NOTE

In re Grant: Where Does Washington Stand on Artificial Nutrition and Hydration?

The Washington Supreme Court in *In re Grant*[1] sought to determine whether life sustaining treatment[2] could be legally withheld from a terminally ill, non-comatose, incompetent individual. In its December 1987 slip opinion, a majority of the court expanded on its previous decisions empowering third parties, including guardians, families, and physicians, to withhold and withdraw life sustaining treatment from incompetent individuals.[3] This was accomplished by characterizing artificial

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1. 109 Wash. 2d 545, 747 P.2d 445 (1987).

2. "Life sustaining treatment" has been defined as "[d]rugs, medical devices or procedures that can keep individuals alive who would otherwise die within a foreseeable, though usually uncertain time period." OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, LIFE SUSTAINING TECHNOLOGIES AND THE ELDERLY 4 (1987) [hereinafter LIFE SUSTAINING TECHNOLOGIES]. While use of life sustaining treatment is often characterized as needlessly prolonging the dying process, this same treatment is "capable of saving and sustaining life and, sometimes, capable of restoring health and independence." *Id.* at 3.

The most common life sustaining treatments are:

(1) *Cardiopulmonary resuscitation (CPR)* — the restoration of heartbeat and the maintenance of blood flow and breathing following cardiac or respiratory arrest. Procedures range from manual, external cardiac massage and mouth-to-mouth ventilation to electronic defibrillators, temporary pacemakers, and mechanical ventilation.

(2) *Mechanical ventilation* — the use of a machine, most commonly a respirator, to induce inhalation and dehalation of the lungs. Mechanical ventilation is used to sustain patients whose own spontaneous breathing is insufficient to sustain life.

(3) *Renal (kidney) dialysis* — the artificial method of maintaining the chemical balance of the blood when a patient's kidneys have failed.

(4) *Artificial nutrition and hydration* — the provision of nourishment and fluids for those unable to take sufficient amounts of food and fluids themselves or for those unable to digest and absorb them adequately.

(5) *Antibiotics* — drug treatment to counter life threatening bacterial, viral, or fungal infections.

Id. at 4.

3. *In re* Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984); *In re* Ingram, 102 Wash. 2d 827, 689 P.2d 1363 (1984); *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983).

nutrition and hydration[4] as removable, life sustaining medical treatment. The court also gave third parties the power to remove artificial nutrition and hydration before the incompetent individual in question slips into a coma or persistent vegetative state.[5] After numerous, bizarre procedural twists, however, any semblance of a majority opinion disappeared, and the resulting decision serves only to further complicate an already complex and controversial issue.[6]

This Note will first show that through the *Grant* decision, the Washington Supreme Court clearly demonstrated the judiciary's institutional incompetence in resolving this complex, social and ethical issue. Though the judiciary legitimately and necessarily determines the rights of incompetent individuals, it is poorly designed to legislate specific medical procedures and ethics. Second, an examination of the history of life sustaining treatment in Washington indicates that the majority's original

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4. *See supra* note 2, at (4). Artificial nutrition and hydration is accomplished by either of two methods:

> (1) *Enteral (tube) feeding* — nutrients and water are infused into the patient's throat, stomach, or abdomen. Two of the most common types are naso-gastric (NG) tubes, which enter through the nose, run down the throat, and into the stomach, and gastonomy (G) tubes, which are placed through the abdomen and into the stomach. (2) *Parenteral feeding* — any method other than enteral feeding. One common type is intravenous (IV) treatment, in which nutrients and water are infused into a small, peripheral vein, usually in the patient's arm. Another is total parenteral nutrition (TPN), also called hyperalimentation, which is an IV technique where highly concentrated fluids are placed in large, central veins. Parenteral feeding cannot be sustained for long periods of time because it causes damage to the vein.

LIFE SUSTAINING TECHNOLOGIES, *supra note* 2, at 275; *see also id.* at 280-86.

5. "Permanent loss of consciousness" has been used to describe individuals in either a deep coma or a persistent vegetative state (PVS). PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE SUSTAINING TREATMENT 174 n.9 (1983) [hereinafter DECIDING TO FOREGO LIFE SUSTAINING TREATMENT].

A "deep coma" is characterized by deep unconsciousness, complete unresponsiveness, and closed eyes. *Id.* Most patients die within a few weeks of slipping into a deep coma. *Id.* at 180-81.

A "vegetative state" is characterized by unconsciousness, persistent brain stem functions that maintain vital body functions, and often, weakness. *Id.* at 174 n.9. Some of these patients "stay alive for an indefinite period and die of some other illness, often contracted while they are unconscious." *Id.* at 178. Thus, PVS and terminal illness are not synonymous, as some commentators have maintained. *See* Comment, *Artificial Nutrition and the Terminally Ill: How Should Washington Decide?*, 61 WASH. L. REV. 419, 419 n.2 (1986) [hereinafter *How Should Washington Decide*].

6. The United States Supreme Court has granted certiorari in a Missouri Supreme Court case which denied a request to withdraw artificial nutrition and hydration from an incompetent individual. Cruzan v. Director of Missouri Dep't of Health, 109 S. Ct. 3240 (1989). Oral arguments in the case were scheduled for the October 1989 term.

opinion was yet another attempt to legitimize illogical and unconstitutional reasoning granting third parties the power to exercise the fundamental rights of incompetent individuals. Finally, and most importantly, this Note will establish that the majority's original opinion wrongly characterized artificial nutrition and hydration as withholdable or withdrawable life sustaining treatment.

I. *IN RE GRANT*

A. The Facts of the Case

Barbara Grant is afflicted with Batten's disease, a genetic, late-juvenile, degenerative disease which affects the central nervous system.[7] Barbara was a normal child of above average intelligence until, at the age of five, she began to experience problems with her vision.[8] These problems were followed by epileptic seizures, uncontrollable staggering, and speech difficulties. In addition, Barbara has suffered severe mental retardation.[9] In 1978, at the age of fourteen, a court declared Barbara incompetent and appointed her mother guardian. Unable to care for her at home, the Grant family committed Barbara to the Rainier School, a state institution in Buckley, Washington.[10]

In September 1985, Barbara's pulse rate dropped and her breathing became irregular. Cardiopulmonary resuscitation and oxygen were administered, and she was transported to Harborview Medical Center in Seattle. The extent of treatment she received at Harborview is unclear.[11] Barbara returned to the school that same day. When the Washington Supreme Court heard oral arguments in her case in November 1986, Barbara could no longer walk or talk, she had difficulty swallowing, and she was completely blind. Brain control over

7. The clinical name of the illness is Batten-Mayou disease, a "late juvenile type of cerebral sphingolipidosis." STEDMAN'S MEDICAL DICTIONARY 404 (5th ed. 1982). Sphingolipidosis is defined as "cerebral lipidosis; . . . any one of a group of inherited diseases characterized by failure to thrive, hypertonicity, progressive spastic paralysis, loss of vision and occurrence of blindness, usually with macular degeneration and optic atrophy, convulsions, and mental deterioration." *Id.* at 1314.

8. *In re* Grant, 109 Wash. 2d 545, 548, 747 P.2d 445, 447 (1987).

9. *Id.*

10. *Id.*

11. Verbatim Trial Transcript at 20, *In re* Grant (No. 89268) (1985) [hereinafter Trial Transcript]. It appears that Barbara received only standard, stabilizing treatment, such as the CPR and oxygen that she received at the Rainier School.

her heart and lungs had also deteriorated.[12]

The Washington Supreme Court quoted physicians from both the Rainier School and Harborview describing Barbara as "nearly comatose" and "in an *almost* vegetative state."[13] The court termed her death in the near future "inevitable."[14]

These findings, however, conflicted substantially with those of the Pierce County Superior Court.[15] The trial judge found Barbara to have "lived longer than what has been medically anticipated for her" and that "[n]o one can say how long Barbara Grant will live or when she will die."[16] Further, "Ms. Grant is not in pain, appears to be at peace, and is able to respond to outside stimuli, such as voices, sound and the presence of other people, at times."[17]

Based on subsequent developments, the trial judge's findings seem the most accurate. Barbara remains alive today, free from any extraordinary medical treatment.[18] Further, because of the indecipherable conclusion to which Barbara's case came,[19] Judith Grant has once again petitioned the Pierce County Superior court for an order to withhold treatment from her daughter.[20]

B. The Court's Slip Opinion

Soon after Barbara's trip to Harborview in September 1985, Judith Grant sought an Ex Parte Order authorizing her to withhold, in the event it became necessary, extraordinary[21]

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12. *Grant*, 109 Wash. 2d at 548, 747 P.2d at 446.

13. *Id.* at 550, 747 P.2d at 447 (emphasis added).

14. *Id.*

15. Findings of Fact and Conclusions of Law and Order, *In re* Grant (No. 89268) (1986) [hereinafter Findings of Fact].

16. *Id.* at 4.

17. *Id.* at 2.

18. Petition for Order Authorizing Guardian to Withhold Extraordinary Medical Treatment, *In re* Grant (No. 89268) (1988) [hereinafter Petition].

19. *See infra* text accompanying notes 57-62.

20. *See* Petition, *supra* note 18, at 1.

21. " 'Extraordinary' treatment has an unfortunate array of alternative meanings." DECIDING TO FOREGO LIFE SUSTAINING TREATMENT, *supra* note 5, at 83. One understanding of the distinction between ordinary and extraordinary treatment is the difference between common and unusual care; another is the difference between simple and complex care. Both of these relative interpretations, however, mean different things to individuals in different situations; what is common and simple for a heart patient may be unusual and complex for a healthy individual.

Perhaps the most useful understanding of "extraordinary" is the difference between useful and burdensome, or proportionate and disproportionate care. This understanding is also open to different interpretations, but it has the advantage of

life sustaining treatment from her daughter. The issue Judith Grant first posed to the courts four years ago remains unresolved today.

On October 2, 1985, a wary Pierce County Commissioner appointed both a guardian ad litem and an "attorney for Barbara Grant," telling the attorney to resist Judith Grant's petition.[22] Barbara's immediate family and her guardian ad litem agreed with her mother's request; only the attorney assigned for Barbara opposed her motion.[23]

The trial began on October 24, 1985, and three months later the judge denied Judith Grant's motion.[24] Judith Grant appealed directly to the Washington Supreme Court. On October 7, 1986, the court decided to hear the case, and because of the alleged "urgency of Barbara Grant's situation,"[25] determined that it would hear the case before the end of the year.[26] The court heard oral arguments on November 19, 1986, and issued an Order with Opinion to Follow that same day. The Order provided:

> The guardian, Judith Grant, natural mother of Barbara Grant, is authorized to approve and direct the withholding of life sustaining procedures utilizing mechanical or other artificial means including cardiopulmonary resuscitation, defibrilation, the use of a respirator, intubation, the insertion of a naso-gastric tube, and intravenous nutrition and

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"moral significance." *Id.* at 88. The common/unusual and simple/complex analyses provide no indication of the effect of the treatment on a specific individual. Proportionality analysis, on the other hand, allows a patient to weigh the burdens and benefits of the treatment and make a personal decision whether to accept or forego the treatment. *Id.* at 84-89; *see also* Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (1980), *reprinted in* DECIDING TO FOREGO LIFE SUSTAINING TREATMENT, *supra* note 5, app. at 299 [hereinafter *Declaration on Euthanasia*].

This proportionality test espoused by the Vatican and the Presidential Commission is not a test of social utility, weighing the impact of treatment on those other than the patient. Rather, the burdens and benefits involved are those burdens and benefits *directly* affecting the decision-making patient *only*. This is contrary to the interpretation of Vatican doctrine referred to in *Grant*. *Grant*, 109 Wash. 2d at 563, 747 P.2d at 454 n.2; *see generally Declaration on Euthanasia*, *supra*.

The President's Commission calls for the abandonment of the ordinary/extraordinary distinction and the adoption of a proportionality test in formulating life sustaining treatment policy. *See* DECIDING TO FOREGO LIFE SUSTAINING TREATMENT, *supra* note 5, at 89.

