

COMMENTS

Life and Death In Washington State After *Cruzan v. Director, Missouri Department of Health*

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I. INTRODUCTION

*There she met sleep, the brother of death.*¹

Picture a young woman sitting cross-legged in her apartment discussing with her roommate the somber topics of life and death on a rainy day over a cup of coffee. During that "somewhat serious conversation,"² the woman states that if she were sick or injured, "she would not want to continue her life unless she could live 'halfway normally.'"³ Next, picture that young woman lying face down in a ditch after being violently thrown from her car in an accident, without detectable respiratory or cardiac function. Finally, picture that woman seven years later lying in a hospital bed. She is in a persistent vegetative state,⁴ with no hope of returning to cognitive life. Nev-

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1. HOMER, THE ILIAD, bk. XIV, l. 231 & bk. XVI, l. 672, from HESIOD, THE THEOGONY, l. 756.

2. *Cruzan v. Harmon*, 760 S.W.2d 408, 411 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990).

3. *Id.*

4. *Cruzan*, 110 S. Ct. at 2845 n.1. Dr. Fred Plum, the originator of the term "persistent vegetative state," described the condition as follows:

Vegetative state describes a body which is functioning entirely in terms of its internal controls. It maintains temperature. It maintains heart beat and pulmonary ventilation. It maintains digestive activity. It maintains reflex activity of muscles and nerves for low level conditioned responses. But there is no behavioral evidence of either self-awareness or awareness of the surroundings in a learned manner.

In re Jobes, 529 A.2d 434, 438 (N.J. 1987).

According to the American Medical Association, patients in a persistent vegetative

ertheless, her body could conceivably survive for another thirty years. Should a court give effect to that woman's somewhat serious statement? Should a court allow her family to withhold all artificial nutrition and hydration, thereby letting her die naturally in the culmination of a process that began seven years previously on the night that her car crashed?

This thumbnail sketch is in fact the real-life scenario that confronted a young woman, Nancy Beth Cruzan, her family, and the courts. In her case, the Missouri Supreme Court answered the above questions: no. Subsequently, in a decision that may have raised more questions than it answered, the United States Supreme Court begrudgingly admitted that the Constitution would grant a constitutionally protected liberty interest to refuse lifesaving nutrition and hydration.⁵ Nevertheless, the Court affirmed the Missouri Supreme Court's decision and delegated the task of crafting appropriate procedures for safeguarding an incompetent's liberty interest to the "laboratory of the States."⁶ In Missouri, the procedure for safeguarding Nancy Cruzan's liberty interest required that evidence of her intent about treatment withdrawal must be proved by clear and convincing evidence.⁷ Because that standard was not met in her case, the Supreme Court agreed that Missouri could refuse to allow removal of the artificial hydration and nutrition equipment.

Thus, in *Cruzan*, the United States Supreme Court allowed individual states to establish their own procedures for protecting patients' liberty interests in so-called right-to-die cases.⁸ Although the Court upheld Missouri's highly restric-

state maintain relatively normal brainstem function and thus can regulate "vegetative" functions, such as heart, lungs, and so forth. Amicus Curiae Brief of the American Medical Association et al. at 14, *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990) (No. 88-1503) (hereinafter AMA Brief) (citing Ronald E. Cranford, *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, 18 HASTINGS CTR. REP. 27, 28 (1988)); PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 174 (1983) (hereinafter PRESIDENT'S COMM'N). They also experience cycles of sleeping and waking; their eyes may move; and they may smile, utter sounds, or move sporadically. According to the AMA, although this activity appears to indicate consciousness, there is none. AMA Brief, *supra* at 14. Patients in a vegetative state do not feel any pain, sense anybody or anything. In short, they are completely unaware. *Id.*

5. *Cruzan*, 110 S. Ct. at 2852.

6. *Id.* at 2859.

7. *Id.* at 2852. "Clear and convincing" is a much more rigorous burden of proof in civil cases, higher than the "preponderance of evidence" standard.

8. Examples of right-to-die cases include: *Cruzan v. Director, Mo. Dep't of Health*,

tive procedure, the Court did not advocate that as the only possible procedure.⁹ As a result, each of the fifty states, including Washington, is free to follow its own course within the confines of *Cruzan*.

