

# THE VARIABILITY OF SCHIZOPHRENIA AND ITS EFFECTS ON PROCREATIONAL AUTONOMY

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## I. INTRODUCTION

The justice system recognizes and attempts to uphold individual autonomy because “[it] is vitally important, even precious—after all, it’s central to who we are as humans on the planet, with free will and self-ownership.”<sup>1</sup> The Supreme Court of the United States in *Planned Parenthood of Southeastern Pennsylvania v. Casey* affirmed that, “[o]ur law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education.”<sup>2</sup> Specifically, the Court acknowledged *Roe v. Wade* as creating a rule “of personal autonomy and bodily integrity”<sup>3</sup> as it reaffirmed “a woman’s right to choose to have an abortion . . . and to obtain it without undue interference from the State . . . .”<sup>4</sup> These holdings call for legislatures and courts to provide all women with an unencumbered opportunity to exercise their autonomy through their right to these fundamental choices.

While California recognizes that the “right to exercise choice over matters of procreation is fundamental and may not be denied to an individual on the basis of disability,”<sup>5</sup> the legislature has yet to enact statutes protecting some of the most vulnerable populations, including women with schizophrenia and other disorders which impair decision-making. Schizophrenia presents especially grievous ethical challenges because it is particularly variable, making it unclear at any moment whether a schizophrenic woman is capable of making a competent choice that aligns

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1. Dora W. Klein, *Autonomy and Acute Psychosis: When Choices Collide*, 15 VA. J. SOC. POL’Y & L. 356, 393 (2008) (quoting ELYN R. SAKS, *THE CENTER CANNOT HOLD: MY JOURNEY THROUGH MADNESS* 262 (2007)) (discussing the interplay between schizophrenia and individual autonomy). Professor Elyn Saks is an accomplished law professor and expert in mental health who has written on relevant topics such as her struggle with schizophrenia and antipsychotics, as well as competency to refuse treatment.

2. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992).

3. *Id.* at 857.

4. *Id.* at 834.

5. CAL. PROB. CODE § 1950 (West 1991). *But cf.* *Conservatorship of Valerie N.*, 707 P.2d 760, 784–85 (Cal. 1985); *In re Grady*, 426 A.2d 467, 481 (N.J. 1981) (allowing for the sterilization of an incompetent woman if there is clear and convincing evidence that it is in her best interest). Justice Bird dissents while arguing that the right to procreate is “paramount” to the “right to be sterilized” because “[s]terilization results in a complete and irrevocable deprivation of the right to procreate while restrictions on an individual’s activities resulting from a ban on sterilization constitute at most a partial deprivation of that individual’s liberty.” *Conservatorship of Valerie N.*, *supra*, at 793 (Bird, J., dissenting).

with her true will.<sup>6</sup> At the same time, women with schizophrenia experience an equal number of pregnancies as do women without this disability, which demonstrates the urgent need to address these issues.<sup>7</sup> As this Note will demonstrate, absent a clear source of law to address these concerns, this population's procreational autonomy is unconstitutionally threatened.<sup>8</sup> The policy proposed in this Note aims to diminish some of the current barriers that prevent an incompetent woman from exercising her right to choose whether to have an abortion or to remain pregnant.

Section II of this Note provides some background on schizophrenia, including complexities that make it difficult for physicians and surrogate decision-makers to know which expressions should be honored as authentic in order to protect a schizophrenic woman's autonomy. Section III explains how the inquiry in Section II is further complicated by the fact that abortion is a "choice" right which requires the exercise of a rational choice to be made in order for the right to be properly exercised. First, Section III(A) explains the difference between choice rights and non-choice rights, while Section III(B) then provides judicial support regarding abortion as a choice right. Next, Section IV describes what capabilities a woman must have in order to make an autonomous choice regarding whether or not to have an abortion. Section V(A) explains how surrogate decision-makers can step in when a schizophrenic woman is unable to properly exercise her right to choose an abortion. Section V(B) describes the various ways in which a surrogate receives her authority as well as the types of court-appointed surrogates currently assigned in California.

Section V(C) explains the multiple standards available to govern a surrogate's decision-making process, some of which may violate a woman's autonomy and therefore are unconstitutional. Section VI then analyzes California's approach to and shortcomings in providing a disabled woman with the ability to choose or deny an abortion through a surrogate decision-maker. By comparison, Section VII examines Florida's and New York's approach to the same issue, both of which also fail to fully promote a woman's autonomy throughout the process. Finally, Section VIII proposes a policy which, if implemented, would provide California with clear policies that allow a woman with schizophrenia methods through which to best exercise her constitutional right to choose whether or not to have an abortion, regardless of her level of competence.

## II. SCHIZOPHRENIA AND ITS COMPLEXITIES

Schizophrenia is a "chronic and severe mental disorder that affects how a person thinks, feels, and behaves," resulting in the individual feeling as if she has "lost touch with reality."<sup>9</sup> It is a "heterogeneous" illness defined as including at least two of the following symptoms: delusions, hallucinations,

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6. Laurence B. McCullough et al., *Ethical Challenges of Decision Making with Pregnant Patients Who Have Schizophrenia*, 187 AM. J. OBSTETRICS & GYNECOLOGY 696, 698 (2002).

7 *Id.* at 696.

8. This is troublesome because it "effectively denies incapacitated women an integral aspect of their reproductive rights." Elizabeth Ann McCaman, *Limitations on Choice: Abortion for Women with Diminished Capacity*, 24 HASTING'S WOMEN'S L.J. 155, 173 (2013).

9. *Schizophrenia*, NAT'L INST. OF MENTAL HEALTH, <https://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml> (last revised Feb. 2016).

disorganized thinking, grossly disorganized or abnormal motor behavior, and negative symptoms.<sup>10</sup> Among these symptoms, delusions and/or hallucinations must be present.<sup>11</sup> These symptoms often result in an inability to distinguish between “real and unreal experiences” as well as “trouble with thinking.”<sup>12</sup>

Within the varyingly present symptoms, the severity, frequency, and duration of which an individual experiences them are vastly different.<sup>13</sup> Furthermore, the symptoms present in any one individual may change from one year to the next.<sup>14</sup> Because the subtypes of schizophrenia are defined according to the “predominant” symptoms present, and these symptoms may vary yearly, individuals may be diagnosed with different subtypes of schizophrenia throughout their lifetime.<sup>15</sup>

Although the exact cause of the disability in each individual may vary, it is likely a combination of “genetic and environmental factors” as well as major life stresses.<sup>16</sup> Individuals with schizophrenia can often learn to control their symptoms through various therapies including drug and psychosocial therapies.<sup>17</sup> However, while some people with schizophrenia may one day lead a close to normal life, many are left requiring the assistance of family, friends, and professionals due to the severity and consistency of their symptoms.<sup>18</sup>

There are two important aspects of schizophrenia that are relevant to this discussion. First, most individuals with schizophrenia were previously free from the disability and its psychotic symptoms.<sup>19</sup> While schizophrenic symptoms in women begin to surface between their late teens to mid-thirties, the first psychotic episode usually occurs in the late twenties.<sup>20</sup> Moreover,

10. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 99 (5th ed. 2013). Negative symptoms “describe thoughts or behavior that the person used to have before they became ill but now no longer have or have to a lesser extent.” On the other hand, positive symptoms are those that the person did not possess before but which have now been “added to their psyche.” *Negative Symptoms of Schizophrenia: Understanding Them*, LIVING WITH SCHIZOPHRENIA, <https://www.livingwithschizophreniauk.org/advice-sheets/negative-symptoms-understanding> (last visited Apr. 3, 2019).

11. *Id.* A delusion is a “belief that is so against the evidence and reason that it must be the product of derangement.” RESTATEMENT (THIRD) OF PROP.: WILLS AND OTHER DONATIVE TRANSFERS § 8.1 cmt. s (2001). Hallucinations can be either auditory or visual. *What Are Hallucinations?*, WEBMD, <https://www.webmd.com/brain/what-are-hallucinations#1> (last visited Apr. 3, 2019).

12. *What is Schizophrenia?*, AM. PSYCHIATRIC ASS’N, <https://www.psychiatry.org/patients-families/schizophrenia/what-is-schizophrenia> (last updated July 2017).

13. *Id.* The cause of schizophrenia is also different for different people. It may be the result of “chemistry and brain structure,” “family history,” or problems during pregnancy. *Schizophrenia*, HEALTHLINKBC, <https://www.healthlinkbc.ca/health-topics/aa46937> (last updated Dec. 7, 2017).

14. *Types of Schizophrenia*, PSYCH CENTRAL, <https://psychcentral.com/lib/types-of-schizophrenia> (last updated Oct. 8, 2018).

15. *See* AM. PSYCHIATRIC ASS’N, *supra* note 10.

16. *What is Schizophrenia?*, *supra* note 12. Some environmental factors believed to be linked to schizophrenia include exposure to viruses, malnutrition before birth, problems during birth, and psychosocial factors. Genetic factors including “chemical reactions of the brain involving the neurotransmitters . . . dopamine and glutamate.” NAT’L INST. OF MENTAL HEALTH, *supra* note 9.