22. Trial Transcript, *supra* note 11, at 10.

23. *Grant*, 109 Wash. 2d at 551, 747 P.2d at 448.

24. *See* Findings of Fact, *supra* note 15.

25. Motion for Accelerated Review at 2, *In re* Grant (No. 52609-5) (1986).

26. Decision to Retain Cause for Decision and Accept Accelerated Review, *Grant* (No. 52609-5) (1986).

hydration.[27]

The opinion that followed on December 10, 1987, over a year after the November 1986 order, has been described as "a piece of legislation."[28] Justice Callow's majority opinion focused on four major issues. First, Justice Callow determined that life sustaining treatment may be withdrawn from a *non-comatose*, incompetent individual provided the individual "is in an advanced stage of a terminal illness," and "is suffering severe and permanent mental and physical deterioration."[29] This was the first time the Washington Court allowed treatment to be withdrawn from an incompetent individual who was not in a coma or a persistent vegetative state.[30]

Second, the majority opinion stated that an order allowing the withholding of all life sustaining treatment from a terminally ill, incompetent individual may be issued before any such treatment is needed.[31] This had been the major issue at trial[32] and the judge had maintained that such an order was "analagous to prior restraint."[33]

Third, Justice Callow, in the first such decision in Washington, characterized artificial nutrition and hydration as life sustaining treatment which may be legally withheld from non-comatose, terminally ill, incompetent individuals.[34]

Finally, the opinion set out criteria[35] by which the decision to withhold will be made by the incompetent individual's guardian and/or immediate family using a substituted judgment standard[36] or a best interests test.[37] Justices Pearson,

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27. Order with Opinion to Follow at 1, *In re* Grant (No. 52609-5) (1986).

28. Telephone interview with Hugh Robinson, attorney for Barbara Grant (Oct. 28, 1988).

29. *Grant*, 109 Wash. 2d at 556, 747 P.2d at 451.

30. No previous Washington court has allowed withdrawal of life sustaining treatment before the patient slipped into a coma or persistent vegetative state. *See generally In re* Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984); *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983).

31. *Grant*, 109 Wash. 2d at 557-59, 747 P.2d at 451-55.

32. Findings of Fact, *supra* note 15, at 3.

33. *Id.*

34. *Grant*, 109 Wash. 2d at 559-65, 747 P.2d at 452-55.

35. *Id.* at 566-67, 747 P.2d at 456.

36. *Id.* at 566, 747 P.2d at 456. Substituted judgment and best interests are two types of vicarious or third party decision-making methods used by the *Grant* court and others. *See* Gutheil and Appelbaum, *Substituted Judgment: Best Interests in Disguise*, 13 HASTINGS CENTER REP. 8 (1983).

Under the best interests test, the guardian and/or family decides whether to continue or forego treatment by determining which course of action would be in the best interests of the incompetent individual. Under the substituted judgment

Utter, Dolliver, and Durham joined in Justice Callow's opinion.

In their concurring opinion, Justices Andersen and Brachtenbach agreed with the majority that Barbara's family could legally decide to remove her life support systems, but vehemently dissented from the majority's characterization of artificial nutrition and hydration as withholdable, life sustaining treatment.[38] Justice Andersen called such a characterization "unadorned euthanasia"[39] and scolded the majority for making a decision that should have been made, if at all, by the

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standard, however, the guardian and/or family base the decision to continue or forego treatment by determining what the incompetent individual would decide if the individual were competent. *Id.*

The best interests test has been attacked by law and psychiatry professors Gutheil and Appelbaum for its inherent tendency to allow the personal biases of third parties to determine what is best for the incompetent individual. *Id.* at 9. This tendency makes it very possible that third parties will make decisions which reflect the third party's personal views but which are in direct contradiction to the views of the incompetent individual.

In response, some courts adopted the substituted judgment standard. *See* Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976). By limiting third parties to a determination of what the incompetent individual would decide, not what the third party would decide for the incompetent individual, it was hoped that the impact of third party personal biases would be minimized.

Some, however, doubt that the third party's decision can possibly "avoid being contaminated by 'best interests' considerations, by his or her own feelings . . . , or by unconscious influences arising from the decision itself or the guardian-ward relationship." Gutheil and Appelbaum, *supra*, at 9.

Further, substituted judgment asks the impossible: "If the incompetent has never before faced the situation at hand, or has never had the capacity to offer an opinion on the subject, how does one assess what decision he would make?" *Id.* Even if the incompetent individual, before becoming incompetent, directly addressed the treatment in question, the fact that the individual now finds him or herself on the threshold between life and death drastically changes the circumstances under which the individual first addressed the treatment. The treatment now sustains his or her life. This drastic change in circumstance casts serious doubt on the probative value of any of the individual's previous statements or actions in determining the individual's judgment. *Id.*; *see also* Bopp, *Nutrition and Hydration for Patients: The Constitutional Aspects*, 4 ISSUES IN LAW AND MEDICINE 3 (1988). Simply put, any method of third party decision making carries with it an extreme danger that an incompetent individual's true wishes about remaining alive will not be carried out. *See In re* O'Connor, 72 N.Y.2d 517, 536, 531 N.E.2d 607, 617, 534 N.Y.S.2d 886, 896 (1988) (Hancock, J., concurring) ("There simply is no way of excluding the possibility that the patient has had a change of mind so that her past statements do not indicate her present wishes.").

37. *Grant*, 109 Wash. 2d at 567, 747 P.2d at 456; *see also supra* note 36.

38. *Id.* at 570-74, 747 P.2d at 458-60 (Andersen, J., concurring in part and dissenting in part).

39. *Id.* at 570, 747 P.2d at 458 (Andersen, J., concurring in part and dissenting in part).

citizens through their legislators.[40]

In contrast, Justices Goodloe and Dore dissented completely from Justice Callow's opinion, stating that Washington law[41] allows only competent adults, not their guardians, to determine whether and when to withhold life sustaining treatment.[42] Justice Goodloe also accused the majority of preempting ongoing legislative debate on the issue of artificial nutrition and hydration.[43] Like Justice Andersen, Justice Goodloe observed that the legislature, not the court, is the appropriate forum for such critical social value judgments.[44]

Even after the court issued its order and opinion, it was far from finished with the case of Barbara Grant. On December 22, 1987, the court received a letter from Assistant Washington Attorney General Steve Milam,[45] which brought to the court's attention new legislation changing the Washington Informed Consent Law.[46] According to Milam's letter, the court's requirement that all family members agree with the decision to withdraw treatment was in error. The new legislation prioritized classes of persons, from guardians and those with durable power of attorney, to family members, who could pro-

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40. *Id.*

41. The Natural Death Act, WASH. REV. CODE § 70.122.010-.905 (1987) [hereinafter NDA]. The NDA allows competent adults to refuse life sustaining treatment, before facing such treatment, through a written directive, or "living will." See *infra* notes 67-80 and accompanying text.

42. *Grant*, 109 Wash. 2d at 578, 747 P.2d at 462 (Goodloe, J., dissenting).

43. *Id.* at 578-79, 747 P.2d at 463 (Goodloe, J., dissenting). *See infra* notes 61-80 and accompanying text and notes 146-47 and accompanying text.

44. *Grant*, 109 Wash. 2d at 579, 747 P.2d at 463 (Goodloe, J., dissenting).

45. Letter to the Washington Supreme Court from Assistant Attorney General Steve Milam, *In re* Grant (No. 52609-5) (Dec. 22, 1987) [hereinafter Letter].

46. WASH. REV. CODE § 7.70.065 (1987):

> (1) Informed consent for health care for a patient who is not competent, as defined in [WASH. REV. CODE] § 11.88.010 (1)(b), to consent may be obtained from a person authorized to consent on behalf of such patient. Persons authorized to provide informed consent shall be a member of one of the following classes of persons in the following order of priority:
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> (a) The appointed guardian of the patient, if any;
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> (b) The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions;
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> (c) The patient's spouse;
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> (d) Children of the patient who are at least eighteen years of age;
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> (e) Parents of the patient; and
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> (f) Adult brothers and sisters of the patient.
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> (2) if the physician seeking informed consent for proposed health care of the patient who is not competent to consent makes reasonable efforts to locate and secure authorization from a competent person in the first or succeeding class and finds no such person available, authorization may be given by any

vide informed consent for incompetent individuals.[47]

The letter also asked the court "to consider errata changes to the opinion which I [Milam] believe would not have any substantive impact on the decision itself" but would eliminate confusion between the opinion and the new law.[48] An opinion revised with Milam's five proposed "changes," however, would not require the unanimous decision of an incompetent individual's immediate family to withhold life support. On the contrary, the changes would allow certain individuals, as they fell within the priority scheme provided in the statute, to decide when incompetent individuals would receive life sustaining treatment, if at all.[49] Milam asked that unanimity, which has been seen as a necessary condition to protect the incompetent individual's true interests,[50] be abandoned.

The court opened reconsideration of the case on the informed consent issue on its own motion,[51] and on January 5, 1988, issued an order that changed its opinion precisely as Milam had suggested.[52] One month later, however, the court reversed itself completely, when it issued another Order which stated that the January 5th Order had been "improvidently

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person in the next class in the order of descending priority. However, no person under this section may provide informed consent to health care:

(a) if a person of higher priority under this section has refused to give such authorization; or

(b) if there are two or more individuals in the same class and the decision is not unanimous among all available members of that class.

(3) Before any person authorized to provide informed consent on behalf of a patient not competent to consent exercises that authority, the person must first determine in good faith that that patient, if competent, would consent to the proposed health care. If such a determination cannot be made, the decision to consent to the proposed health care is in the patient's best interests.

47. Letter, *supra* note 45, at 1.

48. *Id.*

49. *Id.* at 2-3. *See* WASH. REV. CODE § 7.70.065 (1987), *supra* note 46. The nature and timing of an incompetent individual's death could be determined by a single individual.

50. *See In re* Grant, 109 Wash. 2d at 567, 747 P.2d at 456 (the court required unanimous approval of the patient's guardian, family members, physician, and health care facility before treatment could be withdrawn).

51. No record exists of either party moving for reconsideration on the informed consent issue. Normally, a decision will be mandated by the Clerk of the Supreme Court if no motion for reconsideration is filed within twenty days after the decision or if the parties stipulate that no such motion will be filed. *See* WASH. R. APP. P. 12.5(c), 12.4(b).

52. Order Changing Opinion, *In re* Grant (No. 52609-5) (Jan. 5, 1988); Letter, *supra* note 45, at 2-3 (court's changes are verbatim from Milam's letter).

granted."[53] The court rescinded the first order, retained jurisdiction for consideration of the application of the Informed Consent Law on its own motion, and directed the parties to submit supplemental briefs on the informed consent issue.[54] For one month, then, the court changed its majority opinion based solely on a letter received from an assistant attorney general *after* the court had released its decision. Though the court later realized the impact of these changes and corrected itself, the fact that it wavered at the behest of another branch of state government, after apparently reaching a decision on its own, dramatically demonstrates the institutional incompetence of the court to settle this difficult issue.

The court finally washed its hands of the *Grant* case in July, 1988. On July 15, the court issued two orders: the first denied its own motion for reconsideration,[55] and the other removed Justice Durham's name from Justice Callow's majority opinion, instead appending it to Justice Andersen's concurring and dissenting opinion.[56]

This final twist completely befuddled an already confused issue. What had previously been a five-vote majority decision with two dissenting camps of two justices each was transformed into a 4-3-2 outcome with no clear determination of exactly what decision had been made. The revised opinion, like the original, lists a majority of justices that sanctions Judith Grant's legal right to withhold life sustaining treatment from her daughter. This majority includes Justices Callow, Pearson, Utter, Dolliver, Anderson, Brachtenbach, and Durham. However, Justice Andersen and Justice Goodloe strongly dissented from Justice Callow's inclusion of artificial nutrition and hydration under the rubric of life sustaining treatment. Thus, the decision also possesses a majority of justices requiring at a minimum, that the legislature and not the court make

53. Order, *In re* Grant (No. 52609-5) (Feb. 16, 1988) [hereinafter Order]. Justice Durham said that the court was concerned with the potential impact of the "ill advised" first Order and revised opinion. Substantial conflicts of interest could arise, the court felt, such as "a second wife making the decision for the children of a first wife." Telephone interview with Justice Barbara Durham, Justice of the Supreme Court of Washington (Oct. 17, 1988) [hereinafter Durham].

