In Re Michael Martin, a Legally Incapacitated Person; MARY MARTIN, Guardian and Conservator of MICHAEL MARTIN, v. LEETA M. MARTIN and PATRICIA MAJOR.

SUPREME COURT OF MICHIGAN
1995
450 Mich. 204; 538 N.W.2d 399

[edited by SA; most footnotes and citations omitted]

MALLETT, J.

We granted leave in this case to consider whether life-sustaining treatment in the form of a gastrostomy tube that provides nutritive support should be removed from a conscious patient who is not terminally ill or in a persistent vegetative state, but who suffers from a mixture of cognitive function and communication impairments that make it impossible to evaluate the extent of his cognitive deficits.

The trial court determined that there was clear and convincing evidence that, before his injuries, Michael Martin "expressed [a medical] preference to decline life-sustaining medical treatment under the circumstances presented . . . ." The Court of Appeals affirmed the trial court's determination.

After painstaking review of the facts of this case, we reverse the Court of Appeals decision because we conclude that there is not clear and convincing proof that Michael made a firm and deliberative decision, while competent, to decline medical treatment in these circumstances.

As we begin our analysis, we are mindful that the paramount goal of our decision is to honor, respect, and fulfill the decisions of the patient, regardless of whether the patient is currently competent. The decision to accept or reject life-sustaining treatment has no equal. We enter this arena humbly acknowledging that neither law, nor medicine nor philosophy can provide a wholly satisfactory answer to this question.

To err either way has incalculable ramifications. To end the life of a patient who still derives meaning and enjoyment from life or to condemn persons to lives from which they cry out for release is nothing short of barbaric. If we are to err, however, we must err in preserving life.

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II A

The right to decline life-sustaining treatment has been based on constitutional, common-law, and statutory sources. The Court of Appeals in In Re Rosebush, 491 N.W.2d 633 (1992), delineated the three sources of the right as follows:

> (1) the common-law right to freedom from unwanted interference with bodily integrity,
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> (2) the constitutional right to privacy or liberty, or
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> (3) statute.

By deciding that Michigan recognizes "a right to withhold or withdraw life-sustaining medical treatment as an aspect of the common-law doctrine of informed consent," the Rosebush Court found it "unnecessary to decide the validity of the constitutional or statutory bases in Michigan." As a prominent commentator in this area has noted, "the legal basis for the right to die is not important because courts have not made the scope of the right depend on whether or not the source is common-law, statutory, or constitutional." Meisel, The Right to Die, § 3.4, p 50. Because the evidentiary and decision-making standards appropriate in a given case do not depend on the source of the right, we need only ground the right in one source.

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Thus, because we find that the common-law doctrine of informed consent allows a person to refuse life-sustaining treatment, we also decline the invitation to reach the propriety of the constitutional and statutory issues in this case.

Given that a competent patient may decide to refuse medical treatment, the next inquiry is whether a decision to refuse medical treatment under the particular circumstances, made while competent, should be honored when the patient is incompetent. Other jurisdictions that have addressed this question have unanimously concluded that a decision to refuse medical treatment in future situations, made while competent, is not lost because of incompetency or the inability to communicate. We wish to make clear that we are deciding only that to the extent the right to refuse medical treatment "refers to decisions already made and communicated by the patient before losing the capacity to make further choices, . . . it is true that the patient's interest in having those choices honored must survive incapacity." The sirens' lure of invented consent: A critique of autonomy-based surrogate decisionmaking for legally-incapacitated older persons, 42 Hastings LJ 779, 806 (1991).

A third person must implement an incompetent patient's previously expressed decisions. Michigan's patient advocate act, MCL 700.496; MSA 27.5496, supports allowing a third person to execute the decisions of patients who are no longer able to effectuate those decisions for themselves. Pursuant to the patient advocacy act, n11 a currently competent person designates a surrogate, the patient advocate, to make treatment decisions in the event the patient is incapacitated. A proper designation allows a third person to execute the patient's treatment decisions, even if the decision will result in death, provided the patient is in the condition delineated in the patient advocate designation.

III

Having concluded that a person's right to refuse life-sustaining medical treatment survives incompetency and may be discharged by a surrogate decisionmaker, we now address how the surrogate effectuates the incompetent patient's decision.

While the facts of this case present an issue of first impression in Michigan, we find guidance in the decisions of our sister states that have addressed the possible surrogate decision-making standards.