Washington's most recent statement of right-to-die law is in the 1992 statutory revisions to the Natural Death Act,¹⁰ passed by the legislature in response to a statewide referendum proposing numerous changes to the Act.¹¹ Although the revisions clarify Washington's policy on using artificial nutrition and hydration for people in a persistent vegetative state, the Act only applies to people who have executed a written directive, or living will, indicating their preferred course of medical treatment. Thus, the Act does not directly apply to people like Nancy Cruzan who have not executed a living will.

Washington's most recent common law statement of right-to-die law is the case of *In re Grant*.¹² The *Grant* decision allowed a guardian or family, in conjunction with the patient's physicians, to act as a surrogate decisionmaker,¹³ exercising the rights of an incompetent patient who is in a persistent vegetative state. These rights included the right to removal of artificial nutrition and hydration.¹⁴ The *Grant* court later amended

110 S. Ct. 2841 (1990); *Gray v. Romeo*, 697 F. Supp. 580 (D.R.I. 1988); *Rasmussen ex rel. Mitchell v. Fleming*, 741 P.2d 674 (Ariz. 1987); *Conservatorship of Drabick*, 245 Cal. Rptr. 840 (Cal. Ct. App.), *cert. denied*, 109 S. Ct. 399 (1988); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986); *In re Browning*, 568 So. 2d 4 (Fla. 1990); *Corbett v. D'Alessandro*, 487 So. 2d 368 (Fla. Dist. Ct. App.), *review denied*, 492 So. 2d 1331 (Fla. 1986); *In re Greenspan*, 558 N.E.2d 1194 (Ill. 1990); *In re Longeway*, 549 N.E.2d 292 (Ill. 1989); *In re Gardner*, 534 A.2d 947 (Me. 1987); *Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626 (Mass. 1986); *In re Hier*, 464 N.E.2d 959 (Mass.), *review denied*, 465 N.E.2d 261 (1984); *In re Jobes*, 529 A.2d 434 (N.J. 1987); *In re Requena*, 517 A.2d 886 (N.J. Super. Ct. Ch. Div.), *aff'd*, 517 A.2d 869 (N.J. Super. Ct. App. Div. 1986); *Delio v. Westchester County Medical Ctr.*, 129 A.D.2d (N.Y. App. Div. 1987).

9. *Cruzan*, 110 S. Ct. at 2854-55, 57-58.

10. 1992 Wash. Laws ch. 98 (to be codified at WASH. REV. CODE ch. 70.122).

11. See Citizens' Initiative Measure No. 119 (1991) (on file with the *University of Puget Sound Law Review*).

12. 109 Wash. 2d 545, 747 P.2d 445 (1987), *modified*, 757 P.2d 534 (1988).

13. The term "surrogate decisionmaking" usually refers to the process whereby a surrogate or proxy exercises an incompetent's right to refuse treatment. The surrogate may have been chosen by the person while still competent and instructed to make medical decisions on her behalf should she become incompetent. See *infra* text accompanying notes 79-81. In the alternative, the surrogate may be a guardian or family member requesting the court's permission to make medical decisions for an incompetent who did not specifically make her wishes known in a living will or physician's directive before becoming incompetent.

14. *Grant*, 109 Wash. 2d at 565, 747 P.2d at 455.

its decision,¹⁵ however, casting doubt on whether Washington law still allows the withdrawal of artificial nutrition and hydration. In addition, this modified procedure for withdrawing life-sustaining treatment conflicts with the Washington Informed Consent Law,¹⁶ making it uncertain which controls. As a result, Washington law needs clarification.

The legislature should amend Washington law to allow the removal of life-support measures, including artificial nutrition and hydration, from an incompetent patient in a persistent vegetative state. Rather than following the ambiguous Informed Consent Law, the legislature should adopt the procedure outlined in the first, unmodified *Grant* decision. That procedure allows decisions about withholding artificial nutrition and hydration to be made by a surrogate decisionmaker, either the patient's family or guardian. Treatment can be withdrawn only if the patient has no reasonable possibility of return to cognitive and sapient life, and the surrogate has determined that the patient, if competent, would choose to refuse treatment. Alternatively, if that intent cannot be determined, treatment can be withheld if it would be in the patient's best interests.¹⁷ Unlike the Washington Informed Consent Law, the original *Grant* procedure provides safeguards against possible abuses, yet allows a patient's family to make these private life and death decisions without interference by the courts.