54. Order, *supra* note 53.

55. Order Denying Motion for Reconsideration, *In re* Grant (No. 52609-5) (July 15, 1988). *See also supra* note 51.

56. *In re* Grant, 757 P.2d 534 (1988) (Revision of the Listing of Concurring Justices, July 15, 1988). This revision is incorporated into the bound edition of the official reporter. *See In re* Grant, 109 Wash. 2d 545 (1987).

such an inclusion.[57] Justices Andersen, Brachtenbach, Durham, Goodloe, and Dore are aligned under this proposition.

The opinion was finally mandated on July 19, 1988, yet the confusion caused by *Grant* was just beginning. Attorneys representing health care providers across the state have struggled to determine the true meaning of *Grant*.[58] Some have claimed that the 1986 Order[59] authorizing the withholding of artificial nutrition and hydration has precedential value.[60] Thus, artificial nutrition and hydration can be withheld in the same way as, for example, kidney dialysis. Others, however, in light of the Andersen and Goodloe opinions, see the case as a clear finding that removal of artificial nutrition and hydration is euthanasia and therefore illegal.[61]

Justice Durham has called *Grant* "very muddy."[62] As for the artificial nutrition and hydration controversy, she states, "I don't think we came to a decision on that issue."[63]

The bizarre procedural twists of *Grant* may also have had an impact on other adjudicated cases.[64] For example, a California court used *Grant* to show that no final decision in the country has found that artificial nutrition and hydration are *not* withholdable, life sustaining treatment.[65] More dramatically, a Washington man was recently convicted of first degree murder for shooting a young girl who died after doctors withdrew life sustaining equipment, including artificial nutrition and hydration.[66] If the mandated version of *Grant* states that artificial nutrition and hydration cannot be withheld without

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57. *See supra* text accompanying notes 39, 43.

58. Interview with Steven P. Helgeson, Deputy Clerk of the Supreme Court, Olympia, Washington (Oct. 10, 1988) [hereinafter Helgeson].

59. *See supra* note 27 and accompanying text.

60. Helgeson, *supra* note 58.

61. *Id.* Both parties in the *Cruzan* case currently before the U.S. Supreme Court, *supra* note 6, interpret the mandated version of *Grant* in this way. *See* Petition for Writ of Certiorari to the Missouri Supreme Court at 15-16, Cruzan v. Director of Missouri Dep't. of Health (No. 88-1503) (1989); Brief in Opposition at 15-16, Cruzan v. Director of Missouri Dep't. of Health (No. 88-1503) (1989).

62. Durham, *supra* note 53.

63. *Id.*

64. *Grant* was cited in a case which has since been vacated. The purpose for vacation is unknown. *See In re* Estate of Prange, 116 Ill. App. 3d 1091, 520 N.E.2d 946 (1988).

65. *In re* Drabick, 200 Cal. App. 3d 189, 189 n.1, 245 Cal. Rptr. 840, 841 n.1., *cert. denied*, 109 S. Ct. 399 (1988).

66. State v. Yates (Kitsap Co. Superior Ct. No. 87-1-00444-7) (1988). Extensive pretrial litigation concerned the issue of whether the girl's nutrition and hydration could be lawfully withdrawn.

legislative approval, the decisions relying on the slip opinion are severely weakened.

II. THE HISTORY OF LIFE SUSTAINING TREATMENT IN WASHINGTON

A. The Natural Death Act

Washington is one of forty-one states with "living will" legislation.[67] The Natural Death Act (NDA) was enacted in 1979 and permits a competent adult to formulate a directive outlining his or her desire to have life sustaining procedures withheld or withdrawn in the event of a terminal, "incurable injury, disease, or illness."[68] Life sustaining procedures are defined as any artificial or mechanical procedure which replaces a vital bodily function of a terminally ill person and serves only to prolong an imminent death.[69]

The NDA is meant to give a competent adult the means to exercise the right to refuse medical treatment before he or she becomes physically unable to convey that refusal. The legislature, however, recognized the "considerable uncertainty" that exists when the legal and medical professions attempt to determine the nature and timing of the death of a patient who cannot directly express his or her views.[70] As a result, the NDA is a cautious statute that strictly limits the circumstances under which life sustaining treatment may be legally withheld or withdrawn from an incommunicative patient.[71]

This caution is evident throughout the statute. It contains witnessing requirements that are more restrictive than those for executing a conventional will.[72] A "living will" is also more

67. Kamen, *When Exactly Does Life End?*, The Washington Post, National Weekly Edition, Sept. 18-24, 1989, at 31.

68. WASH. REV. CODE § 70.122.030(1) (1987).

69. WASH. REV. CODE § 70.122.020(4),(6),(7) (1987).

70. WASH. REV. CODE § 70.122.010 (1987).

71. The NDA also declares that neither euthanasia nor "any affirmative or deliberate act or omission to end life other than to permit the natural process of dying is permitted." WASH. REV. CODE § 70.122.100 (1987).

72. *Cf.*, WASH. REV. CODE § 11.12.010, .020 (1987) (witnesses to wills can also be beneficiaries of the will). *See* Chambers Estate, 187 Wash. 417, 60 P.2d 41 (1936) (witnesses of a "living will," however, cannot be related to the declarant by blood or marriage, cannot be the declarant's attending physician or an employee of the health care facility in which the declarant is a patient, and cannot be entitled to any portion of the declarant's estate upon the declarant's death. WASH. REV. CODE § 70.122.030(1)). Clearly, the legislature sought to keep the directives completely free from conflicts of interest.

easily revoked than a conventional will.[73] Further, the directive is not absolute. State interests, such as the protection of "potential human life," make the directive void; it is therefore not effective if the declarant is pregnant.[74]

The NDA also deals with the issue of how declarants who become incompetent should be treated. The directive remains in effect for the duration of the declarant's incompetency or until the declarant is able to communicate with the attending physician.[75] Moreover, if the attending physician refuses to effectuate the directive, he or she must make a good faith effort to refer the declarant to a physician who will.[76]

Clearly, the NDA attempts to insure that the declarant's actual decision regarding withholding or withdrawing life sustaining procedures will be fulfilled. Because of the gravity of this decision, only a competent declarant, and not a guardian or physician substituting his or her judgment[77] for that of the declarant or acting in the declarant's best interests,[78] can make or change the written directive. The NDA does not empower third parties to make decisions about life sustaining treatment for incompetent individuals.[79]

Despite the cautionary tone of the "living will" statutes, the enforceability of these directives is unclear. In making decisions about the nature and timing of an incommunicative patient's death, doctors, lawyers, and judges face considerable uncertainty. As one author observed, a directive "is not conclusive in any state. The attending physician who has potential civil or criminal liability has a large say in the matter of when

73. *Cf.*, WASH. REV. CODE § 11.12.040 (1987) (a conventional will can be revoked only by another written will or by destruction by the testator or someone in the testator's presence acting under his or her direction, as proved by two witnesses. A "living will," on the other hand, can be revoked by physical act (cancellation, defacement, or destruction) of the declarant or someone in the declarant's presence acting under his or her direction, by written revocation, or by verbal expression).

74. WASH. REV. CODE § 70.122.030(1)(c) (1987). Even the fundamental right to refuse medical treatment can be superceded by a state interest in protecting what has been termed "potential human life." Roe v. Wade, 410 U.S. 113 (1973). This position was challenged in DeNino v. State *ex rel.* Gorton, 102 Wash. 2d 327, 684 P.2d 1297 (1984), but the case was dismissed for failure to present a justiciable controversy.

75. WASH. REV. CODE § 70.122.040(3) (1987).

76. WASH. REV. CODE § 70.122.060(2) (1987).

77. *See supra* note 36.

78. *Id.*

79. In fact, if a person either intentionally causes life sustaining procedures to be withheld or withdrawn by falsifying a directive or by withholding personal knowledge of a revocation, that person can be prosecuted for murder. WASH. REV. CODE § 70.122.090 (1987). *See* discussion at Section II. B. 1, *infra*.

to pull the plug."[80]

B. Judicial History in Washington: Colyer, Hamlin & Ingram

The NDA did not specify that any action should be taken to withhold or withdraw life sustaining treatment from incompetent individuals who, if they had ever been competent to do so, had not formulated a directive. Prior to *Grant*, then, the Washington Supreme Court was forced to address the issue of withholding and withdrawing medical treatment from incompetent individuals on three occasions.[81] Familiarity with these decisions is crucial to a clear understanding of *Grant*.

1. *In re Colyer*

In re Colyer,[82] a 1983 case, involved a 69-year old woman who sustained a heart attack and was resuscitated only after oxygen deprivation had caused massive brain damage.[83] She existed in a "persistent vegetative state,"[84] was unresponsive to pain[85] or verbal stimuli, unable to breathe without a respirator, and, presumably, received artificial nutrition and hydration.[86] The attending physicians felt that the likelihood of any improvement in brain function was extremely remote, and that she would "persist" in an infantile state.[87] Mrs. Colyer's hus-

80. J. DUKEMINIER & S. JOHANSON, WILLS, TRUSTS, AND ESTATES 285 (3d ed. 1984).

81. *See* cases cited *supra* note 3.

82. 99 Wash. 2d 114, 660 P.2d 738 (1983).

83. *Id.* at 116, 660 P.2d at 740.

84. *See* definition *supra* note 5.

85. A finding of "unresponsiveness" is, at best, hypothesis.

> Physicians today assume that as the patient slips into a coma, no further awareness is present. This assumption is impossible to prove or disprove at this time. Because an organism in a coma does not usually respond to even deep pain, we assume that organism is unlikely to perceive the more subtle sensations of hunger or thirst. The patient who recovers from a coma typically has no memory of the experience. Yet if future sophisticated studies in neurology were to suggest the presence of awareness even in deep coma, many treatment approaches, including nutritional support, would require reassessment.

Dresser and Boisaubin, *Ethics, Law, and Nutritional Support*, 145 ARCHIVES OF INTERNAL MED. 122, 124 (1985).

86. No specific reference to artificial nutrition and hydration appears in the case, but the court indicated that Mrs. Colyer was completely incapacitated. *Colyer*, 99 Wash. 2d at 116-17, 660 P.2d at 740. The case, however, addressed only withdrawal of Mrs. Colyer's respirator.

87. *Id.* at 117, 660 P.2d at 740. Although such prognoses are usually borne out, it must be recognized that they rest on statistics; most patients do not recover, but the evidence shows that some in fact do. In 1962, Dr. Lev Landau, Nobel Prize winning

band was appointed her guardian, and he sought and obtained a court order authorizing him to withdraw his wife's life support systems.[88]

The Washington Supreme Court in *Colyer* largely followed previous cases from other jurisdictions in upholding the trial court.[89] It began by stating the well-founded theory that, under the constitutional right to privacy[90] and the common law right to freedom from bodily invasion,[91] competent adults

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physicist, was critically injured in a car accident. He suffered massive internal injuries, fractures, and brain damage. Even while on a respirator, his breathing and circulation failed numerous times. He suffered paralysis in his extremities, he was deaf, blind, speechless, without reflexes, and his brain received insufficient amounts of oxygen for over 100 days. Fourteen weeks after the accident and seven weeks after being removed from life sustaining treatment, Landau began to recover and eventually resumed his career in theoretical physics. "[T]he Landau case undermined the argument—which was just then being advanced in the English medical journal, *Lancet*—that doctors should not seek to prolong the lives of brain-damaged patients in 'irrevocable comas' . . . . Landau had been in such a coma for months." Currie, *The Redefinition of Death*, ORGANISM, MEDICINE, AND METAPHYSICS 184-85 (S. Spicker ed. 1978).