Courts have created "two traditional [decision-making] standards for guiding guardians in carrying out their responsibilities: the best interests

standard and the substituted judgment standard." The best interest standard is an objective analysis under which the benefits and burdens to the patient of treatment are assessed by the surrogate in conjunction with any statements made by the patient if such statements are available. The best interest analysis is generally invoked, if at all, only as a secondary approach when subjective evidence of a particular patient's decision is lacking because it involves a qualitative assessment of the patient's condition, a decision the state may legitimately decline to make.

The substituted judgment standard has subjective and objective components. Through this standard, the surrogate attempts to ascertain, with as much specificity as possible, the decision the incompetent patient would make if he were competent to do so. The surrogate first determines whether the patient, while competent, explicitly stated his intent regarding the type of medical treatment in question. In Re Westchester Co Medical Center, 72 N.Y.2d 517; 534 (1988). Where there is no explicit evidence of what the patient would choose, the surrogate may still decide to terminate treatment on the basis of evidence of the patient's "value system." The surrogate should determine the patient's "value system" through an assessment of the patient's behavior during the time he was competent

"including his or her philosophical, religious and moral views, life goals, values about the purpose of life and the way it should be lived, and attitudes toward sickness, medical procedures, suffering and death . . ." [In Re Jobes, 529 A.2d 434 1987), quoting Newman, Treatment refusals for the critically ill: Proposed rules for the family, the physician and the state, III N Y L S Human Rights Annual 45-46 (1985).]

Courts have generally acknowledged that the substituted judgment standard entails some level of objective analysis. For this reason, commentators, as well as many judges, have forcefully assailed the substituted judgment standard as a legal fiction that in reality substitutes the surrogate's decision to withdraw treatment for that of the patient.

Rather than choose between the best interest standard and the substituted judgment standard, the New Jersey Supreme Court attempted to synthesize these two standards by creating an hierarchical decision-making continuum. The starting point on the continuum is anchored by a purely subjective analysis, an approach that requires more definitive evidence of what the patient would choose than the substituted judgment standard. The other end of the continuum is anchored by a purely objective analysis, which is, in essence, a best interest standard.

We find that a purely subjective analysis is the most appropriate standard to apply under the circumstances of this case. The pure subjective standard allows the surrogate to withhold life-sustaining treatment from an incompetent patient "when it is clear that the particular patient would have refused the treatment under the circumstances involved." Given that the right the surrogate is seeking to effectuate is the incompetent patient's right to control his own life, "the question is not what a reasonable or average person would have chosen to do under the circumstances but what the particular patient would have done if able to choose for himself." The patient's statements, made while competent, must illustrate "a firm and settled commitment to the termination of life supports under the circumstances like those presented." In Re Westchester Co Medical Center, supra at 531.

The subjective and objective standards involve conceptually different bases for allowing the surrogate to make treatment decisions. The subjective standard is based on a patient's right to self-determination, while the objective standard is grounded in the state's *parens patriae* power. An objective, best interest, standard cannot be grounded in the common-law right of informed consent because the right and the decision-making standard inherently conflict. The Illinois Supreme Court recently explained this conflict:

> The problem with the best-interests test is that it lets another make a determination of a patient's quality of life, thereby undermining the foundation of self-determination and inviolability of the person upon which the right to refuse medical treatment stands.

Thus, while the facts of the present case do not require that we decide whether the state's *parens patriae* authority may be expansive enough to encompass a best interest analysis, we do note that such an analysis cannot be based on the common-law right of informed consent.

Although respondent accurately notes that the Florida Supreme Court in In Re Guardianship of Browning, 568 So.2d 4, 13 (Fla., 1990), believed that the common-law right of self-determination "cannot be qualified by the condition of the patient," any move from a purely subjective standard to an analysis that encompasses objective criteria is grounded in the state's *parens patriae* power, not in the common-law right of informed consent or self-determination. Thus, while the clearly expressed wishes of a patient, while competent, should be honored regardless of the patient's condition, we find nothing that prevents the state from grounding any objective analysis on a threshold requirement of pain, terminal illness, foreseeable death, a persistent vegetative state, or affliction of a similar genre.