In Part II, this Comment examines the *Cruzan* decision by the United States Supreme Court, including the facts of the case, holding of the court, aftermath of the decision, and long-term effects of the case. Part II also includes an extensive analysis and critique of *Cruzan*. Part III examines the status of Washington law both before and after *Cruzan*, including the *Colyer*, *Hamlin*, and *Grant* cases, which have resulted in confusion over the legal status of withholding artificial nutrition and hydration from incompetent patients in Washington. In Part IV, this Comment compares *Cruzan* to the Washington cases, analyzing the two major impacts of *Cruzan* and pointing out why Washington state needs to clarify its law in light of *Cruzan*. Finally, this Comment proposes that Washington

15. *In re Grant*, 757 P.2d 534 (1988) (modifying earlier decision).

16. WASH. REV. CODE § 7.70.065 (1989).

17. *Id.* See also *Conservatorship of Drabick*, 245 Cal. Rptr. 840, 861 (Cal. Ct. App. 1988).

adopt the original *Grant* procedure. Under that procedure, a family or guardian may decide, based on the patient's medical prognosis and the patient's intent or best interests, that artificial life support, including artificial nutrition and hydration, should be withdrawn and the patient permitted a natural death.

II. THE STATUS OF FEDERAL LAW: *CRUZAN V. DIRECTOR, MISSOURI DEPARTMENT OF HEALTH*

A. *Facts of the Case*

On Tuesday, January 11, 1983, at approximately 12:50 a.m., Nancy Beth Cruzan was driving her 1963 Rambler Classic Sedan east on Elm Road in Jasper County, Missouri, on her way home from work at a Carthage cheese plant. It was a clear, cool, dry January night.¹⁸ For unknown reasons, Nancy lost control of her Rambler. The car ran off the north side of the road, hit a mailbox and some small trees, swerved back across the road to the south side, ran through a fence, overturned several times, and came to rest upside down in a ditch some 210 feet from the mailbox.¹⁹ During the collision, Nancy was thrown about thirty-five feet from her car and landed face down in the ditch. At 12:54 a.m., the Missouri Highway Patrol dispatched Trooper Dale Penn to the scene. He arrived at 1:00 a.m. and found Nancy without detectable respiratory or cardiac function. "She had apparently expired."²⁰ Paramedics Robert Williams and Rick Maynard arrived at 1:09 a.m., diagnosed Nancy as code blue, and immediately began cardiopulmonary resuscitation at 1:11 a.m. Although cardiac function and spontaneous respiration recommenced by 1:12 a.m., Nancy had suffered significant anoxia, or deprivation of oxygen, for a minimum of twelve to fourteen minutes.²¹

Nancy was transported to Freeman Hospital where she was diagnosed with a laceration to the liver and a probable cerebral contusion compounded by the significant anoxia, with the prognosis hinging on the unknown duration of her oxygen

18. *Cruzan v. Harmon*, 760 S.W.2d 408, 430 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990).

19. *Id.*

20. *Id.*

21. *Id.* at 431. Note the crucial nine minutes that passed between the arrival of the state trooper and the paramedics. One wonders whether a different outcome would have resulted if the trooper had started CPR rather than concluding that Nancy had died.

deprivation.²² Nancy remained in a coma²³ for three weeks and then progressed to an unconscious state.²⁴ To assist recovery and ease feeding, a gastrostomy feeding tube was surgically implanted in Nancy's stomach on February 5, 1983, with her then-husband's consent.²⁵ Over time, however, efforts to rehabilitate Nancy proved to no avail. After her family attempted home care at her grandmother's house and at a nursing home

22. Six minutes is the maximum period of oxygen deprivation before the brain suffers permanent brain damage. The degree of damage depends on the duration of lack of oxygen, with greater damage resulting from longer periods. *Id.* at 430. Although some people, particularly children, have recovered from anoxia, the circumstances usually involve the face being thrust in icy water, which triggers a physiological response. This circumstance was not present in Nancy's case. The damage from her anoxia was later confirmed by CT scans showing significant degeneration of her cerebral cortical tissue. *Id.* at 432.