Numerous other cases of individuals defying "irreversible" comas and "brain death" exist: a soldier who stepped on a land mine could not be resuscitated, he registered a flat EEG, and was declared dead. An embalmer preparing to inject the soldier's femoral artery with embalming fluid, however, detected a faint pulse. The soldier was resuscitated successfully and recovered, sustaining only a speech impediment and no other brain damage.

A woman sustained severe brain stem injury in a car accident, and X-rays revealed that her brain was "a jumble." Doctors declared her "a vegetable" and suggested it would be more humane to withdraw her nutrition and hydration. She was "brain dead" for four months yet recovered to marry and raise a family. Slightly slurred speech was the only evident, permanent damage. *See* Currie at 184-91 for these and more cases; *see also* DECIDING TO FOREGO LIFE SUSTAINING TREATMENT, *supra* note 5, at 179 n.22 (citing the cases of two patients who recovered consciousness and cognitive function after a year in a persistent vegetative state caused by lack of oxygen).

88. *Colyer*, 99 Wash. 2d at 117, 660 P.2d at 740.

89. *See In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981); Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

90. *See* Griswold v. Connecticut, 381 U.S. 479, 484 (1965). Most subsequent decisions are in accord. *Saikewicz*, 373 Mass. at 739-49, 370 N.E.2d at 424; *Quinlan*, 70 N.J. at 40, 355 A.2d at 663. *But see Storar*, 52 N.Y.2d at 376, 420 N.E.2d at 70, 438 N.Y.S.2d at 272-73 (court called this a "disputed question . . . which the Supreme Court has repeatedly declined to consider").

The *Colyer* court found that the state's ability to impose criminal sanctions, its regulation of physicians and hospitals, its involvement in the guardianship process, and its parens patriae responsibility for incompetents constituted sufficient "state action" to apply the right to privacy to the state through the fourteenth amendment. *Colyer*, 99 Wash. 2d at 121, 660 P.2d at 742.

91. Union Pac. Ry. v. Botsford, 141 U.S. 250 (1891). *Accord Storar*, 52 N.Y.2d at 376, 420 N.E.2d at 70; 438 N.Y.S.2d at 272; *Saikewicz*, 373 Mass. at 738-39, 370 N.E.2d at

have the right to refuse medical treatment. The court also found, like courts in other jurisdictions, that this right is subject to the state interest of protecting the sanctity of life and is therefore not absolute.[92] Quoting the Supreme Judicial Court of Massachusetts, the court determined that the state interest finds its expression in four areas: (1) the preservation of life; (2) the protection of interests of innocent third parties; (3) the prevention of suicide, and; (4) the maintenance of the ethical integrity of the medical profession.[93]

Colyer held that the first interest, the preservation of life, prevails over a patient's right to refuse treatment when the patient does not consent to life *saving* treatment.[94] For cases in which treatment only prolongs an incurable condition, however, the court adopted the balancing test from *In re Quinlan*.[95] It weighed the degree of bodily invasion involved in the treatment against the state's interest in preserving life.[96] Clearly, under this analysis, only very slightly intrusive treatment could be administered over a patient's objections.[97]

The second interest, the protection of innocent third parties, prevails only when the patient has dependents who will not be provided for after the patient's death.[98] Since Mrs. Col-

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424. The *Colyer* court observed that this right forms the basis of the informed consent doctrine. *Colyer*, 99 Wash. 2d at 121-22, 660 P.2d at 743.

92. *Colyer*, 99 Wash. 2d at 122, 660 P.2d at 743. *See Storar*, 52 N.Y.2d at 377, 438 N.Y.S.2d at 273, 420 N.E.2d at 71; *Saikewicz*, 373 Mass. at 740-41, 370 N.E.2d at 424-25; *Quinlan*, 70 N.J. at 40-41, 355 A.2d at 663-64.

93. *Colyer*, 99 Wash. 2d at 122, 660 P.2d at 743 (citing *Saikewicz*, 373 Mass. at 741, 370 N.E.2d at 425).

94. *See In re* President & Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir. 1984), *cert. denied*, 377 U.S. 978 (1984). The court granted an order authorizing a hospital to administer a blood transfusion over the religious objections of a competent, adult patient.

95. 70 N.J. 10, 40-41, 355 A.2d 647, 663-64, *cert. denied*, 429 U.S. 922 (1976). This *Quinlan* balancing test is different from the proportionality analysis described above. *See supra* note 21. The *Quinlan* court instituted its test for the benefit of third party decision making; the Presidential Commission's report and the Vatican's declaration, on the other hand, foresaw individuals facing their own death using the proportionality analysis to weigh their *personal* burdens and benefits to arrive at their own decision.

96. *Colyer*, 99 Wash. 2d at 122-23, 660 P.2d at 743.

97. In the cases where the patient's decision was overridden by the state's interest, "the medical procedure required (usually a transfusion) constituted a minimal bodily invasion and the chances of recovery and return to functioning life were very good." *Quinlan*, 70 N.J. at 41, 355 A.2d at 664.

98. *Colyer*, 99 Wash. 2d at 123, 660 P.2d at 743. *See also In re* Osborne, 294 A.2d 372 (D.C. 1972) (father allowed to refuse blood transfusion because his family promised to care for his children); *In re* President & Directors of Georgetown College, Inc., 331

yer's husband and immediate family all requested withdrawal of treatment, there were no third party interests involved in this case.

The court found that the third interest, the prevention of suicide, did not apply to cases of terminally ill patients seeking to withdraw treatment that only prolonged their lives.[99] Again following the lead of previous decisions from other jurisdictions, the court found that "a death which occurs after the removal of life sustaining systems is from natural causes, neither set in motion nor intended by the patient."[100]

Finally, the court found that the state's interest in preserving the ethical integrity of the medical profession does not outweigh a terminally ill patient's right to refuse treatment that merely prolongs life.[101] In fact, the court reasoned, recognizing the patient's right to refuse artificial support is part of a doctor's general duty of care and comfort.[102]

While the court recognized that a patient's right to refuse life sustaining treatment *may* be outweighed by a state interest, it appears that the patient's right would rarely be disallowed by the limited state interest outlined in *Colyer*.[103] The court broke no new ground with its examination of a patient's right to refuse medical treatment; the right to be free from bodily invasion and the right to privacy have long been the foundation of the informed consent doctrine.[104] However, when the court determined that third parties have the power to withdraw life sustaining treatment from incompetent individuals who have not specifically expressed their views on the subject, it adopted new and perplexing reasoning.

In re Quinlan[105] first gave third parties the power to with-

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F.2d 1000 (denial of patient's refusal of blood transfusion based at least partially on the fact that she was the mother of a seven-month old infant).

99. *Colyer*, 99 Wash. 2d at 123, 660 P.2d at 743.

100. *Id.* (citing Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 743 n.11, 370 N.E.2d 417, 426 (1977)). *See also Quinlan*, 70 N.J. at 43, 355 A.2d at 665.

101. *Colyer*, 99 Wash. 2d at 123, 660 P.2d at 743 (quoting *Saikewicz*, 373 Mass. at 743-44, 370 N.E.2d at 426-27). *See also Quinlan*, 70 N.J. at 48-50, 355 A.2d at 668-69; *In re* Storar, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 71, 438 N.Y.S.2d 266, 273, *cert. denied*, 454 U.S. 858 (1981).

102. *Colyer*, 99 Wash. 2d at 123, 660 P.2d at 743-44.

103. *See Storar*, 52 N.Y.2d at 377, 420 N.E.2d 64, 71, 438 N.Y.S.2d at 273, *cert. denied*, 454 U.S. 858 (1981) (state interests were even more limited; medical procedures would be administered against patient's will only if patient posed a health threat to the community or if he or she engaged in activities inherently dangerous to his or her life).

104. *See* case cited *supra* note 91.

105. 70 N.J. 10, 355 A.2d 647.

draw life sustaining treatment in 1976,[106] and several courts have followed suit.[107] Like the *Quinlan* court, the *Colyer* court made the unfounded determination that, because the incompetent patient could not exercise her personal right to refuse life sustaining treatment, her personal right was not necessarily unexercisable.[108] In *Quinlan*, Karen Quinlan's father made the decision to withdraw life sustaining treatment, while in *Colyer*, Bertha Colyer's husband exercised his wife's personal right.

The *Colyer* court based its determination on the reasoning of the New Jersey Supreme Court that an incompetent individual's guardian and family must exercise the individual's right to refuse treatment or the right will be lost.[109] The New Jersey court's opinion is conspicuously void of any authority from common, statutory, constitutional, federal, or state law to support its determination that third parties, under the guise of exercising an incompetent individual's "personal" right, may determine the nature and timing of that incompetent individual's death. In addition, the court failed to even consider that this third party decision making might itself be the means of destroying an individual's personal right to privacy and self determination. As law professor Yale Kamisar writes:

> Was [Quinlan] really a 'right to die' case? No. It is far more accurate—albeit more troublesome—to view it as a 'power to let someone else die' case. Why? Because letting people die when you have a special relationship with them and a duty to care for them is the equivalent of killing them.[110]

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106. *Id.* at 41-42, 355 A.2d at 664.

107. *See* Gray by Gray v. Romeo, 697 F. Supp. 580 (D.R.I. 1988); Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983); Brophy v. New England Sinai Hosp. Inc., 398 Mass. 417, 497 N.E.2d 626 (1986); *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977).

108. *Colyer*, 99 Wash. 2d at 124, 660 P.2d at 744.

109. *See Quinlan*, 70 N.J. at 41-42, 355 A.2d at 664. The court specifically stated:

> If a putative decision by Karen to permit this non-cognitive, vegetative existence to terminate by natural forces is regarded as a valuable incident of her right of privacy, as we believe it to be, then it should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice. The only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render their best judgment, subject to the qualifications hereinafter stated, as to whether she would exercise it in these circumstances.

110. Kamisar, *The Real Quinlan Issue*, N.Y. Times, June 17, 1985, § 1, at 19, col. 1. *See also* J. NOWAK, R. ROTUNDA, J. YOUNG, CONSTITUTIONAL LAW, 720-21 (3d ed. 1986):

> It may be that society will recognize some ability of family members or doctors to engage in 'passive euthanasia' based on a societal decision that the quality of an individual's life is such that it should not be continued under

Kamisar cuts to the heart of the courts' flawed reasoning: the third party decisions authorized by the *Quinlan* and *Colyer* courts and their progeny accomplish results which conflict with those the courts claim they accomplish. These decisions do not protect the rights of incompetent individuals; instead, they broaden the power third parties have over these helpless individuals.

The *Colyer* court also adopted New Jersey's decision making procedure. The incompetent individual's guardian, *with or without regard to the previous statements of the individual*,[111] is "to use his best judgment and exercise, when appropriate, an incompetent's personal right to refuse life sustaining treatment."[112] It is of no consequence to the guardian's substituted judgment[113] that the incompetent individual never "explicitly expressed her desire to refuse life sustaining treatment."[114] Further, the *Colyer* court required that the guardian's judgment be upheld because it presumed that the vast majority of similarly situated individuals would choose to refuse such treatment as well.[115] As Kamisar points out, however,

> [e]ven if only a very few patients . . . were determined to

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certain circumstances. Nevertheless, failure to recognize this decision as one of allowing persons to take the life of another will lead to poorly reasoned decisions.

See also Kamisar, *Some Non-Religious Views Against Proposed 'Mercy Killing' Legislation*, 42 MINN. L. REV. 969 (1958); L. TRIBE, AMERICAN CONSTITUTIONAL LAW § 15-11 (2d ed. 1988); Note, *The Refusal of Life Sustaining Medical Treatment vs. the State's Interest in the Preservation of Life: A Clarification of the Interests at Stake*, 58 WASH. U.L.Q. 85.