17. NAT’L INST. OF MENTAL HEALTH, *supra* note 9.

18. *Id.*

19. *See id.*

20. *Id.* The DSM-V explains that “[e]arlier age at onset has traditionally been seen as predictor of worse prognosis.” Because males usually experience their first psychotic episode in their early to mid-twenties, this leads to a generally “worse outcome” for men. AM. PSYCHIATRIC ASS’N, *supra* note 10, at 46.

while onset can be abrupt, it is usually “slow and gradual.”<sup>21</sup> Unlike many other types of disabilities, an individual with schizophrenia usually lives their entire childhood and some of her early adulthood free from the disability and able to make choices and develop preferences and values unencumbered by the symptoms which may later preclude this. This delay in onset provides an opportunity for a woman to express her values, desires, and preferences to her family and friends for many years prior to onset. Due to its gradual inception, she may even create an advance health care directive<sup>22</sup> for her future medical needs.<sup>23</sup>

Second, schizophrenia is variable in many ways, and therefore provides a unique situation where a woman may be incompetent with regards to a specific task in one moment, but more or even fully competent in the next.<sup>24</sup> A schizophrenic woman may be able to competently articulate her values and desire to have a child one day, and then enter into a psychotic episode where she might express paranoid beliefs about the fetus the next day.<sup>25</sup> For example, the woman may believe that her fetus is an alien that “needs to be expelled from her body,”<sup>26</sup> even though she previously understood the reality of her pregnancy and desired to keep the child. This variability creates uncertainty in the amount of weight to give a woman’s expressed preferences at any given moment.<sup>27</sup> As a result, her autonomy is threatened if her expressed desires during a psychotic episode are given too much weight, or on the other hand, her rationally created expressions are given too little weight, leading to an outcome in opposition to her true will.<sup>28</sup> Moreover,

21. *Id.*

22. An advance directive is a document that a person fills out that designates a surrogate decision-maker who must “make decisions in accordance with the principal’s relevant instructions.” *Advance Care Directive*, BLACK’S LAW DICTIONARY (10th ed. 2014); Cameron Stewart, *Advanced Directives, the Right to Die and the Common Law: Recent Problems with Blood Transfusions*, 23 MELB. U. L. REV. 161, 162 (1999) (describing advance directives as the “right to make binding anticipatory decisions”).

23. Sarah Baddeley, *Guardianship and the Abortion: A Model for Decision-Making*, 9 J. HEALTH & BIOMEDICAL L. 493, 494 n.3 (2014) (Most people fail to complete advance directives even though they “can make decision making easy when a person becomes incapacitated,” because “young, healthy people do not anticipate needing an advanced directive.”).

24. See McCullough, *supra* note 6 (explaining that “schizophrenia can disrupt one or more of the seven steps of exercising the capacity for autonomous decision making over time and to varying degrees”). See generally John H. Coverdale et al., *Assisted and Surrogate Decision Making for Pregnant Patients Who Have Schizophrenia*, 30 SCHIZOPHRENIA BULLETIN 659 (2004). Furthermore, the predominant symptoms present in an individual with schizophrenia can change from year to year and throughout his or her lifetime. PSYCH CENTRAL, *supra* note 14.

25. See McCullough, *supra* note 6. Likewise, a woman could competently articulate her disdain for having children one day, and then enter in to a psychotic episode the following day where she expresses a desire to have a child.

26. *Id.*

27. See generally *In re Yetter*, 62 Pa. D. & C.2d 619 (1973) (distinguishing a schizophrenic woman’s expression made under psychosis from those made while competent). The issue of variability is not confined to schizophrenia; it presents problems of ambivalence whenever a conservator must make a decision for a conservatee. For example, a court reversed a finding that an elderly woman was incompetent to make a decision regarding the amputation of her foot because she repeatedly changed her mind about the procedure and expressed confusion over other matters. Instead, the court held that, although her decision would likely lead to her death, she was competent to reject treatment. See generally *Lane v. Candura*, 376 N.E.2d 1232 (Mass. App. Ct. 1978).

28. See Klein, *supra* note 1, at 389. True autonomy is more than just making choices. It must include positive freedom, not merely freedom from external force (negative freedom), but also freedom from internal constraint.

Allowing someone who is experiencing acute psychotic symptoms to refuse treatment might promote negative autonomy but only by sacrificing positive autonomy; or conversely, compelling treatment might sacrifice negative autonomy but promote positive autonomy. Under this more comprehensive view of autonomy, whether involuntary treatment is justified

because the severity and symptoms vary from individual to individual, it is difficult to create bright-lined policies and procedures for providing assistance to individuals with this disability.

### III. ABORTION AS A “CHOICE” RIGHT

#### A. DEFINING CHOICE RIGHTS

There is a stark difference between legal rights that are choice rights and those that are not. Choice rights allow the rights holder to choose “both  $X$  and not- $X$  . . . and therefore limit the government’s power to restrain or compel  $X$ .”<sup>29</sup> Substantive examples of choice rights include the freedom of speech and religious practice.<sup>30</sup> Holders of these choice rights can choose whether to engage in speech or religious practices or, on the other hand, they can choose not to engage in speech or religious practices.<sup>31</sup> Similarly, the right to counsel in criminal cases is a procedural choice right; the defendant can choose to be represented by counsel or deny representation.<sup>32</sup> In these examples, the government cannot either compel an individual to choose to engage in or refrain from these rights. In the abortion context, one can choose either to have an abortion or not to have an abortion and carry the child to term. This freedom to prohibit “both restraint and coercion” and the freedom to “choose whether or not to do  $X$ ” provides choice rights with an extra layer of autonomy.<sup>33</sup>

In contrast, some rights “can be invoked in only one direction,” and therefore do not guarantee both the ability to exercise the right as well as the ability to deny the right.<sup>34</sup> For example, a criminal defendant’s right to a speedy trial is a “one way” right, as the defendant cannot also demand the right to a “slow” trial.<sup>35</sup> On the other hand, some rights only guarantee protection from “government coercion but not government restraint.”<sup>36</sup> For

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might depend upon whether the gain in positive freedom outweighs the loss in negative freedom.

*Id.* Theorists also vary on the degree of importance they place on external conditions in determining autonomy. Some argue that true personal autonomy requires certain “external enabling conditions . . . which are more than less out of the agent’s control, but which must be in place in order for fully autonomous living to be possible.” These include “social freedom, an array of substantive options of choice . . . and autonomy-supporting networks.” Mark Piper, *Autonomy: Normative*, INTERNET ENCYCLOPEDIA OF PHILOSOPHY, <http://www.iep.utm.edu/aut-norm/#SH2c> (last visited Apr. 4, 2019).

29. Joseph Blocher, *Rights To and Not To*, 100 CAL. L. REV. 761, 770 (2012) (using “ $X$ ” to describe any given choice right). Blocher explains the value of these rights through the metaphor of a sword and shield against the government. “If a right to  $X$  is a sword that enables its bearer to cut through government restraint, a right to not- $X$  is a shield that protects its bearer from government coercion.” *Id.*

30. *Id.*

31. *Id.* The Court explained that the “First Amendment guarantees ‘freedom of speech,’ a term necessarily comprising the decision of both what to say and what *not* to say.” *Riley v. Nat’l Fed’n of the Blind*, 487 U.S. 781, 796–97 (1988).

32. Blocher, *supra* note 29, at 774.

33. *Id.* at 775. There are various arguments for why choice rights should be classified as including both the option to act and the right not to act. Blocher argues that some rights only “function properly” if they include the “right to” as well as the “right not to.” *Id.* at 791. Alternatively, some are justified as requiring both options because they are inherently “personal” as opposed to “public” rights. Blocher argues that when a “right is designed to protect the interests of the individual alone, it should generally, though not always, be considered a choice right.” *Id.*

34. *Id.* at 771–72.

35. *Id.* at 771.

36. *Id.* at 772.

instance, the right against cruel and unusual punishment only goes one way; rights holders cannot demand that the government impose cruel and unusual punishment on them.<sup>37</sup>

#### B. JUDICIAL RECOGNITION OF A WOMAN'S RIGHT TO CHOOSE AN ABORTION

The recognition of a woman's constitutional right to choose whether or not to have an abortion began with the Supreme Court's acknowledgement of the right to "marital privacy" in *Griswold v. Connecticut*.<sup>38</sup> Accordingly, Connecticut's statute precluding the use of contraception for married couples was declared unconstitutional.<sup>39</sup> Several years later, the Court in *Eisenstadt v. Baird* analyzed a similar statute in Massachusetts which allowed married couples to receive contraception while denying the same right to single individuals.<sup>40</sup> The Court expanded the right recognized in *Griswold v. Connecticut* to apply to both married and unmarried couples and to include the right to "be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."<sup>41</sup>

In *Roe v. Wade*, the Supreme Court acknowledged a woman's constitutional right of privacy to be "broad enough to encompass a woman's decision whether or not to terminate her pregnancy."<sup>42</sup> The Court recognized that the fundamental right established in *Eisenstadt v. Baird* to decide whether or not to "bear or beget a child"<sup>43</sup> "necessarily includes the right of a woman to decide whether or not to terminate her pregnancy."<sup>44</sup> The Court then addressed the "detriment" to the woman were she denied this "choice."<sup>45</sup> Similarly, the Court re-emphasized this concern in *Planned Parenthood of Southeastern Pennsylvania v. Casey* by stating that "the liberty of the woman is at stake in a sense unique to the human condition . . . [t]he mother who

37. *Id.*

38. *See generally* *Griswold v. Connecticut*, 381 U.S. 479 (1965) (holding a state ban on contraception use violated the right to marital privacy).

39. *Id.*

40. *See generally* *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (holding a state law prohibiting distribution of contraceptives to unmarried people violated the 14th Amendment's Equal Protection Clause).

41. *Id.* at 453.

42. *Roe v. Wade*, 410 U.S. 113, 153 (1973) (emphasis added). *But see* *Conservatorship of Valerie N.*, 707 P.2d 760, 784-85 (Cal. 1985) (Bird, J., dissenting) ("None of the opinions in *Skinner* characterized the right to procreate as a right of choice or privacy. Rather, the majority referred to the right to bear and beget children as 'a basic liberty' and 'one of the basic civil rights of man,' arguing that recognizing it as a choice right 'deprive[s] many women permanently of the right to conceive and bear children.'"). This right to choose an abortion is not without bounds; it is subject to "state regulation that is necessary to further a compelling state interest" which becomes legitimate at "fetal viability." Mark A. Goldstein, *Choice Rights and Abortion: The Begetting Choice Right and State Obstacles to Choice in Light of Artificial Womb Technology*, 51 S. CAL. L. REV. 877, 887 (1978).

