Study L-4005 January 10, 2002

Memorandum 2002-2

Health Care Decisions by Conservator: Decision of Supreme Court in *Conservatorship of Wendland*

This memorandum reviews the California Supreme Court's recent decision in *Conservatorship of Wendland*, 6 Cal. 4th 519, 28 P.3d 151, 110 Cal. Rptr. 2d 412 (2001), which interpreted Probate Code Section 2355, originally enacted in 1979 and amended in 1999, on Commission recommendation. *Wendland* holds that, in the case of a "conscious" conservatee (as distinct from a conservatee in a persistent vegetative state or permanent unconscious condition), the conservator must demonstrate by clear and convincing evidence that withholding or withdrawing life-sustaining treatment was desired by the conservatee or is in the conservatee's best interest.

The immediate issue is whether the Commission would like to consider any amendments to Section 2355 or other provisions in response to the *Wendland* decision.

The *Wendland* Decision

Robert Wendland was severely injured in a 1993 truck accident. For over a year he was unconscious, but eventually he regained some level of consciousness, though remaining dependent on artificial hydration and nutrition. Characterizations of his status vary, depending on the time period in question, and on which side of the controversy is making the evaluation. Commentators generally appear to characterize Robert's condition as "minimally conscious" or MCS, although not everyone agrees on this type of classification. The *Wendland* opinion includes the following description:

> … Rose "first noticed signs of responsiveness sometime in late 1994 or early 1995 and alerted [Robert's] physicians and nursing staff." Intensive therapy followed. Robert's "cognitive responsiveness was observed to improve over a period of several months such that by late spring of 1995 the family and most of his health care providers agreed that he was inconsistently interacting with his environment. A video recording of [Robert] in July 1995 demonstrated clear, though inconsistent, interaction with his environment in response to simple commands. At his highest level of function between

> February and July, 1995, Robert was able to do such things as throw and catch a ball, operate an electric wheelchair with assistance, turn pages, draw circles, draw an 'R' and perform two-step commands." For example, "[h]e was able to respond appropriately to the command 'close your eyes and open them when I say the number 3.' … He could choose a requested color block out of four color blocks. He could set the right peg in a pegboard. Augmented communication was met with inconsistent success. He remained unable to vocalize. Eye blinking was successfully used as a communication mode for a while, however no consistent method of communication was developed."
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> Despite improvements made in therapy, Robert remained severely disabled, both mentally and physically. The same medical report summarized his continuing impairments as follows: "severe cognitive impairment that is not possible to fully appreciate due to the concurrent motor and communication impairments ..."; "maladaptive behavior characterized by agitation, aggressiveness and non-compliance"; "severe paralysis on the right and moderate paralysis on the left"; "severely impaired communication, without compensatory augmentative communication system"; "severe swallowing dysfunction, dependent upon non-oral enteric tube feeding for nutrition and hydration"; "incontinence of bowel and bladder"; "moderate spasticity"; "mild to moderate contractures"; "general dysphoria"; "recurrent medical illnesses, including pneumonia, bladder infections, sinusitis"; and "dental issues."

(26 Cal. 4th at 525, footnotes omitted.) By 1997, and certainly by 2001, Robert's condition had further deteriorated, although the court's decision is largely set in the context of the trial court's early findings. (See, e.g., *id.* at 525, n.6 ("These assertions, which we have no reason to doubt, do not affect our analysis.) — it is telling that the court did not consider Robert's deteriorating condition to be relevant to the case.)

Rose, Robert's wife, acted as common law surrogate for some time, making health care decisions apparently without challenge, including three times authorizing surgery to replace dislodged feeding tubes. Eventually, Rose came to a different decision:

> When physicians sought her permission a fourth time, she declined. She discussed the decision with her daughters and with Robert's brother Michael, all of whom believed that Robert would not have approved the procedure even if necessary to sustain his life. Rose also discussed the decision with Robert's treating physician, Dr. Kass, other physicians, and the hospital's ombudsman, all of whom apparently supported her decision. Dr. Kass, however, inserted a

> nasogastric feeding tube to keep Robert alive pending input from the hospital's ethics committee.
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> Eventually, the 20-member ethics committee unanimously approved Rose's decision. In the course of their deliberations, however, the committee did not speak with Robert's mother or sister. Florence learned, apparently through an anonymous telephone call, that Dr. Kass planned to remove Robert's feeding tube. Florence and Rebekah applied for a temporary restraining order to bar him from so doing, and the court granted the motion ex parte.