23. Coma, along with brain death and the vegetative state, are the three major categories of sustained and total loss of consciousness. AMA Brief, *supra* note 4, at 13. In all three, the cerebral hemispheres, which are responsible for conscious behavior, do not function. As a result, the patient has no thoughts, feelings, sensations, desires, emotions, memory, pain, or suffering. *Id.* at 13 (citing PRESIDENT'S COMM'N, *supra* note 4, at 174)). Brain death, coma, and the vegetative state differ in the extent to which the brainstem, which controls unconscious activity, still functions. In brain death, the patient has suffered complete and irreversible loss of brainstem function, including the ability to regulate "vegetative" functions, such as heart, lungs, kidneys, and so forth. *Id.* at 14 (citing PLUM & POSNER, *THE DIAGNOSIS OF STUPOR AND COMA* 1 (3d. ed. 1982); PRESIDENT'S COMM'N, *supra* note 4, at 175).

Coma is a condition that exists between brain death and the vegetative state. The brainstem retains some function but not as much activity as in a vegetative state. Unlike someone in a vegetative state, *see supra* note 4, a person in a coma is in a sleep-like state, with eyes closed, impaired breathing, and no reflexes. *Id.* at 15 (citing PLUM & POSNER, *supra*, at 5). Comas and vegetative states also differ in length. Comas rarely last longer than four weeks. By that time, the patient has either died, entered a vegetative state, or begun to regain some consciousness. *Id.* at 15.

Patients have recovered from both comas and vegetative states, but their prognosis depends on multiple factors. For patients, children in particular, whose vegetative state is caused by head injury, their possibility of recovery after a long delay is greater. One eighteen-year-old emerged from a persistent vegetative state 30 months after injury. *Id.* at 17 (citing W.F.M. Arts et al., *Unexpected Improvement After Prolonged Posttraumatic Vegetative State*, 48 J. NEUROLOGY, NEUROSURGERY & PSYCH. 1300 (1985)). For patients such as Nancy, however, whose condition was caused by "hypoxiaischemia," or a lack of oxygen to the brain, significant recovery is rare. Although an estimated 100,000 patients over the last 20 years have been in persistent vegetative states because of oxygen deprivation, only three recoveries have been documented. Moreover, none of those lingered in a vegetative state for as long as Nancy. *Id.* at 16 (citing Shuttleworth, *Recovery to Social and Economic Independence From Prolonged Postanoxic Vegetative State*, 33 NEUROLOGY 372 (1983)).

24. *Cruzan v. Harmon*, 760 S.W.2d 408, 431 (Mo. 1988).

25. Prior to the accident, Nancy lived with her husband, Paul; they had been married about a year. After Nancy's accident, her parents were appointed guardians and conservators following a court hearing on January 25, 1977. Nancy's husband did not attend or inquire about the proceedings. A dissolution of marriage was subsequently decreed. *Id.*

following a bout with 107 degree fever, Nancy was eventually placed in Mount Vernon State Hospital.²⁶ She remained unconscious, with muscular atrophy and contracture of her four extremities, causing her fingernails to cut into her wrists. Her condition was described as follows:

- (1) [H]er respiration and circulation are not artificially maintained and are within the normal limits of a thirty-year-old female;
- (2) she is "oblivious to her environment except for reflexive responses to sound and perhaps painful stimuli";
- (3) she suffered anoxia of the brain resulting in severe brain damage. "A recent CAT [sic] scan of her head reveals abnormalities suggesting severe irreversible upper hemisphere brain damage with massive enlargement of ventricles filling with cerebrospinal fluid because the brain is degenerating." The degeneration is called "cerebral cortical atrophy, which is progressive from her initial condition reflected on the CAT [sic] scan. The fluid is replacing the area where there is no more brain tissue. . . . This cerebral cortical atrophy is irreversible, permanent, progressive, and ongoing";
- (4) "her highest cognitive brain function is exhibited by her grimacing perhaps in recognition of ordinarily painful stimuli indicating the experience of her pain and apparent response to sound";
- (5) she is a spastic quadriplegic;
- (6) her four extremities are contracted with irreversible muscular and tendon damage to all extremities;
- (7) "she has no cognitive or reflexive ability to swallow food or water to maintain her daily essential needs," and "she will never recover her ability to swallow sufficient [sic] to satisfy her needs."²⁷