43. *Roe*, 410 U.S. at 170 (quoting *Eisenstadt*, 405 U.S. at 453).

44. *Id.*

45. *Id.* The Court acknowledged that:

Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved.

*Id.*

carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear.”<sup>46</sup> Accordingly, a woman’s decision whether or not to terminate her pregnancy is of a “deep, personal character” and is afforded constitutional protection.<sup>47</sup>

Moreover, the Supreme Court of California recognized that California’s Constitution provides even “greater protection of a woman’s right of choice than that provided by the federal Constitution”<sup>48</sup> and declared that it is “among the most intimate and fundamental of all constitutional rights.”<sup>49</sup> In *Committee to Defend Reproductive Rights v. Myers*, the Supreme Court of California struck down the Budget Acts of 1978, 1979, and 1980, which denied medical funding for “elective abortions.” The court found that they infringed on a woman’s “procreative choice,” which the California Constitution guarantees under the “right of privacy.”<sup>50</sup> The court explained that a denial of funds for elective abortions “threatens not only the woman’s interest in life, health, and personal bodily autonomy but also her right to decide for herself whether to parent a child . . . .”<sup>51</sup> The court expressed concern over the detriment that any violation of this right could have on a woman and her autonomy because the “constitutional right of choice is essential to [a woman’s] ability to retain personal control over her own body.”<sup>52</sup> Furthermore, the court emphasized that this right to choice did not rest on any questions of the “morality or immorality of abortion,”<sup>53</sup> but rather the fact that “each woman . . . is guaranteed the constitutional right to make that decision *as an individual* . . . .”<sup>54</sup>

#### IV. ABILITY TO MAKE AN AUTONOMOUS CHOICE

Autonomous decision-making requires the ability to make a meaningful choice as well as the freedom to decide whether and how to make such choices. Competency to exercise one’s legal choice rights does not require the same level of abilities across the board. Rather, competency to make a meaningful choice “will depend on the decision to be made; a given individual might be competent to make some decisions but incompetent to make others.”<sup>55</sup> Because competency depends on the decision at hand, it is important to analyze which specific abilities a given right necessitates, as well as what level of those abilities is required to make a specific meaningful choice.<sup>56</sup> This understanding of meaningful choice prevents individuals with

46. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 852 (1992).

47. *Id.*

48. Am. Acad. of Pediatrics v. Lungren, 16 Cal. 4th 307, 327 (1997).

49. Comm. To Defend Reprod. Rights v. Myers, 29 Cal. 3d 252, 275 (1981). This right of choice was recognized four years prior to the Supreme Court’s decision in *Roe v. Wade*.

50. *Id.* at 274.

51. *Id.* at 275.

52. *Id.* at 274.

53. *Id.* at 284.

54. *Id.*

55. Elizabeth S. Scott, *Sterilization of Mentally Retarded Persons: Reproductive Rights and Family Privacy*, 1986 DUKE L.J. 806, 836 (1986). The author describes the importance of an individualized assessment to determine one’s capabilities regarding a specific decision. For example, “an individual might be capable of driving a car and managing simple finances, but incapable of making an informed medical decision.” *Id.* at 836 n.103.

56. Elyn R. Saks & Stephen H. Behnke, *Competency to Decide on Treatment and Research: MacArthur and Beyond*, 10 J. CONTEMP. LEGAL ISSUES 103, 105 (1999).

a mental illness from being labeled as incompetent to make a choice if they “suffer no more irrationality in the relevant regard than many . . . .”<sup>57</sup> In regard to abortion, one must have the ability to make a meaningful choice about multiple aspects of a woman’s reproductive rights,<sup>58</sup> including the decision of whether she desires to bear or beget a child at all and whether she consents to the medical procedure itself.<sup>59</sup>

Moreover, a “positive respect for patients as autonomous persons requires promotion of, and respect for, their capacities as rational decision-makers involved in complex processes of self-determination.”<sup>60</sup> It is essential that a decision-maker have the ability<sup>61</sup> to make a rational choice,<sup>62</sup> otherwise, there is a “misalignment” between the woman’s will and her ultimate decision.<sup>63</sup> Irrationality occurs when there is a deficiency in the process of decision-making.<sup>64</sup> More specifically, irrationality is the inability to understand a “material term,” which leads to the “breakdown of reason.”<sup>65</sup> However, a decision is not irrational if the misunderstanding is not material; the term must be relevant to the specific decision being made.<sup>66</sup> For example, a pregnant woman’s failure to acknowledge that pregnancy leads to the birth of a child would be a material misunderstanding which would deprive her from a meaningful choice of whether she desires to remain pregnant. However, a failure to appreciate the detailed scientific process of fetus development would be immaterial, and would therefore not preclude her from making an autonomous choice regarding reproduction. In the medical procedure context, a patient must have the ability to give informed consent.<sup>67</sup> Beyond access to full disclosure, she must have the ability to understand and

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57. *Id.*

58. *See* Scott, *supra* note 55, at 837. Those who are competent to make a meaningful reproductive choice should have “a legally protected interest in reproductive autonomy.” The mentally disabled person has an interest in reproductive autonomy if she is capable of making a meaningful decision about whether or not to have a child. *Id.* at 840.

59. Rima Kundnani, Note, *Protecting the Right to Procreate for Mentally Ill Women*, 23 S. CAL. REV. L. & SOC. JUST. 59, 73 (2013); *see* Scott, *supra* note 55, at 840. There are a variety of abortion methods and procedures available in California including medical and surgical abortions. JENNIFER TEMPLETON DUNN ET AL., *ABORTION IN CALIFORNIA: A MEDICAL-LEGAL HANDBOOK* (2012).

60. Rebecca L. Walker, *Respect for Rational Autonomy*, 19 KENNEDY INST. ETHICS J. 339, 360 (2009).

61. As will be discussed below, an ability to make a rational choice is wholly different from one’s decision to exercise that ability in what most consider to be a rational manner. *See* Saks & Behnke, *supra* note 56.

62. *But see* John Christman, *Autonomy in Moral and Political Philosophy*, STAN. ENCYCLOPEDIA OF PHIL. (last updated Jan. 9, 2015), <https://plato.stanford.edu/entries/autonomy-moral> (“Respect for autonomy is meant to prohibit [paternalistic] interventions because they involve a judgment that the person is not able to decide for herself how best to pursue her own good. Autonomy is the ability to so decide, so for the autonomous subject of such interventions paternalism involves a lack of respect for autonomy.”).

63. *See* Walker, *supra* note 60, at 344.

64. *See id.* at 345.

65. Elyn R. Saks, *Competency to Refuse Treatment*, 69 N.C. L. REV. 945, 961 (1991).

66. *Id.* at 955–56. Saks argues for the “understanding and belief” theory to competence which requires only that “the decisionmaker comprehend the caregiver’s information and form no patently false beliefs . . . that affect the decision.” Saks compares false beliefs and values while explaining that, “unless one’s belief in some way conforms to the world, it represents a failed attempt to describe the world. By contrast, one is entitled to choose values and desires without constraint because values and desires are neither objectively right nor objectively wrong in a straightforward way.” *Id.*

67. *See* McCaman, *supra* note 8, at 158.



weigh the risks involved.<sup>68</sup> These risks include those to the woman's own health as well as any risk to the fetus.<sup>69</sup>

On the other hand, autonomy does not require a choice or a process of decision-making that is aligned with society's views of what is correct.<sup>70</sup> This freedom to choose while being uninhibited by interference from others, regardless of varying moral views or even a common societal view in opposition, was recognized by the Court in *Planned Parenthood of Southeastern Pennsylvania v. Casey*:

Men and women of good conscience can disagree, and we suppose some always shall disagree, about the profound moral and spiritual implications of terminating a pregnancy, even in its earliest stage. Some of us as individuals find abortion offensive to our most basic principles of morality, but that cannot control our decision. Our obligation is to define the liberty of all, not to mandate our own moral code.<sup>71</sup>

After the recognition of the right to "personal autonomy and bodily integrity"<sup>72</sup> as defined in *Roe v. Wade*, whether a woman chooses an abortion or to carry the child to term is constitutionally protected regardless of moral or political opposition.

Furthermore, there is an important distinction between one's ability to engage in rational decision-making and one's choice to engage in rational decision-making.<sup>73</sup> For example, valid waivers of information in a medical decision-making context do not impede an individual's ability to make an

68. See Coverdale et al., *supra* note 24, at 660. The authors explain that informed consent requires a patient to attend to, "absorb, retain, and recall the information disclosed." These processes require the need for cognitive understanding, the ability to reason from present events to their future likely consequences, and the appreciation of the consequences to her and her fetus. Furthermore, she must achieve evaluative understanding through analyzing these consequences against her own beliefs and values. *Id.*

69. One important consideration is the effect of antipsychotic medications on the fetus as weighed against the risks associated with untreated schizophrenia during pregnancy. For example, a 2016 study found no evidence of increased defects in fetuses as a result of the mother's atypical antipsychotic medication intake. However, the study still recommended lowering the dose to the safest level possible. See generally Sarah Tosato et al., *A Systemized Review of Atypical Antipsychotics in Pregnant Women: Balancing Between Risks of Untreated Illness and Risks of Drug-Related Adverse Effects*, 78 J. CLIN. PSYCHIATRY 477 (2017). Another study involved 1.3 million women in order to study the effects of antipsychotic drugs on fetus development during the first trimester. The study found "no significant increased risk for any type of birth defect" associated with the antipsychotics. Robert Preidt, *Antipsychotic Meds Pose Little Danger to Fetus*, WEBMD (Aug. 16, 2016), <https://www.webmd.com/baby/news/20160817/antipsychotic-meds-pose-little-danger-to-fetus-study-finds#1>.