(26 Cal. 4th at 526.) Numerous legal proceedings follows, ultimately ending with this summer's Supreme Court decision, which concludes as follows:

> [W]e conclude the superior court correctly required the conservator to prove, by clear and convincing evidence, either that the conservatee wished to refuse life-sustaining treatment or that to withhold such treatment would have been in his best interest; lacking such evidence, the superior court correctly denied the conservator's request for permission to withdraw artificial hydration and nutrition. We emphasize, however, that the clear and convincing evidence standard does not apply to the vast majority of health care decisions made by conservators under section 2355. Only the decision to withdraw life-sustaining treatment, because of its effect on a conscious conservatee's fundamental rights, justifies imposing that high standard of proof. Therefore, our decision today affects only a narrow class of persons: conscious conservatees who have not left formal directions for health care and whose conservators propose to withhold life-sustaining treatment for the purpose of causing their conservatees' deaths. Our conclusion does not affect permanently unconscious patients, including those who are comatose or in a persistent vegetative state …, persons who have left legally cognizable instructions for health care …, persons who have designated agents or other surrogates for health care …, or conservatees for whom conservators have made medical decisions other than those intended to bring about the death of a conscious conservatee.

(26 Cal. 4th at 554-55, citations omitted.)

Legislative Background

The Commission's involvement in the area of health care decisionmaking for adults who lack capacity dates back nearly 25 years, with studies resulting in enactment of the 1979 guardianship-conservatorship law. That statute included a special set of procedures governing medical decisionmaking by conservators of

the person and court-authorized medical treatment. Recognizing the procedural expense and weaknesses of the formal conservatorship process, the Commission later recommended enactment of durable power of attorney statutes, in particular the durable power of attorney for health care that became operative in 1983. The Commission monitored the experience under this pioneering statute and recommended a series of improvements in the following years, which were recodified in the Probate Code in 1994, in connection with the general Power of Attorney Law. At that time, the Commission recognized that further study of the health care decisionmaking area was needed to take account of developments in other states and in the then newly promulgated Uniform Health-Care Decisions Act of 1993. Thus, starting in 1996, the Commission undertook a comprehensive review of the law concerning health care decisionmaking, culminating in the 1999 enactment of the Health Care Decisions Law (1999 Cal. Stat. ch. 658, AB 891 (Alquist)). The provision at issue in *Wendland* was a conforming revision intended to make the standards applicable under the guardianship-conservatorship law consistent with the standards governing health care decisionmaking by agents, designated surrogates, and anyone else acting for a patient who lacked capacity to make health care decisions.

The Health Care Decisions Law had several basic goals, as explained in the Commission staff summary letter sent to all legislative committee members before each committee hearing in which AB 891 was considered, and to the Governor when the bill was on his desk for signature:

> AB 891 proposes a new Health Care Decisions Law to consolidate the Natural Death Act and the durable power of attorney for health care in a simplified and reorganized statute. Drawing heavily on the Uniform Health-Care Decisions Act (1993), the bill includes new rules governing individual health care instructions, and provides a new optional statutory form of an advance health care directive.
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> The bill's guiding principle is to effectuate the stated desires of the patient, as set out in an advance directive or, in the absence of an advance directive, as expressed to authorized surrogate decisionmakers. If the patient has not made his or her wishes known, health care decisions are to be made in the patient's best interest, as determined by the appropriate surrogate decisionmaker, taking into account the patient's personal values known to the surrogate. The Health Care Decisions Law is intended to fulfill the incapacitated patient's desires and best interest without resort to judicial proceedings, except as a last resort.