111. *Colyer*, 99 Wash. 2d at 131-32, 660 P.2d at 748; *Quinlan*, 70 N.J. at 41, 355 A.2d at 664.

112. *Colyer*, 99 Wash. 2d at 128, 660 P.2d at 746.

113. *See supra* note 36.

114. *Colyer*, 99 Wash. 2d at 132, 660 P.2d at 748.

115. *Id.* at 134, 660 P.2d at 749. The court stated that "[i]f the patient's condition is hopeless or there is 'no reasonable possibility of returning to a cognitive, sapient state,' the patient's right of privacy outweighs the State's interest in preserving life." *Id.* (citations omitted). This statement represents a massive leap in logic wherein "the right to privacy" is equated with termination of a "hopeless" life; if there is no reasonable hope of recovery, the court seemed to say, everyone would exercise his or her right to privacy by terminating the use of life sustaining treatment. It appears that this equation is based on the following, equally illogical premise found in *Quinlan*: "The decision to terminate life sustaining treatment should be accepted by a society, the overwhelming majority of whose members, we think, in similar circumstances, exercise such a choice in the same way for themselves or for those closest to them." *Quinlan*, 70 N.J. at 41-42, 355 A.2d at 664. The court reasoned that most people would not wish to live what the court had deemed a hopeless life. Accordingly, a decision by a guardian to terminate such a life, despite the fact that the incompetent individual might have disagreed, must be upheld.

> struggle on, their being in a distinct minority is no justification for denying them their personal right to do so. After all, a court, even society's silent majority, cannot speak for *all* comatose people . . . .[116]

Finally, the *Colyer* court completed its adoption of New Jersey law by finding that the decision to withdraw life sustaining treatment was the sole province of an incompetent individual's guardian, family, and physician, free from judicial intervention.[117] The court reasoned that "the judicial process [is] an unresponsive and cumbersome mechanism for decisions of this nature."[118] Contrary to decisions in other jurisdictions,[119] the court found that the rights of incompetent individuals are sufficiently protected by the existing state system of guardians[120] and guardians ad litem, supplemented by attend-

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116. Kamisar, *The Real Quinlan Issue*, *supra* note 110.

117. *Colyer*, 99 Wash. 2d at 127-28, 660 P.2d at 746; *Quinlan*, 70 N.J. at 50, 355 A.2d at 669.

118. *Colyer*, 99 Wash. 2d at 127, 660 P.2d at 746; *see Quinlan*, 70 N.J. at 50, 355 A.2d at 669.

119. *See* Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 759, 370 N.E.2d 417, 435 (1977). The court held:

> [this] most difficult and awesome question—whether potentially life-prolonging treatment should be withheld from a person incapable of making his own decision [is not, as the *Quinlan* court found,] . . . 'a gratuitous encroachment' on the domain of medical expertise. Rather, such questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created. Achieving this ideal is our responsibility and that of the lower court, and is not to be entrusted to any other group purporting to represent the 'morality and conscience of our society,' no matter how highly motivated or impressively constituted.

120. *Colyer*, 99 Wash. 2d at 129, 660 P.2d at 746-47. The *Colyer* court cited Washington's guardianship statute, which provides that an appointed guardian has the power "to care for and maintain the incompetent or disabled person, assert his or her rights and best interests, and to provide timely, informed consent to necessary medical procedures." WASH. REV. CODE § 11.92.040 (1987). The court also observed that the statute contains exceptions to what the guardian can consent to without a court order:

> (a) Therapy or other procedure which induces convulsion;
>
> (b) Surgery solely for the purpose of psychosurgery;
>
> (c) Amputation;
>
> (d) Other psychiatric or mental health procedures which are intrusive on the person's bodily integrity, physical freedom of movement, or the rights set forth in [WASH. REV. CODE] § 71.05.370.

Id. The court found that its newly recognized doctrine of guardian power to withdraw life sustaining treatment did not fit into these necessarily "narrowly construed" exceptions. *Colyer*, 99 Wash. 2d at 129, 660 P.2d at 747. It is difficult to fathom, however, how a guardian cannot provide consent for an amputation to be performed on his or her ward without court approval, yet can determine the nature and timing of the ward's death without such approval. The Massachusetts court in *Saikewicz*, unlike the

ing physicians and a "prognosis board" of other physicians.[121] Only in the event of disagreement among these parties may the courts intervene.[122]

2. *In re Hamlin*

The Washington Supreme Court addressed the specific issue of withdrawing life sustaining treatment a year and a half later in the 1984 case of *In re Hamlin*.[123] Joseph Hamlin was a 42-year old man, severely retarded from birth, who suffered a heart attack and lapsed into a vegetative state.[124] Because of his lifelong condition, Joseph Hamlin had never expressed his views on the provision or withdrawal of life sustaining procedures.[125]

The court followed the reasoning it employed in *Colyer* in all but two respects. First, it greatly broadened the power of a family to withhold or withdraw life sustaining treatment from one of its members by finding that, when a family exists, a guardian need not be appointed.[126] Second, the court limited its own dictum in *Colyer* which stated that the judiciary may be required to intervene in the substantive decision to withhold or withdraw treatment from incompetent individuals who have never let their wishes be known.[127] The court held that even in these cases, if the individual's guardian, physician, and prognosis committee agree upon the individual's best interests,[128] the judiciary need not become involved.[129]

3. *In re Ingram*

The final Washington case prior to *Grant* addressing the

Colyer court, was at least able to grasp the magnitude of the interest involved in these cases. *See supra* text accompanying note 119.

121. *Colyer*, 99 Wash. 2d at 134-37, 660 P.2d at 749-50.

122. *Id.* at 136, 660 P.2d at 750. For the court's complete presentation of its system of guardians, guardians at litem, and physicians, see *id.* at 128-37, 660 P.2d at 746-51.

123. 102 Wash. 2d 810, 689 P.2d 1372 (1984).

124. *Id.* at 812-13, 689 P.2d at 1374.

125. *Id.* at 812, 689 P.2d at 1374.

126. *Id.* at 818, 689 P.2d at 1377. Two of the limited "safeguards" the court provided an incompetent individual in *Colyer*, the guardianship hearing and the additional voice of the guardian, disappeared because the court found the safeguards too "cumbersome." *See id.* at 824-26, 689 P.2d at 1380-81 (Rosellini, J., dissenting).

127. *Id.* at 819-21, 689 P.2d at 1378; *see also Colyer*, 99 Wash. 2d at 136, 660 P.2d at 750 (1983).

128. *In re* Hamlin, 102 Wash. 2d 810, 820, 689 P.2d 1372, 1378 (1984); *see also supra* note 36.

129. *Id.*; *but see supra* note 119.

medical treatment of incompetent individuals was a companion case to *Hamlin*, *In re Ingram*.[130] Opal Ingram, a sixty-six-year-old woman, had malignant cancer of the larynx. Though adjudicated incompetent, she expressed her preference for radiation treatment rather than removal of her vocal cords. Removal offered a higher success rate than radiation, but necessitated the loss of speech. Ingram's guardian petitioned the court to authorize the surgery.

The court recognized that this case shared with *Colyer* and *Hamlin* the common issues of an individual's right to refuse medical treatment and the authority of the guardian under the Washington guardianship statute.[131] The court, however, found few other similarities to those two prior cases. The court characterized *Ingram* as a case of choice not between life and death but between two different treatments.[132] Surgery provided a better chance of a cure while radiation offered less severe side effects.[133]

The court also construed the exceptions to the rule that guardians obtain court approval before consenting to medical procedures more broadly than it had in *Colyer*.[134] The *Colyer* court found that a guardian need not seek judicial approval to withhold or withdraw life sustaining treatment.[135] In *Ingram*, on the other hand, the court searched for the guardianship statute's intent. The court declared that a guardian must gain court approval before consenting to any "highly intrusive, irreversible medical treatment."[136] It is ironic that a guardian may determine the nature and timing of a ward's death with no judicial supervision, yet he or she cannot consent to surgery for the ward without obtaining judicial approval.

The Washington Supreme Court, beginning with *Colyer*, has allowed guardians, families, and/or physicians to terminate

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130. 102 Wash. 2d 827, 689 P.2d 1363 (1984).

131. *Id.* at 836, 689 P.2d 1368; *Colyer*, 99 Wash. 2d at 119-22, 128-32, 660 P.2d at 741-43, 746-48; *see also supra* note 120 and accompanying text.

132. *Ingram*, 102 Wash. 2d at 843, 689 P.2d at 1371-72.

133. *Id.*

134. *Id.* at 836-38, 689 P.2d at 1368-69.

135. "These exceptions do not seem applicable to the situation we are addressing here." *Colyer*, 99 Wash. 2d at 129, 660 P.2d at 747 (construing statute identical to WASH. REV. CODE § 11.92.040(3)(a)-(d)); *see also supra* notes 117-22 and accompanying text.

136. *Ingram*, 102 Wash. 2d at 837, 689 P.2d at 1369. Under this definition, treatment to which a guardian could previously consent without petitioning the judiciary became subject to judicial approval. Virtually any surgery comes under the umbrella of "highly intrusive" and "irreversible treatment."

life sustaining treatment for incompetent individuals by use of the substituted judgment test or a best interests standard without requiring court approval. The *Grant* case used *Colyer* and *Hamlin* as a foundation, broadening this power of guardians and consequently reducing protection for incompetent individuals. In *Grant*, the court further weakened the rights of incompetent persons in two, distinct ways: first, it allowed guardians to withhold or withdraw life sustaining treatment from *non*-comatose, incompetent individuals;[137] and second, it classified artificial nutrition and hydration as withholdable and withdrawable life sustaining treatment. In doing so, the court usurped the general authority of the legislature to formulate law, especially in complex areas requiring exhaustive fact-finding, and effectively preempted ongoing legislative debate.

C. *The Current Legislative Debate*

A common thread running through most decisions relating to the withholding or withdrawal of life sustaining treatment is the appeal by many judges for the legislature to resolve the issue.[138] Yet, the courts are not uncomfortable with broaching the issue of incompetent individuals' rights. In the absence of legislative guidance, the issue is within their rightful authority even though they attempt to resolve it with illogical and unconstitutional reasoning.[139] The courts, however, continue to plead for legislative action on the issue of definitions. Courts, comprised of at most nine individuals and relying solely on briefs and sporadic, supplemental research, admit that the legislature is better equipped to determine just what constitutes withholdable or withdrawable life sustaining treatment.[140]

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137. Both *Colyer* and *Hamlin* pertained to individuals in "irreversible comas" or "persistent vegetative states." The *Grant* court was not willing to wait until Barbara Grant passed this threshold.

138. *See* Barber v. Superior Court, 147 Cal. App. 3d 1006, 1014, 1018, 1021, 195 Cal. Rptr. 484, 488, 491, 492-93 (1983); Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 447, 497 N.E.2d 626, 643 (1986) (Lynch, J., dissenting in part, calling for judicial restraint); Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 755 n.18, 370 N.E.2d 417, 432 n.18 (1977).

139. *See supra* notes 105-10 and accompanying text. The *Quinlan* court and those which followed its reasoning failed to appreciate the stark difference between a competent adult's decision and the decisions made *by* third parties *for* incompetent individuals.