70. See Saks, *supra* note 56. Autonomy is the "right to make choices, even when those choices are unconventional and stray from commonly held beliefs, views, and desires." *Id.* But see generally Michael Moore, *Moral Reality*, 1982 WIS. L. REV. 1061 (1982) (arguing that there may be right answers to legal and moral questions). Choice and process of choice are different things which must both be respected. One may make a choice based on thorough investigation and normally accepted procedures but society may still view it as an irrational decision. On the other hand, one may choose to make a life-altering decision based on a flip of a coin that leads to a decision which is aligned with society's views of what is a correct choice while the process is not.

71. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 850-51 (1992).

72. *Id.* at 857.

73. Alexander McCall, *Beyond Autonomy*, 14 J. CONTEMP. HEALTH L. & POL'Y 23, 30 (1997) (while arguing that autonomy is the capacity to make a fulfilling choice, he acknowledges that there are some autonomy "enthusiasts" who believe that choice is "desirable in itself, and not for what it can bring to life").

autonomous choice.<sup>74</sup> Rather, “[a]llowing a patient the right to waive his [or her] right to be informed is part of the full recognition of a patient’s right to autonomy or self-determination.”<sup>75</sup> Moreover, people may make decisions based on emotions or values that may seem “foolish to an outside observer, [however,] it cannot be said to be incompetent in order to permit the State to override the decision.”<sup>76</sup> Autonomy therefore requires not only the ability to make a choice, but also the freedom to arrive at the choice in the manner of one’s choosing, whether or not that entails a lesser informed or an uninformed decision.<sup>77</sup>

## V. SURROGATE DECISION-MAKING

### A. WHY SURROGATES ARE NECESSARY

As discussed above, in order to respect an individual’s constitutionally mandated autonomy when it comes to the decision of whether to keep a child to term or to have an abortion, before a physician can honor what the individual expresses as their preference, the physician must be sure that the individual has the competence necessary to make the decision.<sup>78</sup> However, “losing capacity does not mean losing autonomy.”<sup>79</sup> A surrogate decision-maker can promote an incompetent woman’s autonomy when the surrogate is granted authority to act as “an extension of the patient” in order to make these important health care decisions in place of the individual.<sup>80</sup> As will be discussed below, the standard of decision-making implemented by the surrogate is essential in fully realizing his or her responsibility of promoting the woman’s individual autonomy.

### B. ASSIGNING A SURROGATE

Surrogates receive their authority through one of several mechanisms.<sup>81</sup> First, the previously competent individual may appoint a surrogate in an advance directive or may informally do so by notifying their physician.<sup>82</sup> Alternatively, a court will appoint the surrogate, and “if none discussed here

74. Margaret A. Somerville, *Structuring the Issues in Informed Consent*, 26 MCGILL L.J. 740, 767 (1981). A woman with access to full disclosure and who is able to weigh the risks and benefits of a procedure may be able to make a competent decision even if she receives no disclosure as a result of her voluntary waiver. *See id.*

75. *See id.*; *see also* Alan Meisel, *The Expectations to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413 (1979). “[T]he primary objective of the doctrine [of informed consent] is to promote individual self-determination . . . [C]ompelling a patient to receive information which he does not wish to receive . . . is to fail to respect that patient’s dignity.” *Id.* at 459. It is also important to note that informed consent does not always match up with autonomy. For example, some jurisdictions only require a “physician to disclose those risks that a reasonable person deems to be material in making an informed decision.” Ladonna L. Griffith, *Informed Consent: Patient’s Right to Comprehend*, 27 HOWARD L.J. 975, 993 (1984); This standard could run afoul of autonomy if the actual patient deems information material that a “reasonable person” would label as immaterial.

76. *In re Yetter*, Pa. D. & C.2d 619, 624 (1973).

77. *See* McCaman, *supra* note 8, at 158.

78. *See* Kundnani, *supra* note 59.

79. Thaddeus Mason Pope, *Legal Fundamentals of Surrogate Decision Making*, 141 CHEST J. 1074, 1075 (2012).

80. *Id.* at 1077.

81. *Id.* at 1075.

82. *Id.*

are available, the health-care provider can designate a surrogate pursuant to default rules.”<sup>83</sup>

In California, a court appointed surrogate is referred to as a “conservator” while the person in need of care is a “conservatee.”<sup>84</sup> Depending on the type of need that the conservatee has, either a probate conservatorship or a Lanterman-Petris-Short (LPS) conservatorship will be assigned.<sup>85</sup> In a probate conservatorship, a “general conservatorship” is assigned by a probate court when an adults cannot care for “themselves or their finances.”<sup>86</sup> These are often used for the elderly.<sup>87</sup> A “limited conservatorship” is used for “adults with developmental disabilities who cannot *fully* care for themselves or their finances.”<sup>88</sup> Conservatees in this category require a lower level of care as compared to general conservatorships.<sup>89</sup> LPS conservatorships are used only for those with severe mental illnesses which are listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM).<sup>90</sup> Schizophrenia is among the most common illnesses to which LPS conservatorships are applied.<sup>91</sup>

### C. STANDARDS FOR GUIDING A CONSERVATOR’S DECISION-MAKING

#### 1. Best Interest Standard

The best interest standard allows a surrogate to decide what “would most benefit” the conservatee.<sup>92</sup> Proponents of a “strict best interest” standard argue that it allows a conservator to “independently decide” what is objectively the best decision in promoting the conservatee’s health.<sup>93</sup> Consequently, the woman’s health becomes the central issue, guiding decisions based on the “objective best health outcome”<sup>94</sup> while entirely disregarding the woman’s values, beliefs, and preferences.<sup>95</sup>

83. *Id.* The author explains that most commonly, the physician appoints a surrogate using a statutorily mandated priority list of individuals which generally begins with the patient’s “spouse, adult child, parent, and adult sibling.” However, some states do not require the physician to strictly adhere to the list, but simply provide the list as guidance. *Id.* at 1076.

84. *Conservatorship*, CAL. COURTS, <http://www.courts.ca.gov/selfhelp-conservatorship.htm> (last visited Apr. 4, 2018).

85. *Id.*

86. *Id.*

87. *Id.*

88. *Id.* (emphasis added).

89. *Id.*

90. *LPS (Mental Health) Conservatorship*, SUPERIOR COURT OF CALIFORNIA, [http://www.scscourt.org/self\\_help/probate/conservatorship/conservatorship\\_lps.shtml](http://www.scscourt.org/self_help/probate/conservatorship/conservatorship_lps.shtml) (last visited Feb. 23, 2018).

91. *Id.*

92. *See* Kundnani, *supra* note 59, at 81.

93. *Id.* Sarah Baddeley argues that under these boundaries, a conservator could only elect an abortion for the conservatee if her health was in danger. Otherwise, she would be forced to birth the baby regardless of her preferences. *See* Baddeley, *supra* note 23, at 506. However, this argument incorrectly presumes that carrying a child to term is normally less risky than an abortion. In fact, mortality rates among those who carry a child to term are higher than those receiving legal abortions. *See generally* David A. Grimes, *The Morbidity and Mortality of Pregnancy: Still Risky Business*, 170 AM. J. OBSTET. GYNECOL. 1489 (1994).

94. *See* Baddeley, *supra* note 23, at 505–06 (arguing that the best interest standard “look[s] at the incapacitated person through the lens that a patient’s only interest is the objective best health outcome”).

95. V.A.M.S. § 475.120 (West 2010). Missouri uses the best interest standard and requires a guardian “acting on behalf of [a] ward” to “act in the best interest of the ward” by assuring that the “ward

The rationale behind a strict model seems to run afoul of a true best interest standard. Thus, many states instruct a conservator to implement a best interest standard as well as call for the conservator to incorporate the conservatee's preferences and values in the decision-making process.<sup>96</sup> This is important because women rarely choose to have an abortion merely for medical reasons.<sup>97</sup> As the Supreme Court pointed out in *Roe v. Wade*, pregnancy may “force upon the woman a distressful life and future” as well as “psychological harm.”<sup>98</sup> Accordingly, a best interest model must take into account more than merely the woman's health.<sup>99</sup> It should also take into account any known preferences and values, as well as what is in the woman's best interest beyond her health, including financial resources, her ability to care for the child,<sup>100</sup> and her future goals and plans. In this way, the best interest model begins to blend with the “substituted judgment standard”<sup>101</sup> discussed below.

Delaware employs a strict best interest standard when instructing a legal guardian on decision-making in the medical context. The statute calls for the guardian to “give such consent or approval as may be necessary to enable the person with a disability to receive medical or other professional care, counsel, treatment or service and . . . take such action as the guardian objectively believes to be in the best interest of the person with a disability.”<sup>102</sup> By calling for the guardian to use an objective standard of best interests, Delaware does not require the guardian to look at the individual's personal values or preferences.

## 2. Substituted Judgment Standard

The substituted judgment standard requires a conservator to base a decision on what the conservatee would have chosen were she competent.<sup>103</sup> When making decisions on behalf of the conservatee, the conservator is required to look at the “whole picture,” including the “subjective values and beliefs” of the conservatee as reliably known to the conservator.<sup>104</sup> Clearly, a conservator's ability to respect the individual's autonomy regarding procreation and abortion through accurate representations of her desires

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receives medical care and other services that are needed,” and that the guardian “[p]romote and protect the care, comfort, safety, health, and welfare of the ward.” *Id.*

96. CAL. PROB. CODE § 2355 (West 2000); see Baddeley, *supra* note 23, at 506.

97. Vija Udenans, *Women Choose Abortions for Economic Reasons*, NAT'L PRESS CLUB (Jan. 19, 2012), <http://www.press.org/news-multimedia/news/women-choose-abortions-economic-reasons-clinic-director-says>.

98. *Roe v. Wade*, 410 U.S. 113, 153 (1973).

99. It should also be noted that a conservator who seeks to promote the best interest of a conservatee must do so “without becoming unduly influenced by the needs of others, no matter how compelling,” as this could be “the first step on a slippery slope leading to exploitation of the [conservatee].” Linda S. Whitton, *Surrogate Decision-Making Standards for Guardians: Theory and Reality*, 2012 UTAH L. REV. 1491, 1513.