> The bill also codifies a number of duties of health care providers and institutions to comply with health care instructions, and to keep records relating to capacity determinations, surrogates, and instructions.
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> In addition, existing limitations on the authority of agents, witnessing requirements, and the prohibition on mercy killing and euthanasia, are continued in the new law.
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> Conforming changes in the procedure for obtaining court authorization for medical treatment would make clear that courts in proper cases have the same authority as other surrogates to make health care decisions, including withholding or withdrawing life-sustaining treatment. Similarly, the statute governing decisionmaking by conservators for patients who have been adjudicated to lack the capacity to make health care decisions are conformed to the standards governing other health care surrogates.
>
> The bill would unify the standards governing health care decisionmaking for adults without decisionmaking capacity so that the same rules apply whether the surrogate decisionmaker is (1) an agent named in the patient's advance directive, (2) a family member or friend acting as a surrogate decisionmaker, (3) a public guardian, or (4) a court making health care decisions as a last resort.

(Most of Sept. 13, 1999, letter on AB 891 to Governor Gray Davis.)

Problems and Commentary

Wendland is a troubling decision. It misses the underlying principles embodied in the Health Care Decisions Law and as reflected in developments during the last 20 years. It ignores the crucial role played by medical advice and medical ethics, particularly as specified in the statute governing exercise of authority by conservators. The court ignores the greater interest of a minimally conscious patient — as compared to a comatose patient — in obtaining a principled decision based on his values and beliefs by those who knew him and heard his views. By focusing on arid *parens patriae* concepts and the state's interest in protecting the right to life, the court diminishes the patient's right not to live, particularly in a minimally conscious state where the patient can feel pain and discomfort, sense degradation, and suffer on a daily basis. By ignoring or minimizing the ethical component and the medical advice of treating physicians and ethics committees, and relying on prepackaged legal doctrines, the court fails to understand the fiduciary principle underlying conservator decisionmaking and *all* decisionmaking under the Health Care Decisions Law. Most unfortunately, the court rejects the wisdom of the court of appeal decision in

Conservatorship of Drabick, which understood the continuum of health care decisionmaking and developed the idea that the patient had a right to have a decision made. Instead, the Supreme Court adopts a rigid, theoretical bifurcation of the health care decisionmaking, relying on *parens patriae* doctrine as an unblinking defender of life in the abstract, apparently without regard to its quality — with the safety valve subject to the clear and convincing evidence standard. But what justification is there for this rule? Put simply, the court decided to balance the factors on a different fulcrum than the Legislature did in the Health Care Decisions Law.

We have seen editorials supporting the position that conscious patients shouldn't have their lives terminated casually — and this may be a typical popular understanding of the case. But of course, that was never authorized by the law; that's not what *Wendland* was about. Nor was this decision needed to protect Californians from such a fate. (Particularly Robert, since he died after oral argument, but before the court rendered its decision.) The editorialists and other commentators have missed the real dangers of *Wendland*. It undermines the integrity and consistency of the law, casts doubt on the vast middle ground of surrogate decisionmaking by family and close friends for patients without advance directives, and raises questions about how to draft advance directives, to interpret patients' wishes, and to determine best interests.

Is more less?

Did Rose Wendland, Robert's wife, *lose* authority by seeking appointment as a conservator of the person of her husband? This would have been a silly question in a pre-*Wendland* understanding of the governing principles. But now, it is a real issue. In its analysis, the Supreme Court generally ignores the salient fact that Rose presumptively had authority to make decisions on her husband's behalf under the common law. For purposes of its analysis, the court classes Rose exclusively as a court-appointed conservator, and then engages in a rigid *parens patriae* analysis to draw a bright line between types of decisionmakers that the statutory law treats similarly. This analysis is deficient, because the court leaves out the vast middle ground, where most cases would arise, particularly for patients in Robert's age group. We can safely assume that fewer than 10% of 40-year olds have executed an advance health care directive.

Attorneys will need to think twice or even three times in the future before advising a family member to petition for appointment as a conservator of the

person. What would have happened if Rose had not become conservator for Robert? What if the case had proceeded under Probate Code Section 3200 (court-approved health care decisions)? One expects the trial judge would have ruled in the same way, but how would the case have been handled on appeal and what would the Supreme Court have done?

What would Robert's advance directive need to provide?