140. Barber v. Superior Court, 147 Cal. App. 3d at 1018, 195 Cal. Rptr. at 491; Superintendant of Public Schools v. Saikewicz, 373 Mass. at 755 n.18, 370 N.E.2d at 432 n.18; *In re* Storar, 52 N.Y.2d 363, 370, 420 N.E.2d 64, 67, 438 N.Y.S.2d 266, 269, *cert.*

Grant is no different in this respect.[141] Justice Callow stated, however, "that the fact remains . . . that the petitioners have addressed the problem dealing with their daughter, her rights and desires, and their circumstances to this court, not the Legislature, and we must answer an immediate problem now not an academic problem at some future date."[142] According to this reasoning, the court will answer any individual who comes to court under the proper "circumstances" and with an "immediate problem." Unfortunately, Justice Callow's rule appears to apply even to problems involving difficult public policy issues, such as *Grant*, where the court, unlike the legislature, is inherently unable to accurately and comprehensively weigh the impact of its answers. Justice Callow stated that "the issue presented here [artificial nutrition and hydration as life sustaining treatment] *has only recently been addressed* by courts, commentators and the medical profession."[143] In addition, Justice Callow never acknowledged that, even as he wrote his opinion, the Washington State Legislature was also embroiled in debate over whether to characterize artificial nutrition and hydration as life sustaining treatment under the NDA.[144] Despite the controversy which raged outside the halls of the supreme court,[145] Justice Callow chose to characterize

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denied, 454 U.S. 858 (1981); *In re* Hamlin, 102 Wash. 2d 810, 821, 689 P.2d 1372, 1379 (1984); *In re* Colyer, 99 Wash. 2d 114, 139, 660 P.2d 738, 752 (1983).

141. *In re* Grant, 109 Wash. 2d at 564, 747 P.2d at 455; *see also id.* at 573-74, 747 P.2d at 459-60 (Andersen, J., concurring in part and dissenting in part); *id.* at 576-79, 747 P.2d at 462-63 (Goodloe, J., dissenting).

142. *Id.* at 564, 747 P.2d at 455.

143. *Id.* at 559, 747 P.2d at 452 (emphasis added).

144. Engrossed Substitute Senate Bill (ESSB) 5401 was first introduced on January 28, 1987, and after the Washington State House and Senate passed conflicting versions, the bill finished the legislative session in Conference Committee. The primary obstacle to agreement, not surprisingly, was artificial nutrition and hydration. The Senate bill read: "Life-sustaining treatment shall not include the administration of medication or the performance of any medical or surgical care or the provision of nutrition and hydration for comfort care deemed necessary to alleviate pain." ESSB 5401 at 3, lines 9-12. The House bill made no such exception for artificial nutrition and hydration. *See* ESSB 5401 — H. Comm. Amendment at 3, lines 9-12.

In addition to ESSB 5401, a bill was introduced in the House on February 3, 1988, before *Grant* was mandated, which stated:

> The legislature finds that food and water are necessary to life, and, therefore, the withdrawal or withholding of food or water constitutes suicide or euthanasia, except in the case when two physicians independently determine that death is imminent . . . or the person is physically unable to tolerate the provision of such food and water.

HB 1965 at 3, lines 11-18. The debate over artificial nutrition and hydration continues in the current legislative session over nearly identical statutory language.

145. Justice Andersen's opinion highlighted commentators and members of the

artificial nutrition and hydration as life sustaining treatment. Further, he effectively preempted the legislature from deciding the appropriate care for patients such as Barbara Grant because of that branch's propensity for "emotional considerations based upon an ignorance of medical reality."[146] In effect, Justice Callow declared that, despite legislative enactments like the NDA, the legislature was too sentimental and obtuse to determine the status of artificial nutrition and hydration with regard to incompetent patients.[147]

One of Justice Callow's major rationales for this expression of judicial activism, in circumstances that cried out for judicial restraint, was that other state courts had acted simi-

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medical profession, who, despite Justice Callow's representations to the contrary, urge prohibiting the withholding or withdrawal of artificial nutrition and hydration. Instead, those commentators plea for "much fuller debate and discussion than has yet taken place." *Grant*, 109 Wash. 2d at 571-72, 747 P.2d at 458-59 (Andersen, J., concurring in part and dissenting in part (quoting Siegler and Weisbard, *Against the Emerging Stream: Should Fluids and Nutritional Support Be Discontinued?* 145 ARCHIVES OF INTERNAL MED. 129 (1985))).

Andersen also chronicled the current legislative debate, commenting on the "great deal of statewide public attention . . . press reports . . . [and the] numerous individuals and professional health care and hospice people" who testified before the legislature. *Grant*, 109 Wash. 2d at 573, 747 P.2d at 460 (fifteen physician, nurse, health care provider, patient, research, senior citizen, and religious organizations are listed).

146. *Grant*, 109 Wash. 2d at 565, 747 P.2d at 455. While Justice Callow's opinion did not preclude further action by the legislature on the issue of artificial nutrition and hydration, it sought to establish the legal status of artificial nutrition and hydration in Washington State: "We hold that the right of a terminally ill patient to have life sustaining procedures withheld includes the right to withhold nasogastric tubes, intravenous feeding, and other artificial means of nutrition and hydration." *Id.* This concluding statement on the issue of artificial nutrition and hydration reads remarkably like a legislative finding. Further, if binding, it unequivocally establishes that artificial nutrition and hydration, not only in Barbara Grant's case but in all cases of the terminally ill, are withholdable and withdrawable. While the legislature may still address this issue, its inquiry will not be entirely free; the legislature may not address the issue without either accepting or rejecting the Supreme Court's decision.

Indeed, Justices Andersen and Goodloe hinted that the legislature was most likely preempted from addressing the issue of artificial nutrition and hydration. Justice Andersen stated that "[t]he legislature had this identical issue under consideration at a recent legislative session and would undoubtedly consider it again *except, perhaps, for the majority's holding in the present case.*" *Id.* at 570, 747 P.2d at 458 (emphasis added). Further, Justice Goodloe stated that "with apparent ease, the majority *cuts off* the debate and concludes that the right to withhold treatment extends to nutrition and hydration." *Id.* at 579, 747 P.2d at 463 (italics added).

For the difficulties involved in a legislative rejection of *Grant*, *see infra* note 147.

147. It is unclear what the fate of future legislative enactments that are contrary to *Grant* would be. *Grant* sought to recognize a constitutional right to have artificial nutrition and hydration withheld. *Grant*, 109 Wash. 2d at 565, 747 P.2d at 455. Therefore, a legislative enactment rejecting this newly created "right" might very well be stricken on constitutional grounds by the justices of the *Grant* court's majority.

larly.[148] Arguably, the doctrine of "two wrongs make a right" has never before been cited to support a decision with such impact.[149]

Justice Andersen's dissent attacked the majority for deciding an issue rightfully within the domain of the legislature. He stated that the judicial system had no better ability to understand and decide the policy issues underlying *Grant* than the electorate or the legislature.[150] He then provided reasons why the legislature is the proper forum for deciding this "very basic public policy."[151]

Justice Andersen observed that the legislature had access to the direct input of its constituents, many of whom personally confront the issue of life sustaining treatment.[152] He also recognized the legislature's ability to hold public hearings where "everyone concerned, including professionals of all types, can be heard and have their views given full consideration."[153]

Justice Andersen's observations about the advantages of the legislature and their sharp contrast with the limitations of the supreme court are well taken. The court deals only with individual attorneys on specific cases in the isolation of its courtroom and chambers. It can tap the knowledge of experts only through the experts' writings which are sometimes discovered in supplemental research.

The illogical leaps in reasoning throughout Justice Callow's opinion demonstrate the strength and logic of Justice Andersen's dissenting opinion. Clearly, it is the role of the legislature to formulate consistent public policy, especially when such policy relates to the complex issue of what constitutes life sustaining treatment. Justice Callow's opinion acknowledged this as the proper role of the legislature. The opinion, however, went beyond the facts of Barbara Grant's case and sought to create a universally applicable rule that artificial nutrition and hydration are withholdable and withdrawable treatment.

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148. *Id.* at 564, 747 P.2d at 455.

149. The possible exception to this claim is the adoption by some courts of the *Quinlan* court's reasoning, which created a right in third parties to exercise another individual's rights of privacy and self determination. *See supra* notes 105-10 and accompanying text.

150. *Grant*, 109 Wash. 2d at 574, 747 P.2d at 460 (Andersen, J., concurring in part and dissenting in part).

151. *Id.*

152. *Id.*

153. *Id.*

While Justice Andersen's arguments support legislative resolution of the artificial nutrition and hydration issue, the court itself demonstrated its institutional incompetence throughout its disposition of *Grant*. First, the majority was unaware of, or ignored, legislative action on the issue that was taking place at the precise time the court was formulating its opinion. If it had acknowledged the existence of ESSB 5401,[154] the majority may have been compelled to let the legislature decide the issue. As Justice Goodloe wrote in dissent:

> The failure of the Legislature to extend the NDA [to cover withholding and withdrawal of artificial nutrition and hydration] demonstrates that, unlike the majority, the Legislature is having a difficult time determining the extent of authority which guardians ought to have in deciding matters of life and death for their wards.[155]

Further, as Justice Andersen stated:

> The Legislature enacted the Natural Death Act and if, with the benefit of all its resources, the Legislature can pass a law allowing the withdrawal of food and water while protecting the infirm and helpless, then well and good; if not, that too should tell us something.[156]

Second, as evidenced by Assistant Attorney General Milam's letter, the court issued an opinion without knowing that the decision apparently contradicted the new informed-consent legislation.[157] The court attempted to correct its mistake but contradicted its own previous order in the process.[158] The court finally mandated an opinion with no clear majority and no clear indication of its position.[159]

In assessing the *Grant* court's mistakes, it is important to recall that the judiciary is isolated from the political process by design.[160] One consequence of this is that the judiciary is ill-equipped to keep abreast of developments in other branches of

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154. *See supra* note 144.

155. *Grant*, 109 Wash. 2d at 579, 747 P.2d at 463 (Goodloe, J., dissenting).

156. *Id.* at 574, 747 P.2d at 460 (Andersen, J., concurring in part and dissenting in part).

157. *See supra* text accompanying notes 45-48.

158. *See supra* text accompanying notes 51-54.

159. *See supra* text accompanying notes 56-63.

160. *See* State *ex rel.* Govan v. Clausen, 108 Wash. 133, 183 P. 115 (1919). The court stated:

> [T]he motive or purpose of the legislature in adopting laws may not be inquired into by the courts . . . [because to do so] "would put an end to that

government. Thus, the court may very likely contradict the legitimate conclusion of another branch of government when considering a complex and controversial issue. While the judiciary must at times infuse itself into such issues,[161] it must do so only with the utmost caution and care. The *Grant* court's attempt to terminate legislative debate and usurp legislative decision making power is the antithesis of caution and care.

III. ARTIFICIAL NUTRITION AND HYDRATION ARE NOT WITHHOLDABLE AND WITHDRAWABLE LIFE SUSTAINING TREATMENT

In re Grant left the issue of artificial nutrition and hydration entirely unresolved. Therefore, it is up to the court or legislature to clear up the court's "very muddy" conclusion, and to determine whether artificial nutrition and hydration are in fact life sustaining treatment. Whichever branch finally decides the issue, it must examine the following arguments, and it should ultimately decide not to classify artificial nutrition and hydration as life sustaining treatment.

A. The Constitutional Argument

In addition to being attacked for illogical reasoning and exceeding the boundaries of judicial responsibility, *Quinlan* and the cases which rely on it have been attacked on constitutional grounds.[162] Attorney and author James Bopp[163] has criticized these decisions as inconsistent with the Equal Protection Clause[164] as well as substantive[165] and procedural due

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> confidence and respect . . . [the separate branches of government have for one another] which it is the purpose of the Constitution to uphold. . . .

Id. at 142, 183 P. at 118 (quoting McCray v. United States, 195 U.S. 27, 55 (1903)).

161. Perhaps the most obvious such case is Brown v. Bd. of Educ., 347 U.S. 483, 495-6 (1954). The Supreme Court later coordinated federal district courts to uniformly implement its non-discrimination policy and overcome recalcitrant local authorities on the issue of school desegregation. Brown v. Bd. of Educ., 349 U.S. 294, 300 (1955).

162. *See* Smith, *In re Quinlan: Defining the Basis for Terminating Life Support Under the Right of Privacy*, 12 TULSA L.J. 150 (1976); Note, *Constitutional Law—No Constitutional Basis Exists to Permit a Parent to Assert for His Adult Child a Right to Die*, 7 TEX. TECH. L. REV. 716 (1976).