100. See Kundnani, *supra* note 59, at 81. Specifically, a woman with schizophrenia who experiences psychotic episodes may have a more difficult time rearing a child and this could in turn have negative consequences on the child. As the Court acknowledged, some people view “the inability to provide for the nurture and care of the infant is a cruelty to the child and an anguish to the parent.” *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 853 (1992).

101. See Baddeley, *supra* note 23, at 506–07.

102. DEL. CODE ANN. tit. 12, § 3922(b)(3) (West 2014).

103. See Baddeley, *supra* note 23, at 515.

104. See *id.* at 507. Proponents argue that this standard best protects the individual's autonomy and self-determination interests. See Whitton, *supra* note 99, at 1505.

depends on the conservator's knowledge of the conservatee's subjective wishes.<sup>105</sup> Consequently, this standard is most effective when the conservatee has been able to express herself, either because she was previously competent or because she is able to communicate her preference in direct or indirect ways.<sup>106</sup>

However, the substituted judgment standard still allows the conservatee's best interest to substitute in areas where the conservator does not have a clear indication of what the conservatee would have chosen, so long as the decision implements her known values.<sup>107</sup> Nevertheless, it is important to clarify that a substituted judgment standard does not mean "best interests" because a substituted judgment may call for a decision that does not objectively best benefit either the woman's health, narrowly considered, or her overall life as the conservator sees it.<sup>108</sup> Instead, it calls for the conservatee's values to control, even if they are in opposition to the conservatee's best interest.<sup>109</sup> As the court in *Guardianship of Mary Moe* explained:

In utilizing the doctrine [of substituted judgment,] the court does not decide what is necessarily the best decision but rather what decision would be made by the incompetent person if he or she were competent. "In short if an individual would, if competent, make an unwise or foolish decision, the judge must respect that decision," assuming the judge were required to respect the same decision by a competent person.<sup>110</sup>

As discussed below, California calls for a best interest standard but it provides an example of how this standard can often overlap with a substituted judgment standard.<sup>111</sup> California Probate Code section 2355 requires the conservator to first look to any relevant health care instructions from the conservatee and then proceed in accordance with the conservatee's best interests.<sup>112</sup> However, in describing best interests, the statute requires the conservator to look to the conservatee's "personal values" and any "wishes to the extent known to the conservator . . . ."<sup>113</sup> Beyond that, the conservator has sole control to make the decision based on what is best for the conservatee's health.<sup>114</sup> This is essentially a hybrid approach of the best interest and substituted judgment standards.

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105. See Baddeley, *supra* note 23, at 507.

106. *Id.* at 507–08.

107. *Id.* at 507.

108. *Guardianship of Mary Moe*, 960 N.E.2d 350, 354 (Mass. App. Ct. 2012).

109. *Id.* at 354–55.

110. *Id.* at 354.

111. See CAL. PROB. CODE § 2355 (West 2000).

112. *Id.* § 2355(a).

113. *Id.*

114. *Id.*

### 3. “Reasonable Person” Standard

A third standard requires the conservator to inquire as to what a reasonable person in the same situation as the conservatee would choose.<sup>115</sup> In this way, the conservator must “compare the burdens, consequences, and potential complications of *the treatment itself*” as well as “the likely realities of *life after treatment*” as compared to non-treatment.<sup>116</sup> The standard asks what a person of sound judgment and of “good will” would likely choose with these considerations in mind.<sup>117</sup> Accordingly, this reasonable person standard may appear to grant undue deference to the conservator,<sup>118</sup> and thus threaten the woman’s autonomy.<sup>119</sup> However, this concern is somewhat mitigated by the requirement that the conservator look at the conservatee’s specific circumstances.<sup>120</sup> This requires the conservator to account for the fact that the conservatee may have different “values, life plans, and opportunities.”<sup>121</sup> Consequently, the reasonable person standard begins to take on the constitutionally required eye towards autonomy<sup>122</sup> that is present in both the best interest and substituted judgment standards.<sup>123</sup> However, if a reasonable person would decide differently from the patient, even when placed in the specific circumstances the patient is in, the patient’s preference become irrelevant. Accordingly, the risk of her preferences becoming immaterial is too great and violates the woman’s autonomy.

### 4. No Guidance

Some states fail to provide guidance to surrogate decision-making. For example, Ohio’s statute, which provides for the “duties of [a] guardian,” states:

A guardian of the person may authorize or approve the provision to the ward of medical, health, or other professional care, counsel, treatment, or services unless the ward or an interested party files

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115. See generally Loretta M. Kopelman, *The Best Interests Standard for Incompetent or Incapacitated Persons of All Ages*, 35 J.L. MED. & ETHICS 187 (2007) (advocating use of the best interest standard for its “consistency, fairness, and compassion,” among other reasons).

116. See *id.* at 188.

117. *Id.*

118. *Id.*

119. See generally Bailey Kuklin, *Constructing Autonomy*, 9 N.Y.U. J.L. & LIBERTY 375 (2015) (explaining the complications of the reasonable person standard’ and its potential for invading one’s personal autonomy).

120. See Kopelman, *supra* note 115.

121. See *id.* at 188 (explaining that, as a result, “informed people of good will may sometimes rank potential benefits and harms differently”).

122. See Superintendent of Belchertown State Sch. et al. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977). The court explains:

The constitutional right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice.

*Id.* at 426.

123. Under the reasonable person standard, a surrogate would also consider the best interest of the woman because that is likely what a person of “sound judgment” and “good will” would consider. This demonstrates a further blending of the surrogate decision-making standards. See Kopelman, *supra* note 115, at 188.

objections with the probate court, or the court, by rule or order, provides otherwise.<sup>124</sup>

The only limitation occurs when a specific objection to the guardian's decision is made or the court provides otherwise.<sup>125</sup> Accordingly, the guardian is given great deference in how to make medical decisions and is not required to consider the ward's preferences, or even what is in her best interest.

## VI. CALIFORNIA LAW: RIGHT TO AND AGAINST AN ABORTION FOR THOSE WITH DISABILITIES

California law recognizes that “the right to choose to procreate is fundamental, and may not be denied to an individual on the basis of disability.”<sup>126</sup> In reference to the assignment of a conservator, California Welfare and Institutions Code section 5005 states that “[u]nless specifically stated . . . [the conservatee] . . . shall not forfeit any legal right or suffer legal disability by reason of the provisions of this part.”<sup>127</sup> Likewise, section 5325.1 states that “[p]ersons with mental illness have the same legal rights and responsibilities guaranteed all other persons by the Federal Constitution and laws of the State of California *unless specifically limited by federal or state law or regulations*.”<sup>128</sup> These statutes affirm that a woman with a disability, even under the guardianship of a conservator, retains her right to reproductive choices.<sup>129</sup> Beyond this, there are no statutes or case law that specifically address how to respect the autonomy of a woman with schizophrenia to choose whether to have an abortion. However, as will be discussed, relevant statutes and case law provide some guidance.<sup>130</sup>

In California, a “conservator” is a legal representative appointed by the court to make surrogate decisions for another adult, referred to as the “conservatee.”<sup>131</sup> In order for a conservator to be assigned as the legal decision-maker, a hearing must take place to determine the “nature and extent” of the impairment.<sup>132</sup> The court will determine whether to appoint a conservator or a limited conservator depending on whether the conservatee lacks the capacity to perform “all of the tasks necessary to provide properly” for her physical health.<sup>133</sup> Furthermore, the court will provide guidelines for the conservator's management of decisions in order to more accurately align with the conservatee's abilities.<sup>134</sup>

124. OHIO R. C. § 2111.13 (2017).

125. *Id.*

126. CAL. PROB. CODE § 1950 (West 1991) (referring to sterilization).

127. CAL. WELF. & INSTS. CODE § 5005 (West 1969).

128. CAL. WELF. & INSTS. CODE § 5325.1 (West 2017) (emphasis added).

129. *But see supra* note 5 and accompanying text.

130. Absent an applicable statute, some courts resort to their common law *parens patriae* power “derive[d] from the inherent equitable authority of the sovereign to protect those persons within the state who cannot protect themselves because of an innate legal disability.” *In re Grady*, 426 A.2d 467, 479 (N.J. 1981). This source of power is sometimes controversial as it assumes a kind of parental authority. However, it is justified as a “more compassionate result than leaving [an incompetent woman] with no way of exercising a constitutional right.” *Id.* at 481.

131. CAL. PROB. CODE § 1982(b) (West 2017).

132. CAL. PROB. CODE § 1828.5(a) (West 1991).

133. *Id.* § 1828.5(d).

134. *Id.* § 1828.5(e).

The scope of the conservator's decision-making powers for the conservatee's health care depends on the extent of the conservatee's impairment relevant to particular choices.<sup>135</sup> Once deemed incompetent to make health care decisions, the court grants the conservator the sole authority to make good faith<sup>136</sup> determinations regarding general medical care, notwithstanding the conservatee's objection.<sup>137</sup> However, the conservator is required to make the decision "in accordance with the conservatee's individual health care instructions, if any, and other wishes to the extent known to the conservator."<sup>138</sup> Outside of known instructions, the conservator is to make the decision in accordance with the conservatee's "best interest" which encompasses any of the conservatee's expressed "personal values"<sup>139</sup> and religious practices, so long as the religious views were established prior to the assignment of conservatorship.<sup>140</sup>

The conservator's authority is more limited if she has not been specifically authorized to override the conservatee's health care decisions because the conservatee has not been adjudicated to lack the relevant capacity.<sup>141</sup> In this case, if a conservatee objects, the conservator must petition a court for authority to consent to medical treatment.<sup>142</sup> However, in emergency cases where the conservatee's life is in peril, the conservator is exempt from this requirement.<sup>143</sup>

Of course, many of these complexities are eased if the conservatee has an advance health care directive.<sup>144</sup> California acknowledges a presumption of the validity of advance health care directives so long as the procedural requirements for proper formation are met.<sup>145</sup> Accordingly, an advance health care directive "is effective and exercisable free of judicial intervention" and, specifically, a health care decision made by the conservator is "effective without judicial approval."<sup>146</sup> Therefore, if the conservatee states her will regarding an abortion in the directive, that choice will automatically be upheld.<sup>147</sup> However, because advance directives are not widely used, the decision-making process is often much more complex.<sup>148</sup> Moreover, advance directives are not always clear on any given point, and once written, individuals may change their mind on relevant issues.