"Let them draft legally binding documents!" says the court, in effect. An expression such as "I don't want to live like a vegetable" would presumably be interpreted by the current California Supreme Court as not including a minimally conscious condition — that is the result in the case. Taking the *Wendland* ruling literally, this expression could have different results depending on whether the health care decisionmaker is a conservator or an agent. The court in *Wendland* seems to be saying as a matter of law that a person who expressed the desire not to "end up in the hospital like a vegetable" is not describing Robert's condition — but then, as noted, the court did not seem to think Robert's condition was relevant as long as there was some type of consciousness. If this is all Robert said in his advance directive, what would be the result? Would that expression be different if it is included in an advance directive? Could health care providers rely on it or could an agent or family member rely on it, as they understand it, based on their knowledge of the patient, without the need to satisfy a clear and convincing test?

What if Robert had executed an advance directive and had named his wife Rose as his health care agent, but not made any further statements of his desires? Strikingly, this was almost the situation in *Wendland*, if we are permitted to ignore the conservatorship and to treat the common law surrogate the same as an agent. A reading of the *Wendland* decision does not disclose what the result would be. We know that the court places great emphasis on advance directives, but what about the 80-90% of patients without advance directives? Are they in a lesser category? Presumably Rose, before she was advised to petition for appointment as conservator of Robert's person, was not subject to any limitations deriving from *parens patriae* doctrines. Is there a third category of authority or can we assume that all non-*parens patriae* decisionmakers can exercise the same authority, whether named by the patient or empowered by tradition and the common law? Statements like the following do not give much guidance, since they leave out this all-important middle ground:

> The constitutional considerations on which we rely justify applying the clear and convincing evidence standard only when a conservator seeks to withdraw life-sustaining treatment from a conscious, incompetent patient who has not left legally cognizable instructions for health care or appointed an agent or surrogate for health care decisions.

(26 Cal. 4th at 551.)

An Aside on Legislative History

Robert Wendland's situation was brought to the Commission's attention during development of the Health Care Decisions Law. Specifically:

(1) Memorandum 98-63 (Sept. 18, 1998) included a letter from Alice Mead, California Medical Association, that discussed the Wendland case. See *id.*, Exhibit pp. 60-62.

(2) Memorandum 98-63 also included a memo from Vicki Michel to the CMA Executive Committee reviewing the Wendland case in detail. See *id.*, Exhibit pp. 63-65.

(3) The Staff Draft of Conforming Revisions (p. 115, attached to Memorandum 98-63), notes the CMA commentary, cites to the Wendland discussion, and states in this connection "that a clear and convincing standard should not be imposed."

(4) The Minutes of the September 24-25, 1998, Commission Meeting report as follows (p. 12):

> The Comment [to Prob. Code § 2355] should make clear that the exercise of authority to make health care decisions by a conservator under this section does not require a determination of the conservatee's wishes or best interest by clear and convincing evidence. There is no higher evidentiary standard under this statute and none should be inferred.

As a result of this discussion, and because of concern that the attempt to unify the law in California might be undermined by lack of clarity on burdens of proof, the Commission decided to make clear in the Comment to Section 2355 that the general rule of preponderance of the evidence applied. See Evid. Code § 115. CMA requested that the issue be treated in the statute, but the Commission did not think that was necessary and that stating the applicable general rule in one section would arguably raise questions about what standard applied where the section was silent. The point of having general rules is that you don't have to keep repeating the rule throughout the statutes.

The *Wendland* opinion contains the following discussion:

> The conservator argues the Legislature understood and intended that the low preponderance of the evidence standard would apply. Certainly this was the Law Revision Commission's understanding. On this subject, the commission wrote: "[Section 2355] does not specify any special evidentiary standard for the determination of the conservatee's wishes or best interest. Consequently, the general rule applies: the standard is by preponderance of the evidence. Proof is not required by clear and convincing evidence." (30 Cal. Law Revision Com. Rep., supra, p. 264.) (5) We have said that "[e]xplanatory comments by a law revision commission are persuasive evidence of the intent of the Legislature in subsequently enacting its recommendations into law." (Brian W. v. Superior Court (1978) 20 Cal.3d 618, 623 [143 Cal.Rptr. 717, 574 P.2d 788].) *Nevertheless, one may legitimately question whether the Legislature can fairly be assumed to have read and endorsed every statement in the commission's 280-page report on the Health Care Decisions Law.* (Cf. Van Arsdale v. Hollinger (1968) 68 Cal.2d 245, 250 [66 Cal.Rptr. 20, 437 P.2d 508] [describing the inference of legislative approval as strongest when the commission's comment is brief].)