163. President, National Legal Center for the Medically Dependent and Disabled, Inc.; General Counsel, National Right to Life Committee, Inc.; Member, Congressional Biomedical Ethics Advisory Committee; Former Member, President's Committee on Mental Retardation; Editor, ISSUES IN LAW AND MEDICINE; J.D. University of Florida, 1973. *See* J. Bopp, 4 ISSUES IN LAW AND MEDICINE 3 (1988).

164. U.S. CONST. amend. XIV, § 1. *Quinlan* and its progeny mandate unequal treatment of the class of incompetent individuals. Incompetent individuals are a

process.[166]

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suspect class because they possess the immutable disability of incompetency, they are precluded from participation in the political process, and they "can claim some degree of prejudice from at least part of the public at large." Bopp, *supra* note 163, at 17 (quoting City of Cleburne, Tex. v. Cleburne Living Center, 473 U.S. 432, 445 (1985)). They are treated differently from competent individuals solely because of their incompetency. The consent of a competent adult is required before one can withdraw life sustaining treatment from him or her, yet a third party may withdraw such treatment from an incompetent individual without that individual's consent. Such disparate treatment between two classes of individuals constitutes a clear violation of the Equal Protection Clause.

State court decisions and legislation allowing the removal of artificial nutrition and hydration from incompetent individuals create specific constitutional violations of their own. By retaining criminal sanctions only for those who remove food and water from non-consenting, competent patients, these states do not equally protect the lives of non-consenting, incompetent patients. *Id.* at 19. In these states, one who withdraws artificial nutrition and hydration from a competent patient who has not consented to the withdrawal may be charged with murder. On the other hand, one acting under a best interests or substituted judgment standard who withdraws artificial nutrition and hydration from a patient who *would not* consent to the withdrawal, but is incompetent to do so, will not be held criminally liable. This kind of blatantly unequal treatment is prohibited by the Equal Protection Clause. *Id.* at 21.

165. U.S. CONST. amend. XIV, § 1. Withholding or withdrawing food and water from incompetent individuals has also been treated as a violation of substantive due process. Bopp, *supra* note 163 at 21-23. All persons have a fundamental right to life. The Declaration of Independence para. 2 (U.S. 1776). The removal of food and water, and thus life, from incompetent individuals who have not consented, absent a compelling state interest, Shapiro v. Thompson, 394 U.S. 618, 634 (1969), deprives these individuals of substantive due process.

Further, in Youngberg v. Romeo, 457 U.S. 307, 316 (1982) the U.S. Supreme Court held that the Fourteenth Amendment granted involuntarily committed, mentally retarded individuals "a right to adequate food, shelter, clothing and medical care." Similarly, in Estelle v. Gamble, 429 U.S. 97 (1976) the Court found that the state must provide for the medical needs of prisoners because of their total dependence on the state. Incompetent individuals are totally dependent on the hospital staff and physician, who are regulated by the state. This regulation is sufficient to classify the provision and denial of artificial nutrition and hydration as state action. Therefore, when this treatment is denied without the patient's consent, the state violates this patient's substantive due process right to life. Bopp, *supra* note 163, at 12-15, 22.

166. U.S. CONST. amend. XIV, § 1. Decisions such as *Grant* violate procedural due process as well because they do not provide appropriate procedures before the right to life is extinguished. Bopp, *supra* note 163, at 24-30. Family members with conflicting interests and unfamiliar attending physicians not chosen by the incompetent individual may not make decisions reflecting that individual's true intent. Likewise, parties motivated to end some perceived emotional and economic burden on the patient, or the real emotional and economic burden on themselves, will not necessarily make decisions in the best interests of the patient. *Id.* at 24.

Most importantly, however, there is the "distorting effect of negative attitudes concerning people with disabilities." *Id.* at 25. Society devalues the lives of retarded or incapacitated individuals and therefore deems these lives to be incapable of enjoyment or void of sufficient worth. This attitude precludes a finding that it is in an incompetent individual's best interest to continue receiving food and water. For these reasons, contrary to the finding in *Grant*, the decisions of relatives, guardians, and physicians must be reviewed by an objective and disinterested court. Conflicting

B. The "Emotional" Argument

Many authorities distinguish artificial nutrition and hydration as basic, required care rather than life sustaining treatment. Some authors and judges[167] belittle this view by claiming that these authorities are acting solely on their emotions. These authors and judges maintain that the cultural identity of food and water with comfort and nurturing prevents most people from shaking the mistaken belief that artificial nutrition and hydration are food and water. This mistaken belief, these judges conclude, precludes emotionally oriented people from agreeing that artificial nutrition and hydration are withholdable and withdrawable.[168] The fallacy that artificial nutrition and hydration are fundamentally different from other types of food and water will be addressed in the next section. First, however, an argument may be made against the *Grant* court's conclusions based upon fundamental human emotions.

Ethicist Daniel Callahan[169] writes that feelings and sentiment are synonymous with a well ordered moral life. "If they [emotions] are not always reliable guides, their absence is even more hazardous, as anyone who has dealt with a sociopath is painfully aware."[170]

Callahan explains that "withholding and withdrawing artificial nutrition and hydration is fast becoming the 'nontreatment of choice' because it is the only way to insure that

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interests and negative attitudes of loving family members are not the norm in these situations. Nevertheless, the possibility of such interests and attitudes cannot be ignored, and the right to procedural due process must be enforced to protect incompetent individuals from wrongly-motivated decisions. *See supra* note 119; *see also In re* O'Connor, 72 N.Y.2d 517, 534, 531 N.E.2d 607, N.Y.S.2d 886 (1988) (New York requires such a system of review).

Finally, incompetent individuals have a fundamental right to be provided with food and water. In Goldberg v. Kelly, 397 U.S. 254 (1970), the Supreme Court accorded the right to welfare benefits, which provide daily sustenance, the strictest procedural protection. Therefore, like the institutionalized incompetent in *Youngberg*, *supra* note 165, the prisoner in *Estelle*, *supra* note 165, and the welfare recipient in *Goldberg*, Barbara Grant's private interest in receiving nutrition and hydration is a fundamental right. Like these individuals, Barbara depends on nutrition and hydration to sustain her life, and she is dependent upon others to furnish it. Bopp, *supra* at 27.

167. *See supra* text accompanying note 146; *How Should Washington Decide*, *supra* note 5.

168. *See How Should Washington Decide*, *supra* note 5.

169. Director, the Hastings Center, a medical ethics research center.

170. Callahan, *On Feeding the Dying*, 13 THE HASTINGS CENTER REP. 22 (Oct. 1983).

'tenacious patients actually die.' "[171] He then characterizes as purely rational and "legitimate" a policy decision that, if food and water cannot return a patient to a "cognitive" life, it should then be withdrawn.[172] Nevertheless, Callahan recognizes that "a cluster of sentiments and emotions" blocks the institution of this kind of policy.[173] These sentiments and emotions require that we not starve someone who is incapable of feeding him or herself. The desire to feed the hungry is greater than pure utility and rationality because "[i]t is the perfect symbol that human life is inescapably social and communal."[174]

Callahan, therefore, sees nothing wrong with being repulsed by the withholding or withdrawal of nutrition and hydration from an individual in need. Even if an anti-starvation policy may not be fully defended on rational grounds, Callahan maintains it could preserve "one of the few moral emotions that could just as easily be called a necessary social instinct."[175] Despite the *Grant* court's condescending approach to "emotional considerations," Callahan's purely emotional opposition to the withholding and withdrawal of artificial nutrition and hydration poses a strong argument against the *Grant* court's conclusions.

Another argument against withholding or withdrawing artificial nutrition and hydration, characterized both as emotional[176] and as a state interest,[177] is that forcing doctors to withhold or withdraw erodes the essential physician-patient relationship.[178] A doctor, because of his or her superior knowledge, owes a fiduciary duty to the patient. This includes the duty to provide medical care and necessities such as food and shelter and to act to preserve the life of the patient. There-

171. *Id.* Karen Quinlan, for example, survived ten years after her respirator was withdrawn. Malcolm, *The End of the Quinlan Case But Not the Issues It Raised*, N.Y. Times, June 16, 1985, § 4, at 22, col. 2.

172. *Id.*

173. *Id.*

174. *Id.*

175. *Id.*

176. Provision of food and water by physicians is belittled in the same way as any "comfort and care" argument. Some commentators state that the inherent human belief that food and water offer comfort to those without such nutrition and hydration clouds rational judgment. Some patients, they maintain, are better off starving, regardless of whether they can tolerate food and water any longer. *See How Should Washington Decide*, *supra* note 5, at 446-47.

177. *In re* Grant, 109 Wash. 2d 545, 556, 747 P.2d 445, 451 (1987).

178. *See* Bopp, *supra* note 163, at 15-16, 44.

fore, if physicians are forced to refuse nutrition and hydration for their patients, they are forced to violate their fiduciary duty. "The presumption that the physician will act to preserve his patient's life and health will erode and the physician-patient relationship will be damaged."[179]

The *Grant* court, quoting *Colyer*, dismissed this concern by stating that doctors must sometimes provide only comfort instead of treatment and that "it is not necessary to deny a right of self-determination to a patient in order to recognize the interests of doctors."[180] However, this claim is legitimate only if the patient has truly exercised his or her right of self-determination, and, as shown above,[181] third party decision making does not always accomplish this end. As a result, doctors may be forced to withhold basic sustenance from a patient who may be vehemently opposed to such action.

Furthermore, *Grant* cited an American Medical Association statement[182] and the report of a Presidential Commission[183] to support the proposition that "[l]ife prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration."[184] Despite the resulting inference that the medical profession approves the withholding and withdrawal of artificial nutrition and hydration from terminally ill patients, "many physicians believe discontinuance of hydration would irrevocably sever the therapeutic relationship, while maintaining hydration would reinforce traditional goals of the physician-patient relationship: to cure sometimes, to relieve occasionally, to comfort always."[185] Thus, many physicians legitimately believe that artificial nutrition and hydration are not life sustaining treatment. This belief rests not only on "emotional" grounds, which alone may be sufficient, but upon logical grounds as well.

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179. *Id.* at 16.

180. *Grant*, 109 Wash. 2d at 557, 747 P.2d at 451 (citations omitted).

181. *See supra* note 36.

182. *Grant*, 109 Wash. 2d at 562, 747 P.2d at 454.

183. *Id.*, citing *How Should Washington Decide*, *supra* note 5, at 3, 90, 288.

184. *Id.*, (quoting Statement by the AMA Council on Ethical and Judicial Affairs (Mar. 15, 1986)).

185. Seigler and Weisbard, *Against the Emerging Stream: Should Fluids and Nutritional Support Be Discontinued?*, 145 ARCHIVES OF INTERNAL MED. 129, 130 (1985).

C. *The Logical Argument*

Grant's contention that artificial nutrition and hydration constitute life sustaining treatment is further weakened when one realizes that food and water are clearly distinguishable from other care given dying patients.

Grant determined that nasogastric tubes and intraveneous infusions are not "typical" ways of receiving nutrition. The court found that artificial nutrition and hydration may be withheld or withdrawn from incompetent individuals when third parties so order because: (1) artificial nutrition and hydration are different from "typical" ways of providing nutrition;[186] (2) they involve invasive procedures;[187] (3) they are similar to life sustaining treatments, such as respirators;[188] (4) they are not completely without risk;[189] (5) their removal *may* be more comfortable to the patient than their provision;[190] and (6) some doctors feel it is life sustaining treatment.[191] The *Grant* court's sixth premise was discussed above; spirited debate continues in the medical profession over whether to classify artificial nutrition and hydration as refusable treatment.[192] The weaknesses of each of the five remaining premises are addressed below.

First, *Grant* failed to adequately define "typical." Some retarded adults and quadraplegic persons, most small children, and all infants "typically" depend upon the assistance of others to provide them with food and fluids. This assistance ranges from oral feeding by bottle and spoon to tube feeding directly into a major artery.[193] In cases such as Barbara Grant's, a fluid nearly identical to infant formula is introduced into the stomach or digestive tract through nasogastric or g-tubes. In all instances of enteral feeding, the concept is the same: a vehicle other than one's hands and one's throat muscles is used to feed one who cannot feed him or herself. Nevertheless, the court chose to distinguish between nasogastric or g-tubes as withholdable and withdrawable, and, apparently, spoon and bottle feeding of swallowing humans as not.