Finally, case law provides guidance as to the requisite standard of proof that must be met before a conservator can in good faith declare a life-

135. See CAL. PROB. CODE § 2355 (West 2000).

136. This is a weak standard. This allows a negligent but good faith determination to suffice.

137. *Id.*

138. *Id.*

139. Conservatorship of Wendland, 28 P.3d 151, 169 (Cal. 2001); Conservatorship of Drabick, 245 Cal. Rptr. 840, 854 (Ct. App. 1988) (noting that California case law "recognize[s] that medical care decisions must be guided by the individual patient's interests and values").

140. § 2355(b). A best interest standard that encompasses the conservatee's personal values is "designed to further the same interests she might pursue had she the ability to decide herself," even if the choice is not ultimately that of the conservatee. *Conservatorship of Drabick*, 245 Cal. Rptr. at 855.

141. *Scott S. v. Sup. Ct.*, 138 Cal. Rptr. 3d 730, 740 (Ct. App. 2012).

142. See CAL. WELF. & INSTS. CODE § 5358.2 (West 2017).

143. *Id.*

144. See *supra* note 22 and accompanying text.

145. CAL. PROB. CODE § 4673 (West 2006).

146. CAL. PROB. CODE § 4750 (West 2017).

147. See *id.*

148. See Baddeley, *supra* note 23, at 494.



impacting decision to be in the best interest of the conservatee.<sup>149</sup> California courts hold that, “the standard of proof may depend upon the ‘gravity of the consequences that would result from an erroneous determination of the issue involved.’”<sup>150</sup> In calling for a clear and convincing standard, the court in *Conservatorship of Wendland* explained that:

The function of a standard of proof is to instruct the fact finder concerning the degree of confidence our society deems necessary in the correctness of factual conclusions for a particular type of adjudication, to allocate the risk of error between the litigants, and to indicate the relative importance attached to the ultimate decision.<sup>151</sup>

Consequently, courts apply a “clear and convincing evidence standard when necessary to protect important rights.”<sup>152</sup> For example, clear and convincing evidence is required to show that sterilization is in the best interest of a disabled conservatee<sup>153</sup> and that parental rights should be terminated.<sup>154</sup> Furthermore, courts have required the same standard when deciding whether or not an individual’s inability to provide for her health requires a conservator.<sup>155</sup>

## VII. COMPARISON OF STATE APPROACHES: FLORIDA AND NEW YORK

Florida and New York employ differing approaches to abortions for those with disabilities, neither of which fully protects a disabled woman’s autonomy. Florida aims to protect the autonomy of incompetent individuals by providing by statute that they retain the right to privacy<sup>156</sup> and the right to a guardian in order to aid them in “remain[ing] as independent as possible . . .”<sup>157</sup> However, these policies are harmed by the procedures required to grant an abortion to a mentally incompetent woman. First, a physician must receive the consent of the woman’s guardian.<sup>158</sup> The guardian must then receive approval from the court after a lengthy list of requirements is satisfied.<sup>159</sup> The court is first required to appoint an “independent attorney to act on the incapacitated person’s behalf . . .”<sup>160</sup> The court then collects evidence on the woman’s “medical, psychological, and social evaluations” and then personally meets with her in order to “obtain its own impression of the person’s capacity . . .”<sup>161</sup> Next, the court must find by “clear and convincing evidence” that the woman is not competent to make the decision for herself and that her ability to decide “is not likely to change in the

149. *Conservatorship of Wendland*, 28 P.3d 151, 169 (Cal. 2001).

150. *Id.*

151. *Id.*

152. *Id.*

153. *Conservatorship of Valerie N.*, 707 P.2d 760, 777 (Cal. 1985).

154. *In re Angelia*, 623 P.2d 198, 205–06 (Cal. 1981).

155. *Conservatorship of Sanderson*, 165 Cal. Rptr. 217 (Ct. App. 1980).

156. FLA. STAT. ANN. § 744.3215(1)(o) (LexisNexis 2017).

157. *Id.* § 744.3215(1)(f).

158. *Lefebvre v. N. Broward Hosp. Dist.*, 566 So. 2d 568, 570 (Fla. Dist. Ct. App. 1990).

159. § 744.3725.

160. *Id.* § 744.3725(1).

161. *Id.* § 744.3725(2), (3).

foreseeable future . . . .”<sup>162</sup> Finally, the court must also find by clear and convincing evidence that the abortion is in the best interest of the woman.<sup>163</sup>

Although Florida aims to protect the woman’s constitutional right to privacy, her autonomy is hampered in two important ways. First, the requirement that the court be persuaded by clear and convincing evidence that the abortion is in the woman’s best interests fails to take into account her personal values and preferences. As discussed above, what is in one’s best interests often conflicts with what one desires and values. Second, the need to convince the court that the abortion is in her best interests in order to receive an abortion while not requiring any evidence at all in order to remain pregnant, let alone a similarly stringent showing, creates a default rule that skews the analysis towards life. Although a default rule is tempting as a way to create consistency and predictability while providing the court with clear guidance, a default rule makes little sense in light of the constitutional demand for autonomy.<sup>164</sup> If a default rule favors preserving the pregnancy over abortion, or vice versa, there is an impermissible risk that bearing a child conflicts with the woman’s values while also failing to be in her best interest. In turn, the default rule becomes arbitrary and does not provide the woman with the court’s best attempt at honoring her autonomy.<sup>165</sup>

Under New York law, greater deference is given to an incompetent woman’s guardian. Prior to performing an abortion on a minor, a physician must receive consent from her parent or guardian.<sup>166</sup> If a woman over the age of eighteen is incompetent to give consent to the abortion, the physician may receive consent from the “spouse, a parent, an adult child, or a court of competent jurisdiction.”<sup>167</sup> However, if the competence of the woman is in question, an “independent opinion” must be obtained regarding her “mental capacity.”<sup>168</sup>

This broad grant of discretion afforded to the decision-maker by New York was illustrated in *Matter of Barbara C.* when the father of a twenty-five-year-old woman who had the mental capacity of a two-year-old consented on her behalf to an abortion.<sup>169</sup> The woman’s guardian ad litem appealed this decision, arguing that parental consent was insufficient and that the court should have been required to decide “whether an abortion was in the best interests of the patient.”<sup>170</sup> The court disagreed and held that consent to an abortion for an incompetent woman by an available relative is sufficient under New York law.<sup>171</sup> Furthermore, when a relative is available to make the decision, “the sole role of the judiciary is to resolve any dispute which

162. *Id.* § 744.3725(4).

163. *Id.* § 744.3725(5).

164. Scott, *supra* note 55; Baddeley, *supra* note 23, at 514–15.

165. However, without a default rule, the standards of proof remain asymmetric. If a court cannot be convinced either way, it is equivalent to stating that keeping the child is in the best interest of the woman because when proof is insufficient, the court will not order an abortion, but rather just allow the pregnancy to continue. This is because a court can similarly not order an abortion absent sufficient evidence because that would also lead to a default rule which violates the woman’s autonomy and her right to bodily integrity. This note does not aim to settle this issue; it only raises the Constitutional issues presented by default rules and a lack thereof.

166. N.Y. COMP. CODES R. & REGS. tit. 14, § 27.9(a) (1975).

167. *Id.* § 27.9(b).

168. *Id.* § 27.9(d).

169. *In re Barbara C.*, 474 N.Y.S.2d 799 (N.Y. App. Div. 1984).

170. *Id.*

171. *Id.*

may arise concerning the patient's ability to grant consent."<sup>172</sup> Accordingly, New York grants an incompetent woman's guardian broad discretion to choose whether to perform an abortion while also failing to provide guidelines to aid in the decision. This method blatantly runs afoul of a woman's autonomy by lacking any requirement to consider her known preferences or values, let alone to uphold her fundamental rights.

### VIII. PROPOSED POLICY

The variability of schizophrenia inevitably leads to uncertainty as to which expressions of a patient's will are authentic.<sup>173</sup> Hence, a schizophrenic woman's autonomy during surrogate decision-making may be threatened<sup>174</sup> absent legislative guidelines that aid the surrogate in advancing what the incompetent woman would have chosen if she were competent.<sup>175</sup>

In considering the complexities presented in surrogate decision-making for a schizophrenic woman, it is imperative to emphasize her constitutional right to autonomy regarding decisions about reproduction, abortion, and bodily and mental integrity at every stage.<sup>176</sup> In order to accomplish this, each woman's situation must be analyzed on an individual basis in order to determine which result best emphasizes her procreational rights.<sup>177</sup>

A woman's right to an abortion is a choice right,<sup>178</sup> and therefore, the court must first determine if the schizophrenic woman has the competency to make a meaningful choice regarding the factors relevant to her decision.<sup>179</sup> Otherwise, the court risks violating the woman's autonomy by allowing her to choose an option which she irrationally expresses because of her disorder.<sup>180</sup> For an abortion, this entails the ability to make a rational decision regarding her desire to beget a child at all, as well as whether she desires to undergo one of the medical procedures required to complete the abortion.<sup>181</sup>

172. *Id.*

173. See *supra* note 27 and accompanying text. Authenticity is about "one's own actions, character, beliefs, and motivations." RUTH R. FADEN & TOM L. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* 238 (1986).