(26 Cal. 4th at 542 [emphasis added].) It is unfortunate that the comment in italics survived into the final opinion. It is a slippery slope for courts to speculate in a vacuum on the attention span of the Legislature. Moreover, it demonstrates a lack of respect for a co-equal branch of government, which happens to be the one vested with authority to write the law.

The court didn't do its homework well. The "280-page report" did not exist when the Health Care Decisions Law was passed. The court erroneously cites a post-enactment report that could obviously not have baffled the Legislature. We can't speculate on what length of report the court thinks the Legislature can "fairly be assumed to have read," but the report before the Legislature when AB 891 was under consideration was 244 pages in length. The Recommendation on *Health Care Decisions for Adults Without Decisionmaking Capacity*, 29 Cal. L. Revision Comm'n Reports 1 (1999), is a 6x9 format report, so perhaps that format should be converted into 8.5 x 11 terms to permit an accurate evaluation. In addition, the publication includes the complete text of the recommended legislation, i.e., the text of AB 891 as introduced. It also includes title pages, a letter of transmittal, tables of contents, and some blank pages, along with a table correlating source materials in the Uniform Health-Care Decisions Act of 1993. Perhaps the Commission should consider eliminating non-essential pages, reducing publications to barebones collections of Official Comments in 10-point

Times, single-spaced in 8.5 x 11 format. A quick reformatting test suggests that the "280-page report" could be reduced to about 50 pages.

Is a *page count* any sort of reasonable determining factor for legislative history? If so, what are the implications for many other Commission recommendations? What of the Evidence Code, in a 338-page publication (see 7 Cal. L. Revision Comm'n Reports 1001 (1965))? Or the Family Code with its 848 pages (see 23 Cal. L. Revision Comm'n Reports 1 (1993))? The Probate Code Comments alone are nearly 1000 pages in length (see *Recommendation Proposing New Probate Code*, 20 Cal. L. Revision Comm'n Reports 1001 (1989) — what legislator can fairly be assumed to have read this publication?

The court's point is even more puzzling when we focus on the issue: what standard of proof applies? The Comment simply states what should be obvious: the general rule under Evidence Code Section 115 applies. The court has the power to apply a higher standard without the need to include its gratuitous statement that, if taken seriously, can only complicate statutory interpretation in the future.

Legislative Reform Possibilities

Probably the best approach to coping with *Wendland* is to focus on the court's summary of its holding and cling to a strict interpretation of the explicit limits on the clear and convincing rule. In this view, it is assumed that the problems caused by the case are contained and that the number of situations to which it would apply is not large. But we don't know how many "Wendland-class" patients there are. Nor do we know how health care providers will respond to the decision.

If legislation is called for, what should be done? The court has indicated that its ruling is constitutionally based, although it didn't directly hold Section 2355 unconstitutional. By mandating the clear and convincing standard for conservators, the court saved the statute from the necessity of the constitutional analysis that might have resulted in unconstitutionality. In this state of affairs, it does not appear wise to seek legislation that would reaffirm the original legislative intent and reject the court's analysis, with its bright line between *parens patriae* and agency.

There may be other useful avenues to address the problems raised by *Wendland.* Some potentially useful approaches include the following:

(1) *Refine the parens patriae fiction.* Section 2355 could be amended to make clear that the *parens patriae*-based rule only applies if a stranger to the patient is appointed as conservator. This approach, if challenged, would force the court to face the greatest flaw in *Wendland* — that the *parens patriae* doctrine should never have been applied in a case involving the patient's wife who, under the common law, would have the authority to make health care decisions for her husband. This type of revision would put the law on sounder footing by validating the rights of the "closest available relative" (*Cobbs v. Grant*) and "closest available relative or friends" (Patient Information Pamphlet) as superior to any limitations deriving exclusively from *parens patriae*. (For more background on common law and traditional surrogates, see generally *Health Care Decisions for Adults Without Decisionmaking Capacity*, 29 Cal. L. Revision Comm'n Reports 1, 24-32 (1999).)

