, child, parent, etc. § 524.5-309.	In guardianship: incapacitated person, or person interested. Minn. Stat. Ann. § 524.5-302(h) (West 2012).
Mississippi	Agent under power of	Patient, the patient's

State	Presumptive decision maker	Who may challenge treatment decision?
	attorney for health care; surrogate, spouse, adult child, parent, sibling, or adult who has shown concern and is familiar with patient's values. Miss. Code. Ann.§§41-41-209, -211 (2012).	agent, guardian or surrogate, a health-care provider or institution involved with the patient's care, or a surrogate. Miss. Code. Ann. § 41-41-229 (2012).
Missouri	Attorney in fact; guardian (order of appointment: spouse, parents, adult children, siblings, other close adult relatives). Mo. Rev. Stat. §§404.800-865, 475.050 (2012).	In guardianship: person interested, including member of family. Mo. Rev. Stat. § 404.731(5) (2012).
Montana	Attorney-in-fact; designee under declaration relating to use of life-sustaining treatment. If no declaration: written consent by spouse, adult child, parents, siblings. *Mont. Code Ann.§§50-9-103*, -106, 72-5-501 (2012).	Any person interested in the welfare of the conservatee. *Mont. Code Ann. § 72-5-413* (2012).
Nebraska	Attorney-in-fact under power of attorney for health care, as guardian, designee, spouse, adult child, parent, relative, etc. Neb. Rev. Stat.§§30-2627, -3403 (2012).	Principal, attorney-in-fact, spouse, parent, sibling, adult child, close friend, guardian, health care provider, any other interested party. Neb. Rev. Stat. § 30-3422 (2012).
Nevada	Agent under declaration regarding life sustaining treatment, if no	In guardianship: any interested person, Nev. Rev. Stat. § 159.044 (2012).

	declaration, written consent may be by spouse, child, parents, sibling, nearest adult relative. Nev. Rev. Stat.§§449.600, .626 (2012).	
New Hampshire	Agent, under power-of-attorney for health care (in absence, no statutorily specified order). N.H. Rev. Stat. Ann. § 137-J:2 (2012).	Principal, near relative, responsible adult directly interested in principal, including guardian, social worker, physician, or clergy. N.H. Rev. Stat. Ann. § 137-J:22 (2012).
New Jersey	Health care representative. *N.J. Stat. Ann. § 26:2H-55* (West 2012). For medical research consent by guardian, health care representative, spouse, child, parent, sibling, grandchild, or relative, see § 26:14-5.	Patient, health care representative, attending physician. N.J. Stat. Ann. § 26:2H-66 (West 2012).
New Mexico	Agent under power of attorney for health care; guardian; spouse or one in similar relationship, child, parent, sibling, grandparent, person who has exhibited special care and concern. N.M. Stat. Ann. §§24-7A-1, -2, -5 (2012).	Patient, agent, guardian or surrogate, health-care provider or health-care institution. N.M. Stat. Ann. § 24-7A-14 (2012).
New York	Agent under health care proxy; if no proxy surrogate: guardian, spouse, child, parent, sibling, close friend. N.Y. Pub. Health§§2980, 2994-d (McKinney 2012).	Any person connected with the case and any member of the hospital ethics review committee. N.Y. Pub. Health § 2994-r (McKinney 2012).

State	Presumptive decision maker	Who may challenge treatment decision?
North Carolina	Guardian, heath care agent, spouse, majority decision of parents and children, siblings, person with relationship. N.C. Gen. Stat. § 90-322 (2012).	Guardian. N.C. Gen. Stat. § 32A-22 (2012).
North Dakota	Agent under health care directive, guardian, spouse, children, parents, siblings, grandparents, grandchildren, close relative or friend. N.D. Cent. Code§§23-06.5-13, 23-12-13 (2012).	Person interested in patient's welfare may object to determination of incapacity, N.D. Cent. Code § 23-12-13.5 (2012), pursuant to guardianship under § 30.1-28.01.
Ohio	Attorney in fact; for withdrawal of life support (patient must be unconscious for twelve months): guardian, spouse, child, parent, sibling, nearest relation, and then after court order. Ohio Rev. Code Ann.§§1337.13, 2133.08 (LexisNexis 2012).	Individuals authorized to consent may object to decision within forty-eight hours. Ohio Rev. Code Ann. § 2133.08(E), .09 (LexisNexis 2012).
Oklahoma	Attorney-in-fact for health care decisions, Okla. Stat. tit. 63, § 3101.16 (2012). For medical research consent by spouse, child, parent, sibling, relative, see § 3102A.	In guardianship: any interested person. Okla. Stat. tit. 30, § 3-101 (2012).
Oregon	Attorney-in-fact for healthcare; guardian; for terminal condition where not designated, guardian, spouse, person designated by	Health care representative, spouse, parents, sibling or child, relative or friend familiar with desires of principal, guardian,