Nancy was in a persistent vegetative state but was not dead.²⁸

26. The entire cost of Nancy's care was borne by the state of Missouri after Nancy's Social Security medical insurance ran out in 1986. *Id.* at 432. The cost estimates ranged from \$112,000 to \$130,000 per year. Tamar Lewin, *Nancy Cruzan Dies, Outlived by Debate Over Right to Die*, N.Y. TIMES, Dec. 27, 1990, at A1; Robert Steinbrook, *Comatose Woman Dies 12 Days After Life Support Halted*, L.A. TIMES, Dec. 27, 1990, at A3.

27. *Cruzan v. Harmon*, 760 S.W.2d at 411, 432.

28. *Id.* Under Missouri law, death is defined as follows:

For all legal purposes, the occurrence of human death shall be determined in accordance with the usual and customary standards of medical practice, provided that death shall not be determined to have occurred unless the following minimal conditions have been met:

- (1) When respiration and circulation are not artificially maintained, there is an irreversible cessation of spontaneous respiration and circulation; or

Neither was she diagnosed as terminally ill because she could continue in this condition for another thirty years as long as she continued to receive artificial nutrition and hydration.²⁹

In 1987, four years after the accident, with no hope of recovery in sight, Nancy's parents and co-guardians, Lester and Joyce Cruzan, requested that the hospital terminate her artificial hydration and nutrition.³⁰ The hospital refused to honor their request without court approval. As a result, on October 23, 1987, the Cruzans petitioned Jasper County Probate Judge Charles E. Teel, Jr., for a declaratory judgment allowing them to remove her feeding tube.³¹

On July 27, 1988, Judge Teel issued an order granting the Cruzans' request for termination.³² Judge Teel stated that a person in Nancy's condition had a fundamental natural right under the Missouri and United States Constitutions, a "right to liberty," which permits a person to refuse or direct the withdrawal of "artificial death prolonging procedures."³³ However, the public policy of the Missouri General Assembly as embodied in the Missouri Living Will Statute³⁴ prohibited the withholding of nutrition and hydration under all circumstances. As a result, state policy was in direct conflict with Nancy's constitutional right to liberty. The court held that denying her co-guardians the authority to exercise Nancy's constitutionally guaranteed right to liberty would violate her right to due process and equal protection of the law under state and federal constitutions.³⁵

Once the court found that Nancy had a constitutionally guaranteed liberty interest, the court next had to determine how she would want that interest exercised. The court found

(2) When respiration and circulation are artificially maintained, and there is total and irreversible cessation of all brain function, including the brain stem and that such determination is made by a licensed physician.

MO. REV. STAT. § 194.005 (1986).

29. *Cruzan v. Harmon*, 760 S.W.2d at 411.

30. *Id.* at 410.

31. *Id.* at 410, 432; *Cruzan's Right-to-Die Case*, CHIC. TRIB., Dec. 15, 1990, § News, at 8 [hereinafter *Right-to-Die Case*].

32. *Cruzan v. Harmon*, 760 S.W.2d at 410, 434; *Right-to-Die Case*, *supra* note 31, at 8.

33. *Cruzan v. Harmon*, 760 S.W.2d at 434.

34. MO. REV. STAT. § 459.010 (1986). Note the statute did not directly apply to Nancy Cruzan because she never drafted a living will. In fact, the statute was not adopted until after her accident. Therefore, the court looked to the statute only for a general expression of state policy on withholding treatment.