(2) *Limit to cases in controversy.* Section 2355 could be amended to codify the *Wendland* rule, but limit its application to court proceedings where burdens of proof are relevant. This would be intended to make clear that the *Wendland* rule should not affect health care decisionmaking in cases where there is no dispute. There is a precedent for this type of limitation. The Due Process in Competency Determinations Act sets out detailed rules for determining capacity, but in Probate Code Section 811(e) specifically provides the following limitation:

> (e) This part applies only to the evidence that is presented to, and the findings that are made by, a court determining the capacity of a person to do a certain act or make a decision, including, but not limited to, making medical decisions. Nothing in this part shall affect the decisionmaking process set forth in Section 1418.8 of the Health and Safety Code, nor increase or decrease the burdens of documentation on, or potential liability of, health care providers who, outside the judicial context, determine the capacity of patients to make a medical decision.

(3) *Elaborate a special higher standard for Wendland-type cases.* To meet the court's concern with the "low" preponderance of the evidence test, a more detailed, special standard could be applied to *Wendland*-type cases, whether limited to the *parens patriae* context or, to make the law more logically consistent, expanded to cover all MCS cases. A serious problem with the *Wendland* decision is that the court simply adopted the blunt instrument of the clear and convincing test, without much analysis of why that standard should be considered to be substantively correct. Perhaps it is best that the court did not legislate a new

standard and place it on a constitutional foundation. In the current cloud of confusion, there may be room for thoughtful development of rational, effective rules that meet constitutional concerns. We have in mind a substantively meaningful standard that relies on the quality and content of the evidence concerning the patient's values, beliefs, preferences, expectations, life-style, hopes, and goals, rather than the legalistic, but empty, application of the clear and convincing test.

Advance Directives

Post-*Wendland* discussions we have had with interested persons frequently touch on the issues involved in drafting advance health care directives. The court drew the line on standards of proof between conservators on one side and patient expressions in the form of advance directives ("legally cognizable instructions for health care," "formal instructions," "instructions for health care") or agent or surrogate designations. See, e.g., 16 Cal. 4th at 534, 551, 555.

If the court's bright line distinction between standards applicable to advance directives and court-appointed conservators is effective and accepted, then there is probably no need to revise the optional statutory advance directive form set out in Probate Code Section 4701. Of course, in all of these matters, *Wendland* causes some lingering concern because of the court's misunderstanding of the scope of "health care decisions" and its implicit distinctions between withdrawal of treatment versus refusal of consent to treatment. The relevant statutory form language in existing law could be more elaborate, but it serves its purpose of providing a basic form for those who don't have another form and don't wish to draft their own:

> (2.1) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:
>
> ☐ (a) Choice Not To Prolong Life
>
> I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

☐ (b) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

Some other prominent forms have more explicit language that may better address the post-*Wendland* environment. For example, the "Five Wishes" form provides the following options:

> **Permanent And Severe Brain Damage And Not Expected To Recover:**
>
> If my doctor and another health care professional both decide that I have permanent and severe brain damage, (for example, I can open my eyes, but I can not speak or understand) and I am not expected to get better, and life-support treatment would only delay the moment of my death (Choose *one* of the following):
>
> ☐ I want to have life-support treatment.
>
> ☐ I do not want life-support treatment. If it has been started, I want it stopped.
>
> ☐ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

The California Medical Association "Health Care Directive Kit" contains the following health care instructions:

> **OPTIONAL**: The statement I have signed below is to apply if I am suffering from a terminal condition from which death is expected in a matter of months, or if I am suffering from an irreversible condition that renders me unable to make decisions for myself, and life-support treatments are needed to keep me alive.
>
> A. I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician(s) allow me to die as gently as possible. I understand and authorize this statement as proved by my signature _____.
>
> **OR**
>
> B. I request that attempts be made to keep me alive in this terminal or irreversible condition by using all available, effective life-support treatments. I understand and authorize this statement as proved by my signature _____.

How the drafters of these and other forms in use in California will respond to *Wendland* remains to be seen.

Conclusion

The staff does not recommend that the Commission study this matter in the current session. Other groups are likely to be actively involved in working on legislation and the Commission has other high-priority subjects consuming all of its staff and meeting resources. However, the door should not be permanently closed on this issue because future developments may call for Commission involvement. Historically, the Commission has been open to addressing problems arising under statutes enacted on its recommendation. The staff proposes to continue to monitor developments in this area and report to the Commission when it appears appropriate.

Respectfully submitted,

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