174. See *supra* note 28 and accompanying text.

175. See FADEN & BEAUCHAMP, *supra* note 173.

176. See *supra* text accompanying note 52; see also Baddeley, *supra* note 23, at 514 (explaining that the surrogate decision-making process should ensure that an incompetent woman's bodily integrity be safeguarded).

177. See Baddeley, *supra* note 23, at 514–15 (arguing that "[a] blanket rule that will apply in all cases is unlikely, as establishing such a rule would diminish the idea that every woman, competent or not, is an individual and is therefore entitled to an individualized decision").

178. See *supra* notes 29–33, 43.

179. These considerations will vary significantly from woman to woman because of the variability and the illness. Therefore, it must be evaluated on a case by case basis. *In re Yetter*, Pa. D. & C.2d 619, 623 (1973).

180. See Saks & Behnke, *supra* note 56 at 104–05 (arguing that in determining competency, there are three values that require consideration: paternalism to protect the vulnerable, the right to make choices, even if unconventional, and the fact that "irrationality permeates decision making").

181. Experts propose varying methods of determining competency in these subjects. McCullough lays out 7 steps in determining if a schizophrenic pregnant woman's ability to make an autonomous decision on whether to keep her child is impaired. She argues that the woman's "impairments in any one step will adversely affect the patient's ability to complete subsequent steps." See McCullough, *supra* note 6, at 697. Elyn Saks advocates for an "understanding and no false beliefs" method. The patient is incompetent if there is a "breakdown of reason leading to a patent misunderstanding of *material* terms" (emphasis added). If the term is immaterial to the decision at hand, a misunderstanding does not necessarily preclude her from competency. See Saks, *supra* note 65, at 961. Coverdale proposes that one look to "potential areas of deficit in participating in the informed consent process. . . ." This requires

If she is deemed to be competent in both respects, her stated preference should be unequivocally respected.<sup>182</sup>

However, if the woman is found to be incompetent to make a meaningful choice in her current state, the court must appoint a conservator. The appointment of a conservator should be limited to the extent of the incompetency.<sup>183</sup> Therefore, if the woman is only incompetent as to medical decision-making, a limited conservator should be appointed as a surrogate decision-maker for only that limited necessity. The woman should retain decision-making authority in the areas she is not deemed to be incompetent. However, it is vital to provide an incompetent woman with a surrogate because, although the surrogate's decision will not be the conservator's, it is a more "just and compassionate result than leaving [her] with no way of exercising a constitutional right."<sup>184</sup>

Because it is vital to aim to uphold her autonomy as accurately as possible, the first step taken by the conservator should be to attempt to assist the incompetent woman in independently making a meaningful choice by diminishing the barriers to her autonomy.<sup>185</sup> For example, medication can be administered in order to stabilize the disorder.<sup>186</sup> This enhances a woman's ability to independently make a choice while unrestricted by the influences of hallucinations and delusions.<sup>187</sup>

An important consideration arises if the woman is either unable to consent to medication or objects to its use. In the search for autonomy, the surrogate decision-maker is presented with a dilemma: force medication to

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looking for a lack of understanding, inability to attend to, retain, and recall relevant information about the pregnancy, inability for evaluative understanding, and impaired voluntariness. See Coverdale, *supra* note 24, at 660.

182. See *supra* notes 22, 58–59 and authorities cited therein.

183. CAL. PROB. CODE § 1801(d) (West 1995).

184. *In re Grady*, 426 A.2d 467, 481 (N.J. 1981).

185. See Coverdale, *supra* note 24, at 661.

186. *Id.*; see McCullough, *supra* note 6, at 698 (explaining that antipsychotic medications can diminish "hallucinatory commands" and "unreasoning fear of the fetus," which allows the woman to better participate in decision-making). See generally Thomas G. Gutheil & Paul S. Applebaum, *Mind Control, Synthetic Sanity, Artificial Competence, and Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication*, 12 HOFSTRA L. REV. 77 (1983) (arguing that antipsychotics "alter mental functioning in the direction of normality"). However, the Court in *Sell v. U.S.*, 539 U.S. 166 (2003), stated that in order for medication to be administered to restore competence, it must be determined whether the drug "will tend to sedate a defendant, interfere with communication with counsel, prevent rapid reaction to trial developments, or diminish the ability to express emotions . . . [or] undermine the fairness of a trial." *Id.* at 185 (citing *Riggins v. Nevada*, 504 U.S. 127, 142–45 (1992)).

187. See *Sell*, 539 U.S. at 185. This freedom from hallucinations and delusions is important because it removes internal influences, such as voices telling a woman to kill her child. Although she competently would not wish to rid herself of a child, the voices may influence her to do so. This matters because in order to "be legally adequate, a subject's informed consent must be competent, knowing and voluntary." MICHAEL H. SHAPIRO ET AL., CASES, MATERIALS AND PROBLEMS ON BIOETHICS AND LAW 461 (West Grp. 2d ed., 2003) (emphasis added). However, this is not to say that in order to be voluntary, a decision must be completely free from internal or external influences. To the contrary, decision-making is almost always influenced by external and internal factors such as socioeconomic status, family, and emotion. See generally FM Hajjaj et al., *Non-Clinical Influences on Clinical Decision-Making: A Major Challenge to Evidence-Based Practice*, 103 J. R. SOC. MED. 178 (2010). However, a schizophrenic woman is often unable to voluntarily choose how much weight to give her delusions when making a choice because "the key feature of a delusion is the degree to which the person is convinced that the belief is true." See Chandra Kiran & Suprakash Chaudhury, *Understanding Delusions*, 18 INDUS. PSYCHIATRY J. 3 (2009). In this way, her decision becomes involuntary.

enable a meaningful choice<sup>188</sup> or allow the woman to refuse treatment.<sup>189</sup> At first glance, these appear to be options that constitutionally require equal weight because both options infringe on her bodily integrity. If she is forced to take medication, the surrogate is violating her desire to remain free from medication. On the other hand, if she is allowed to refuse treatment, she will remain unable to make a rational choice, and therefore, will remain unable to exercise her right to choose whether or not to have an abortion. Here, a more “comprehensive view” distinguishes among strands of autonomy and presents occasions where forced medication promotes autonomy.<sup>190</sup> For example, “mental illness [itself] might limit autonomy to a greater degree, or in a more important way, than does involuntary treatment”<sup>191</sup> due to the psychosis it may entail, and in turn, the inability to exercise one’s fundamental rights. In this way, forcing an incompetent woman to take medication may limit her autonomy to a degree, but it promotes autonomy overall as it allows a woman to more readily make a meaningful choice.<sup>192</sup>

Further strategies that may weaken the barriers to a schizophrenic woman’s autonomy include training and education.<sup>193</sup> Communication skills training and problem-solving strategies can erode some of the impediments created by the underlying disorder and help the woman become a “more effective advocate for her own preferences.”<sup>194</sup> Additionally, education about the woman’s pregnancy, illness, and the effects that her illness has on her decision-making abilities can better help her engage in meaningful decision-making regarding her pregnancy, while education about abortion options and procedures can aid in deciding whether to consent to the procedure.<sup>195</sup> These strategies protect a woman’s right to procreational autonomy by promoting her self-determination prior to resorting to any other form of surrogate decision-making.

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188. Gutheil and Applebaum explain that “competence contingent solely upon proper medication” is referred to as “synthetic sanity.” See Gutheil & Applebaum, *supra* note 186, at 95.

189. See generally Klein, *supra* note 1 (discussing the interplay between schizophrenia and individual autonomy).

190. See *id.* at 388–89 (distinguishing between negative freedom and positive freedom provides occasions where forced treatment promotes autonomy).

191. See *id.* at 388 (explaining that in considering forced medication, one “must consider the erosion of autonomy that psychosis produces”).

192. See generally Klein, *supra* note 1. When using antipsychotic medication, “[p]sychotic symptoms, such as disordered thinking, agitation, and hallucinations, have been found to be suppressed or eliminated, thereby facilitating the re-emergence of normal patterns of cognition.” See Gutheil & Applebaum, *supra* note 186, at 118. However, the potential benefits of medications must be carefully weighed against the potential risks, such as the risk to the fetus. Coverdale explains that there is a “small increase in the risk of congenital malformations with low-potency antipsychotic medications”; less is known about higher potency medications. On the other hand, medication may lower the risk of “poor prenatal care and precipitous or unassisted delivery,” and of a non-autonomous decision being made for the woman. See Coverdale, *supra* note 24, at 661.

193. See McCullough, *supra* note 6, at 698.

194. *Id.* “Problem-solving strategies and communication skills training can assist the patient by reducing psychosocial stresses and by reducing the possibility of future illness episodes, by contributing to stability of her values and beliefs, and by enhancing her ability to become a more effective advocate for her own preferences.” See Coverdale, *supra* note 24, at 661.

195. See McCullough, *supra* note 6, at 698 (explaining that education regarding pregnancy can improve evaluative understanding). Specifically, education relating to how schizophrenia can contribute to difficulties in decision-making, and particularly how paranoia can influence evaluative understanding and contribute to a wish to terminate pregnancy can aid the woman’s ability to make a meaningful choice. See Coverdale, *supra* note 24, at 661.