While the circumstances of some cases have led courts to progress along the decision-making continuum and apply tests that encompass more objective criteria, the facts of this case do not present us with that situation. In the cases that have applied a more objective test or suggested that an objective test would be proper, the patient generally has been comatose or in a persistent vegetative state, In Re Jobes, supra; In Re Torres, 357 N.W.2d 332 (Minn, 1984) (terminally ill); In Re Guardianship of Barry, 445 So. 2d 365 (Fla App, 1984) (experiencing great pain); Conroy, supra at 365 (very limited life expectancy); In Re Rosebush, supra (never been competent or able to express her wishes or desires). In this case, Michael's life and health are not threatened by infirmities of this nature. Because he was competent and able to express his wishes and desires, we decline to move along the continuum from the subjective standard. By all accounts, Michael is not experiencing any type of pain that would outweigh any enjoyment or pleasure he is experiencing.

In all cases where the courts have been persuaded that the patient, while competent, made clear and convincing statements that he would reject treatment under the circumstances at issue, the patient's decision has been honored, regardless of whether the patient is currently competent. The Kentucky Supreme Court recently noted that all but Missouri and New York n18 would allow treatment to be withdrawn under a substituted judgment standard even where the express wishes of the patient are unclear. Missouri and New York only allow treatment to be withheld when it is clear that the particular patient, while competent, expressly decided to reject treatment in the circumstances presented. In Re Westchester, supra at 531-532.

The subjective standard has been attacked as possibly creating too stringent a standard, inhumanely condemning a patient to a "prolonged and painful death," however, the facts of this case do not dictate that we progress beyond a purely subjective standard, and we refuse to do so. We cannot stress too strongly that the complexity and ramifications of any decision in this area caution against moving too swiftly or adopting controversial decision-making standards in cases that do not present facts compelling such decision. The right of informed consent extends only to the decisions this particular patient has made. Any objective analysis is not encompassed within the right of informed consent. As we noted at the outset, if we are to err, we must err in preserving life. Our first step in this area must be a careful one.

IV

Having concluded that a surrogate may make treatment decisions for a patient who is unable to do so on the basis of that specific patient's statements made while competent, we must now decide the evidentiary standard of proof those statements must meet before the surrogate is allowed to effectuate them.

Proof may be required by a preponderance of the evidence, by clear and convincing evidence, or beyond a reasonable doubt. The predominant evidentiary standard chosen by the courts that have addressed this question, however, is clear and convincing evidence.

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We agree that the clear and convincing evidence standard, the most demanding standard applied in civil cases, n21 is the proper evidentiary standard for assessing whether a patient's statements, made while competent, indicate a desire to have treatment withheld. Evidence is clear and convincing when it

> "produces in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, evidence so clear, direct and weighty and convincing as to enable [the factfinder] to come to a clear conviction, without hesitancy, of the truth of the precise facts in issue." . . . Evidence may be uncontroverted, and yet not be "clear and convincing." . . . Conversely, evidence may be "clear and convincing" despite the fact that it has been contradicted. [In Re Jobes, supra at 407-408.]

Among the factors identified as important in defining clear and convincing evidence, the predominant factor is "a prior directive in which the patient addresses the situations in which the patient would prefer that medical intervention cease." Cantor, Legal Frontiers of Death and Dying, ch.3, p64. Optimally, the prior directive would be expressed in a living will, patient advocate designation, or durable power of attorney. While a written directive would provide the most concrete evidence of the patient's decisions, and we strongly urge all persons to create such a directive, we do not preclude consideration of oral statements, made under the proper circumstances.

The amount of weight accorded prior oral statements depends on the remoteness, consistency, specificity, and solemnity of the prior statement. The decision-maker should examine the statement to determine whether it was a well thought out, deliberate pronouncement or a casual remark made in

reaction to the plight of another. In Re Westchester Co Medical Center, at 529. Statements made in response to seeing or hearing about another's prolonged death do not fulfill the clear and convincing standard.

> If such statements were routinely held to be clear and convincing proof of a general intent to decline all medical treatment once incompetency sets in, few nursing home patients would ever receive life-sustaining medical treatment in the future. The aged and infirm would be placed at grave risk if the law uniformly but unrealistically treated the expression of such sentiments as a calm and deliberative resolve to decline all life-sustaining medical assistance once the speaker is silenced by mental disability.

While the degree of similarity between the physical conditions contemplated in the patient's prior statement and the patient's current physical situation also partakes of the fiction of substituted judgment, we do not exclude it as a factor to be considered in assessing the probative value of the prior statement. Only when the patient's prior statements clearly illustrate a serious, well thought out, consistent decision to refuse treatment under these exact circumstances, or circumstances highly similar to the current situation, should treatment be refused or withdrawn. In all events, the proofs in sum must meet the exacting standard of clear and convincing evidence.