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186. *Grant*, 109 Wash. 2d at 560, 747 P.2d at 453.
187. *Id.*
188. *Id.*
189. *Id.*
190. *Id.* at 561, 747 P.2d at 453.
191. *Id.* at 562, 747 P.2d at 454.
192. *See supra* text accompanying note 185.
193. *See supra* note 4.

In this respect, the *Grant* court used the same flawed analysis of artificial nutrition and hydration used by prior courts; it looked to form instead of substance. Because nasogastric and g-tubes are inserted into an individual's body, the court claimed, they are invasive and therefore withdrawable.[194] Not only is this analysis flawed, it is inconsistent: the invasive procedure of inserting a spoon or bottle into an individual's mouth is not likewise deemed withholdable or withdrawable. Providing nutrition to a patient through a plastic tube is inherently no different than providing nutrition through a plastic spoon or bottle. As Massachusetts Justice Nolan stated in dissent in *Brophy v. New England Sinai Hospital*:

> . . . the court has built its entire case on an outrageously erroneous premise, i.e., food and liquids are medical treatment. The issue is not whether the tube should be inserted but whether food should be given through the tube. The process of feeding is simply *not* medical treatment. . . . Food and water are basic human needs.[195]

Nutrition and hydration, whether provided in typical or atypical fashion, satisfy basic human needs; they are not withdrawable medical treatment.

The *Grant* court's third rationale for characterizing artificial nutrition and hydration as life sustaining treatment is that it is similar to a respirator, a mode of treatment already deemed withholdable or withdrawable. Both a respirator and artificial nutrition and hydration involve intubation, but that is where the similarity ends.

A respirator does more than supply oxygen like an oxygen mask or tent; it supplants the normally spontaneous, bodily functions of respiration. Proof of this proposition is found in cases where otherwise helpless patients, removed from the assistance of a respirator, resume breathing on their own.[196] In contrast, feeding through nasogastric and g-tubes serves the sole purpose of providing a basic resource; it does *not* supplant a spontaneous bodily function. Therefore, unlike those patients who have been removed from respirators and continue to breathe on their own, no otherwise helpless patient who has been removed from artificial nutrition and hydration has ever

194. *Grant*, 109 Wash. 2d at 560, 747 P.2d at 453.

195. Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 442, 497 N.E.2d 626, 640 (1986) (Nolan, J., dissenting).

196. *See* sources cited *supra* note 171.

spontaneously become nourished or hydrated on his or her own. Clearly, denial of artificial nutrition and hydration more closely resembles suffocation, the denial of oxygen, than removal of a respirator.[197]

The Washington court failed to grasp this difference as well as the similarity of artificial nutrition and hydration to a treatment the courts have allowed only competent adults to refuse: blood transfusions.[198] In *In re Storar*,[199] a guardian requested termination of blood transfusions for her severely retarded adult son. The son was losing blood because of a terminal case of bladder cancer. Death by loss of blood and death by cancer were the son's only two options. The court ruled that the transfusions must continue because "[they] were analogous to *food*—they would not cure the cancer, but they could eliminate the risk of death from another treatable cause."[200]

Similarly, artificial nutrition and hydration do not treat an underlying disease; they eliminate the risk of death by starvation. The *Grant* court's failure to grasp the analogy between blood transfusions and artificial nutrition and hydration reflects either an ignorance of medical reality, a failure to consider reasoning which challenges the court's conclusion, or both.

The *Grant* court also relied on evidence that nasogastric and g-tubes "are not without risks."[201] In doing so, the court merely stated a truism: no medical care, life sustaining or not,

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197. Like *Grant*, a recent U.S. District Court opinion did not distinguish between a respirator and artificial nutrition and hydration. The court stated that "there is no legal difference between a mechanical device that allows a person to breathe artificially and a mechanical device that artificially allows a person nourishment." Gray by Gray v. Romeo, 697 F. Supp. 580, 587 (D.R.I. 1988). The court's statement, however, demonstrated the difficulty of equating a respirator and artificial nutrition and hydration. A respirator allows one "to breathe"; the verb "to breathe" reflects the respirator's function of taking over one's repiratory system. Artificial nutrition and hydration provide "nourishment"; the noun "nourishment" reflects the purpose of artificial nutrition and hydration not to supplant one's digestive system but to provide the basic element with which that system works (enteral feeding) or bypass the system completely (parenteral feeding). The inherent difference between a respirator and artificial nutrition and hydration prohibits even a grammatical similarity from being drawn.

198. *See In re* President & Directors of Georgetown College, Inc., 331 F.2d 1000, *cert. denied*, 377 U.S. 978 (1964).

199. 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

200. *In re* Storar, 52 N.Y.2d 363, 381, 420 N.E.2d 64, 73, 438 N.Y.S.2d 266, 275, *cert. denied*, 454 U.S. 858 (1982) (emphasis added).

201. *Grant*, 109 Wash. 2d at 560, 747 P.2d at 453.

is without risks. The risks of intubation are well-documented,[202] yet it is just as widely accepted that, once the tube is placed through a relatively simple procedure, complications are rare.[203]

Perhaps the *Grant* court's weakest rationale is that dehydration and malnourishment may not be "distressful" to a terminally ill patient.[204] One need only ask what impact the withholding and withdrawal of artificial nutrition and hydration have on one's body to determine the degree of "distress" experienced. Justice Lynch, another dissenter in *Brophy v. New England Sinai Hospital*,[205] asserted that such withholding is "particularly difficult, painful and gruesome"[206] and summarized the impact of withdrawing food and water as follows:

> Brophy's mouth would dry out and become caked or coated with thick material. His lips would become parched and cracked. His tongue would swell, and might crack. His eyes would recede back into their orbits and his cheeks would become hollow. The lining of his nose might crack and cause his nose to bleed. His skin would hang loose on his body and become dry and scaly. His urine would become highly concentrated, leading to burning of the bladder. The lining of his stomach would dry out and he would experience dry heaves and vomiting. His body temperature would become very high. His brain cells would dry out, causing convulsions. His respiratory tract would dry out, and the thick secretions that would result could plug his lungs and cause death. At some point, within five days to three weeks his major organs, including his lungs, heart, and brain, would give out and he would die. The [trial] judge found that death by dehydration is extremely painful and uncomfortable for a human being. The [trial] judge could not rule out the possibility that Paul Brophy would experience pain in such a scenario. Paul Brophy's attending physician described death by dehydration as cruel and violent.[207]

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202. *See How Should Washington Decide*, *supra* note 5.

203. *See* LIFE SUSTAINING TECHNOLOGIES, *supra* note 2, at 280-86.

204. *Grant*, 109 Wash. 2d at 561, 747 P.2d at 453. The court concedes that " 'clinicians and researchers are *just beginning* to explore the complex effects nourishment and *even* hydration can have on terminally ill patients.' " *Id.*, (quoting Dresser and Boisaubin, *Ethics, Law, and Nutritional Support*, 145 ARCHIVES OF INTERNAL MED. 122, 124 (1985) (emphasis added)).

205. 398 Mass. 417, 497 N.E.2d 626 (1986) (Lynch, J., dissenting in part).

206. *Id.* at 444, 447 N.E.2d at 641.

207. *Id.* at 444 n.2, 497 N.E.2d at 641 n.2.

In spite of such descriptions, the argument is made that the patient from whom artificial nutrition and hydration is withdrawn can feel no pain and is not aware of his environment; death is not an ordeal at all.[208] If this argument is valid, the purpose of terminating treatment, to lessen the pain and preserve the dignity of the incompetent individual, loses all force. If no additional pain can be inflicted on the presumably unresponsive patient, and his or her dignity is not compromised by the long, degenerative process of starvation, waiting for death brought about by an underlying condition, rather than starvation, will not impose additional pain on the patient or compromise his or her dignity. On the other hand, if death by starvation proceeds as Paul Brophy's attending physician believed, such a painful affront to one's dignity should not be allowed.

A final "logical" argument against the characterization of nutrition and hydration as refusable treatment concerns the state interests in preserving life and preventing suicide. The *Grant* court dismissed these interests in less than a paragraph, citing *Colyer* for the proposition that a death occurring after removal of life sustaining treatment results from natural causes.[209] However, because death after removal of artificial nutrition and hydration is not caused by an underlying terminal condition, but is rather caused by starvation and dehydration, artificial nutrition and hydration cannot be characterized as a withdrawable life sustaining system. *Colyer*'s proposition that death following withholding or withdrawal of nutrition and hydration is the result of natural causes is false, and the state interests of preventing homicide and suicide must be more deeply considered.

The right to self-determination, a primary rationale of Justice Callow's opinion, foresees individuals who intend to suspend their medical treatment so that natural forces can take their course. This right, however, does not allow *others* to make this decision for patients undergoing medical treatment nor is it a validation of a patient's intent to die. If nutrition and hydration are withdrawn from an individual who has not specifically consented to withdrawal and with the intent that death occurs, such withdrawal should be considered homi-

208. *See How Should Washington Decide*, *supra* note 5.

209. *Grant*, 109 Wash. 2d at 556, 747 P.2d at 451 (citing Colyer, 99 Wash. 2d at 123, 660 P.2d at 743).

cide.[210] Further, the court in *Matter of Conroy*[211] correctly observed that, in distinguishing between death by suicide and death by natural causes, "the difference is between self-infliction or self-destruction and self-determination."[212] When an individual refuses artificial nutrition and hydration, refusal is often accompanied by an express suicidal intent.[213] Regardless of *expressed* intent, if nutrition and hydration are withdrawn from a consenting individual who intends to die as a result, it should be considered suicide.

IV. CONCLUSION

The Washington Supreme Court failed in its first attempt to determine what right incompetent individuals have to artificial nutrition and hydration. *Grant* built upon the flawed reasoning of previous decisions that allowed third parties, while professing to exercise an incompetent's exclusive, personal rights to self-determination and privacy, to withhold or withdraw life sustaining treatment from those individuals. *Grant* not only upheld this faulty reasoning but further prejudiced incompetent individuals' rights to self determination, privacy, and life by classifying artificial nutrition and hydration as withholdable and withdrawable life sustaining treatment.

The *Grant* decision has not ended the debate over this crucial medical, social, and moral issue; Barbara Grant remains alive, attorneys and physicians across the state are confused, and the legislature continues to discuss the issue. Clearly, in light of the *Grant* court's failure and the inherent weaknesses of the judiciary, the legislature is the proper branch to decide where Washington stands. Whichever branch eventually decides, however, must consider constitutional, emotional, and

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210. Bopp, *supra* note 163, at 48.

211. 98 N.J. 321, 486 A.2d 1209 (1985).

212. *Id.* at 351, 486 A.2d at 1224.

213. Bouvia v. Superior Court, 225 Cal. Rptr. 297, 179 Cal. App. 3d 1127 (1986). In a well-known case, Elizabeth Bouvia, a competent young woman with a long life expectancy, was afflicted with severe cerebral palsy. She first refused intubation while expressing a suicidal intent. The court denied her petition because allowing the refusal would implicate the attending physicians and hospital staff in her suicide. Bouvia reapplied, stating she wanted only to refuse medical treatment with no intention of suicide. Because California had classified nutrition and hydration as withholdable and withdrawable life sustaining treatment, *see* Barber v. Superior Court, 195 Cal. Rptr. 484, 147 Cal. App. 3d 1006 (1983), the court had no choice but to grant her petition. Although Bouvia attempted to starve herself to death after being discharged, she later gave up the attempt.

logical reasons which all refute the *Grant* court's majority decision. Artificial nutrition and hydration are not life sustaining treatment and should not be legally withholdable or withdrawable from incompetent individuals.

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