Once strategies to promote meaningful decision-making have been implemented, it must be determined whether the schizophrenic woman is then competent to make her own decision. If she is deemed competent, the Constitution once again requires a total respect for her decision.<sup>196</sup> On the other hand, if these strategies still fail to provide her with the competency required to make her own procreational decisions, the woman's right to procreational autonomy requires the conservator to implement substituted judgement.<sup>197</sup> The surrogate's goal here should be to "substitute [himself or herself] as nearly as possible for the incompetent person and to act on the same motives and considerations as would move the incompetent person."<sup>198</sup> Accordingly, if the conservatee has an advance directive, it should be the first place a surrogate should look for guidance because it is an explicit<sup>199</sup> and accurate assertion of her preferences.<sup>200</sup> However, as discussed, because advance directives are rarely completed, the surrogate will most likely need to look elsewhere for direction.<sup>201</sup> Absent an advance directive, the surrogate should look to any relevant preferences that the conservatee is able to communicate, with emphasis on her statements and behaviors while previously competent.<sup>202</sup> Moreover, the surrogate must be sure that the expression is not the result of her incompetency.<sup>203</sup> For example, the court in

196. Baddeley points out that "[b]y definition, both the decision to end life-sustaining treatment and the decision to have an abortion have lasting implications for the patient; one ends a life and the other prevents life from beginning." The decision of whether or not to have a child is "potentially life-changing" for the woman, and therefore, extraordinary measures should be taken to ensure the decision is as close to what the woman would have chosen. See Baddeley, *supra* note 23, at 499–500. The court in *Saikweks* argues that "the value of life" is "lessened" by the "failure to allow a competent human being the right of choice," and therefore, an incompetent person's preferences should be of great focus in surrogate decision-making. Superintendent of Belchertown State Sch. et al. v. Saikewicz, 370 N.E.2d 417, 426 (Mass. 1977).

197. Sean M. Dunphy & John H. Cross, *Medical Decisionmaking for Incompetent Persons: The Massachusetts Substituted Judgment Model*, 9 W. NEW ENG. L. REV. 153, 155 (1987). Substituted judgment not only promotes autonomy, but it also mitigates the risk that the decision-makers will abuse their power and implement their own preferences by making the hypothetically competent conservatee the main focus. See Kundnani, *supra* note 59.

198. Dunphy & Cross, *supra* note 197.

199. It should be noted that advance directives can be ambiguous or may not specifically address the issue at hand. However, they are meant to provide clear guidance on issues such as these.

200. CAL. PROB. CODE § 4750 (West 2017). However, as Whitton acknowledges, preferences change over time so it is important that the surrogate take this into consideration and look to see if she made conflicting rational expressions after completing her advance directive. See Whitton, *supra* note 99, at 1492. Being mindful of this possibility is crucial because an advance directive that is based on desires one does not currently possess is no longer "morally binding" and does not honor the incompetent woman's autonomy. See generally Eric Vogelstein, *Autonomy and the Moral Authority of Advance Directives*, 41 J. MED. & PHIL.: A FORUM FOR BIOETHICS & PHIL. MED. 500 (2016). Moreover, the justice system upholds the doctrine of *locus poenitentiae*, allowing for a change of heart or mind, absent a legally binding contract, before binding an individual to a choice. See generally Peyton Carter, *The Doctrine of Locus Poenitentiae*, 9 AM. LAW. 386 (1901) (explaining locus poenitentiae and its jurisprudential treatment).

201. Johannes Gobertus Meran, *Advance Directives and Surrogate Decision Making: Ethical Questions, Legal Response and Clinical Summary—A Critical View*, 4 ANN. REV. L. & ETHICS 381, 381 (1996).

202. See generally *Guardianship of Mary Moe*, 960 N.E.2d 350 (Mass. App. Ct. 2012). In deciding whether to force an amputation on an elderly woman who continuously changed her mind regarding the procedure and who demonstrated some confusion, the court found that she was competent to reject treatment because it was consistent with her desire not to burden her children with caretaking and she demonstrated awareness of the likely consequences of her choice, including death. See generally *Lane v. Candura*, 376 N.E.2d 1232 (Mass. App. Ct. 1978) (overturning a finding of a patient's legal incompetence and holding the patient had the right to refuse physician-recommended amputation of her gangrenous leg).

203. The surrogate should take into consideration whether the woman's currently stated preferences conflict with previous statements, values, or religious expressions, and whether they are

*Guardianship of Mary Moe* was able to differentiate a schizophrenic woman's rational expressions of her will from incompetent ones.<sup>204</sup> The trial judge had deemed her incompetent to make her own decision after she incorrectly stated that she had a daughter and she denied being pregnant.<sup>205</sup> In vacating the judgment, the appellate court noted that the incompetent woman had stated that she was Catholic and that she "[did] not believe in abortion."<sup>206</sup> In applying the substituted judgment standard by prioritizing her rationally stated preferences, the court concluded that the woman would have decided against the abortion "if she were competent" and accordingly ruled against the procedure.<sup>207</sup>

Absent an advance directive or current rationally stated preferences, the decision-maker can look to other reliable sources. Because the average age of onset for schizophrenia in a woman is in her early to mid-twenties, the woman is likely to have expressed values and preferences prior to becoming incompetent.<sup>208</sup> The conservator should speak with family members, friends, medical providers, and other individuals to whom the conservatee may have expressed her preferences.<sup>209</sup> Importantly, previous expressions of preference do not have to be explicit statements made by the conservatee; rather, the conservator can also look to previous actions taken<sup>210</sup> and religious ties<sup>211</sup> that may lead to a clear inference of values and preferences.

When applying the substituted judgment standard to surrogate decision-making, the surrogate must provide "clear and convincing" evidence that the conservatee, if competent, would have chosen the proposed decision.<sup>212</sup> Because the substituted judgment standard does not look to anything other than what the woman would have chosen if competent, such as what is in her best interest, clear and convincing evidence is required for either the choice to keep the child or the choice to provide an abortion.<sup>213</sup> Absent such a strict standard of proof, the woman's autonomy risks being violated.<sup>214</sup>

Only when the surrogate is unable to provide clear and convincing evidence as to what the incompetent woman would have chosen if competent should the surrogate then resort to the best interest standard.<sup>215</sup> The surrogate should look to what choice would most benefit the woman while considering

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stable or alternating. *See generally In re Yetter*, Pa. D. & C.2d 619 (1973) (balancing the patient's health risk with the right to refuse treatment, the court refused the petition for appointment of a legal guardian).

204. *See generally Guardianship of Mary Moe*, 960 N.E.2d (overturning court-ordered abortion under the substituted judgment standard, and overturning court-ordered sterilization where no apparent standard was applied).

205. *Id.* at 352.

206. *Id.* at 353.

207. *Id.*

208. *See supra* note 13.

209. *See Whitton, supra* note 99, at 1493.

210. Relevant actions could include whether she previously chose to have a child or an abortion.

211. *See Baddeley, supra* note 23, at 514.

212. *Conservatorship of Wendland*, 28 P.3d 151, 169 (Cal. 2001) (stating that courts apply the clear and convincing evidence standard "when necessary to protect important rights"). *See generally In re Angelia*, 623 P.2d 198 (Cal. 1981) (sustaining the trial court's decision to sever the relationship between Angelia P. and her parents under the clear and convincing evidence standard).

213. If clear and convincing evidence were only required to give an abortion, or vice versa, then the likely difficulty of meeting this standard would often result in the decision not requiring the strict standard. In turn, the incompetent woman's autonomy would be threatened by a system that values one choice over another, as opposed to the woman's choice above all.

214. *See supra* note 130.

215. *See Kundnani, supra* note 59, at 83; *McCaman, supra* note 8, at 156.

her health, resources, ability to care for the child, and any other factor that could affect her future well-being. Importantly, the surrogate should also consider any known preference and values in her decision-making process that may be indicative, even if not decisive enough to satisfy a substituted judgment standard.<sup>216</sup> Furthermore, the surrogate should look to the incompetent woman's family and friends for guidance, but it is important that the surrogate not become unduly influenced by their opinions as this could lead to a result that promotes the preferences of third parties at the expense of the incompetent woman's best interests.<sup>217</sup>

It is important to remember the reasoning for the policy that, in the absence of clear and convincing evidence of what the incompetent woman would have chosen, a surrogate should look to the best interest standard as opposed to a default rule that resorts either to preserving pregnancy or to an abortion in the face of uncertainty. A default rule arbitrarily imposes a decision on a woman without taking her specific circumstances, known values, or best interests into consideration, and therefore, threatens her autonomy. Accordingly, when presented with conflicting evidence that cannot be reconciled to the point of clear and convincing evidence of what the incompetent woman would have chosen if competent, the Constitution demands a best interest standard that is individualized to what most benefits the woman in her particular situation.<sup>218</sup>

## IX. CONCLUSION

The Supreme Court's recognition of the constitutional right to "personal autonomy and bodily integrity"<sup>219</sup> mandates that every woman, regardless of her level of competency, be guaranteed the right to choose whether to have an abortion or to bear a child.<sup>220</sup> Accordingly, the California legislature should implement standards that aim to combat the complexities of schizophrenia in order to meet the autonomous rights of women with schizophrenia and other incompetent women alike. Absent a clear source of law, courts and surrogates, whether inadvertently or not, may violate the constitutional rights of this population.

As proposed, courts should only assign surrogate decision-makers after a schizophrenic woman is deemed incompetent to make the relevant decisions required when choosing whether to have an abortion. If a surrogate is needed, the surrogate should first aim to help the woman make her own autonomous choice by diminishing any barriers to rational decision-making. This can be done through the use of medication, therapies, and education which promote the woman's ability to effectively advocate for her own true preferences. If self-advocacy proves to be unattainable, the substituted judgment standard should be implemented, looking to what the incompetent woman would have chosen if she were competent. Here, even decisions contrary to the woman's best interest should be upheld, so long as it complies

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216. CAL. PROB. CODE § 2355 (West 2000).

217. See Kundnani, *supra* note 59, at 81.

218. See *In re Yetter*, Pa. D. & C. 2d 619 (1973); Baddeley, *supra* note 23, at 514; Scott, *supra* note 55.

219. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 857 (1992).

220. See Blocher, *supra* note 29.



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with her true wishes and values as known to the surrogate. Only absent clear and convincing evidence of what the incompetent woman would have chosen should the surrogate then resort to a best interest standard. However, even within this standard, the surrogate should implement any known values and preferences when deciding what is in the incompetent woman's best interest. These guidelines help uphold the woman's constitutional right to procreational autonomy regardless of whether she is competent to make the relevant decision.