V

In the present case, appellants claim that Mr. Martin expressed a pre-accident statement that he did not want to live like a vegetable. However, our review of the record reveals that virtually all the witnesses agreed that Mr. Martin is not in a vegetative state and is not suffering from the type of incapacitation referenced in his expression of a desire not to continue life-sustaining medical treatment.

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Conclusion

We hold that, once it is determined that the individual is conscious and was competent at some time before his present injuries were sustained, a surrogate decision-maker cannot make a decision for or in place of a conscious incapacitated individual regarding his decision to waive the right to continue life-sustaining medical treatment. However, where the surrogate decision-maker can establish by clear and convincing evidence that the conscious incapacitated individual, while competent, made a statement of his desire to refuse life-sustaining medical treatment under these circumstances, then the surrogate must be allowed to effectuate the incapacitated individual's expressed preference. In the absence of clear and convincing evidence of the conscious incapacitated individual's pre-injury statement expressing his decision to refuse life-sustaining medical treatment under the present circumstances, courts will not authorize the removal of life-sustaining medical treatment.

Accordingly, we reverse the Court of Appeals determination because petitioner's testimony and affidavit do not constitute clear and convincing evidence of Mr. Martin's pre-injury decision to decline life-sustaining medical treatment in the form of a gastrostomy tube that provides hydration and nutritive support.

LEVIN, J. (dissenting)

Two issues are presented. The first is whether the trial court clearly erred in finding by clear and convincing evidence that before his injuries, Michael Martin expressed a medical "preference to decline life-sustaining medical treatment under the circumstances presented."

The second asks what showing, if any, justifies the withdrawal of life-sustaining medical treatment in the absence of clear and convincing evidence of such pre-injury wishes.

I dissent from the majority's holdings on both issues. On the second issue, I do not agree with the majority that, on the facts of this case, life-sustaining medical treatment can only be removed with clear and convincing evidence of the patient's expressed pre-injury wishes. I would not reach the question what showing, other than clear and convincing evidence, would justify withdrawal of life-sustaining medical treatment, because the trial court did not clearly err in finding that clear and convincing evidence was presented that Michael Martin, before his injury, did not want to be kept alive in his current condition.

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The majority characterizes its ruling as a cautious approach to a life-or-death decision. It suggests that "'an erroneous decision not to terminate [life-sustaining medical treatment] results in a maintenance of the status quo'" and that such an error can be corrected in the future. But keeping Michael Martin alive is not the neutral, safe solution. As Justice Brennan stated in Cruzan,

> from the point of view of the patient, an erroneous decision in either direction is irrevocable. An erroneous decision to terminate artificial nutrition and hydration, to be sure, will lead to . . . complete brain death. An erroneous decision not to terminate life support, however, robs a patient of the very qualities protected by the right to avoid unwanted medical treatment. His own degraded existence is perpetuated; his family's suffering is protracted; the memory he leaves behind becomes more and more distorted.

The majority's tightly constricted inquiry greatly increases this risk. In this case, it has sentenced Michael Martin to life in a helpless, degraded condition against his prior wishes. To quote the majority's own opinion, "to condemn persons to lives from which they cry out for release is nothing short of barbaric."

Dissent footnote #23

For various reasons, most persons neglect to formalize their wishes this way, even though they may feel strongly about them. Appellants also argue that even if clear and convincing evidence exists of Michael's pre-accident wishes not to continue life-sustaining medical treatment in this situation, he has since changed his mind. They claim that he has shown "a present desire to accept treatment . . ." The majority does not reject this contention. The evidence, however, demonstrates that Michael lacks the ability to understand or express a decision about ending his life.

The majority does not question the trial court's ruling that "Michael does not have, nor will he regain, sufficient decision-making capacity with respect to a decision to withdraw life-sustaining medical treatment." Several physicians testified at trial that Michael has only a very limited comprehension of his condition. Doctors testified that he lacks the capacity to "understand [the treatment choices,] or the consequences of those." One physician opined that Michael could comprehend a question phrased in terms of "does he want to live or die?" Another doctor disagreed, however.

Michael lacks the ability to communicate. The guardian *ad litem* testified that Michael "is unable to communicate on any meaningful level." Appellants point to Michael's head nods and constant smile as evidence of his desire to live. But the head nods given "in response" to questions are far too inconsistent to allow him to communicate with any effectiveness.

In light of Michael's inability to express or even understand such a choice, appellants' claim that he has changed his mind about life-sustaining medical treatment seems overly optimistic at best. Their well-intentioned hopes should not be allowed to override the wishes he clearly expressed while competent.