	other decision-makers, children, parents, siblings, relative or friend, if none available, then physician. Or. Rev. Stat.§§127.545, .635 (2012).	conservator, attending physician or health care provider. Or. Rev. Stat. § 127.550(3) (2012).
Pennsylvania	Guardian, health care representative; if no designation: spouse, child, parent, sibling, adult with knowledge of principal's preferences. 20 Pa. Cons. Stat. § 5461 (2012).	In guardianship, person interested in the alleged incapacitated person's welfare. Pa. Cons. Stat. §§5511, 5513 (2012).
Rhode Island	Agent under health care power of attorney; in absence of designation, surrogate not specified. In guardianship, relatives, friends of individual considered. R.I. Gen. Laws §§23-4.10-2, 33-15-6(c) (2012).	In guardianship petition, any person. R.I. Gen. Laws § 33-15-2 (2012).
South Carolina	Guardian, attorney-in-fact, anyone with statutory priority, spouse, parent or child, sibling, grandparent, grandchild, or other relative. S.C. Code Ann. § 44-66-30 (2012).	Health care provider, nursing care provider, agent, or other interested person. S.C. Code Ann. § 62-5-504(H) (2012).
State	Presumptive decision maker	Who may challenge treatment decision?
South Dakota	If no agent or guardian, spouse, child, parent, sibling, grandparent or grandchild, aunt, uncle,	Incapacitated person, person authorized to make a health care decision, health care provider, or any other

	cousin, niece or nephew, or close friend. S.D. Codified Laws § 34-12C-3 (2012).	interested person. S.D. Codified Laws § 34-12C-5 (2012).
Tennessee	If no guardian or agent, a surrogate may be designated by patient or appointed from the following: spouse, child, parent, sibling, other adult relative, person familiar with patient and his values. Tenn. Code Ann. § 68-11-1806 (2012).	Patient, patient's agent, guardian, surrogate, health care provider, or individual described in Tenn. Code Ann. § 68-11-1806(c)(5) (2012).
Texas	Medical power of attorney/ agent; if no directive, surrogate: spouse, children, etc. Tex. Health & Safety Code Ann. § 166.039 (West 2012).	Patient's guardian, any person who is a relative or directly interested. Tex. Health & Safety Code Ann. § 166.165 (West 2012).
Utah	Agent under directive, guardian; in absence of directive: spouse, parent, sibling, grandchild or grandparent; person who has exhibited special care. *Utah Code Ann. § 75-2a-108* (LexisNexis 2012).	Health care provider, patient, agent, guardian, surrogate, health care provider or facility or default surrogate. Utah Code Ann.§§75-2a-108(7), -120 (LexisNexis 2012).
Vermont	Agent under advance directive, or guardian. Any "interested individual" can request reevaluation of patient's capacity. "Interested individual" means: spouse, child, parent, sibling, grandchild, reciprocal beneficiary, etc. Vt. Stat. Ann. tit. 14, § 3069(b)(5), tit. 18, §§9701, 9706(c), 9711 (2012).	Principal, guardian, agent, ombudsman, or interested individual (see prev.), social worker, defender general, state advocate. Vt. Stat. Ann. tit. 18, § 9718 (2012).

State	Presumptive decision maker	Who may challenge treatment decision?
Virginia	Agent under advance directive; when no directive: guardian, spouse, child, parent, sibling, other relative in descending order of blood relationship, or (if not involving life-sustaining treatment) adult who has special care, quorum of patient care consulting committee. Va. Code Ann. §§54.1-2983, -2986 (2012).	Any person. Va. Code Ann. § 54.1-2985.1 (2012).
Washington	Guardian, designated attorney-in-fact, spouse, children, parents, siblings. Wash. Rev. Code § 11.94.010 (2012); § 7.70.065 (informed consent for incapacitated person).	Attorney-in-fact, principal, spouse, guardian, any other person, interested in principal's welfare. Wash. Rev. Code§§11.94.090, .100 (2012).
West Virginia	Medical power of attorney representative; if not designated, surrogate decision maker, chosen by the caregiver from roster of close family, friends, or any other person designated by the Department of Health and Human Resources. W. Va. Code§§16-30-3, -4, -8-9 (2012).	Other "potential" surrogate; challenger may seek injunctive relief or file a petition for review. W. Va. Code § 16-30-8(e) (2012).
Wisconsin	Agent under power of attorney for health care. *Wis. Stat. § 155.05* (2012). For commitment to certain facilities: if no power of	Any interested party. Wis. Stat. § 155.60(4)(a) (2012).

	attorney for health care or guardian, spouse, child, parent, sibling, grandparent, grandchild, then close friend. § 50.06(3).	
Wyoming	Agent under power of attorney for health care; guardian or surrogate: spouse, child, parent, grandparent, sibling, grandchild; or individual who showed special care. Wyo. Stat. Ann.§§35-22-402, -406 (2012).	Patient, agent, guardian or surrogate, or health care provider. Wyo. Stat. Ann. § 35-22-415 (2012).

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