35. *Cruzan v. Harmon*, 760 S.W.2d at 410, 434.

that Nancy's intent regarding the withholding of artificial nutrition and hydration was expressed by a "somewhat serious conversation" with her friend, Athena Comer,³⁶ by other statements to family and friends, and by the overwhelming evidence of her lifestyle as a vivacious, outgoing, independent person who preferred to take care of herself. Based on these criteria, the court concluded that Nancy would not want to continue with artificial nutrition and hydration in her current condition.³⁷ As a result, the court authorized Nancy's parents and co-guardians, Joyce and Lester Cruzan, to exercise her constitutionally guaranteed right to withhold nutrition and hydration. The guardian ad litem³⁸ and the State appealed.

On November 16, 1988, the Missouri Supreme Court reversed in a 4-3 decision, holding that the Cruzans lacked authority to effectuate their request because no clear and convincing evidence existed of Nancy's desire to have life-sustaining treatment withdrawn under such circumstances.³⁹ The court stated that a person's right to refuse treatment, regardless of whether from a constitutional right or a common law right, is not absolute, but must be balanced against the state's interest in life. The state's interest was not in quality of life, but was a strong, unqualified policy in favor of the preservation of life, as embodied in the Missouri Living Will Statute.⁴⁰ Because Nancy was alive and the burdens of her treatment were not excessive to her,⁴¹ the court ruled that her right to

36. At age twenty-five, during this somewhat serious conversation with her housemate, Athena Comer, Nancy stated that if she were sick or injured she would not want to continue living unless "she could live at least halfway normally." *Id.* at 433.

37. *Id.* at 432-33 (quoting Judge Teel's Order of July 27, 1988).

38. Although Nancy's parents were appointed as her guardians, once they became a party petitioning the court to authorize removal of her artificial treatment, they had a potential conflict of interest. In addition, Nancy was a ward of the State of Missouri, which was bearing the entire cost of her care in the Mt. Vernon State Hospital. *See supra* note 26. As a result, the court appointed as guardians ad litem and attorneys for the State's ward, Thad C. McCanse and David Mouton. *Cruzan v. Harmon*, 760 S.W.2d at 433.

The guardians ad litem found themselves in the predicament of agreeing with the Cruzans and Nancy's doctors that it was in Nancy's best interest to disconnect the feeding tube. Nevertheless, because the case was one of first impression in Missouri, the guardians believed that it was their duty as Nancy's attorneys to appeal the ruling to the highest court in the state. *Id.* at 410 n.1. For a discussion of the duties of the guardian versus the guardian ad litem, *see infra* note 152.

39. *Cruzan v. Harmon*, 760 S.W.2d at 434-36, 443.

40. *See supra* note 34 and accompanying text.

41. The court based this statement on evidence from the trial court indicating that Nancy's care did not cause her pain. The court concluded that her care was not

refuse treatment did not outweigh the "immense, clear fact of life in which the state maintains a vital interest."⁴² The court disagreed with Judge Teel, stating that Nancy's conversation with Athena Comer was not reliable⁴³ for determining Nancy's intent and was insufficient to support her parents' request to exercise her right to withdraw treatment. In conclusion, the court held that no person could assume the choice of terminating medical treatment for an incompetent person without clear and convincing, inherently reliable evidence of that person's intent.⁴⁴ Because such evidence was absent,⁴⁵ the Missouri

burdensome to her because she was not responsive to it. *Cruzan v. Harmon*, 760 S.W.2d at 424.

42. *Id.*

43. As Judge Higgins noted in his dissent to the Missouri Supreme Court decision, this testimony by Athena Comer about her conversation with Nancy took only half-an-hour during a three-day trial. But this testimony was not the sole basis for Judge Teel's conclusion that Nancy would choose to remove the feeding tube. In addition to Ms. Comer's testimony, the court heard other evidence relevant to Nancy's intent, including statements of family, friends, and in particular, Nancy's sister, Christy. When, after three days of testimony, Judge Teel concluded that Nancy would choose to remove the feeding tube, he based his conclusion not only on Ms. Comer's evidence, but also on "other statements to family and friends" and the overwhelming evidence of "[h]er life-style." *Cruzan v. Harmon*, 760 S.W.2d at 443-44 (Higgins, J., dissenting) (quoting Tr.Ct.Op. 4, 6 (L.F. 254, 256)). Both the Missouri Supreme Court and the United States Supreme Court, however, focused only on the "somewhat serious conversation," largely ignoring this additional testimony. In finding that evidence of Nancy's intent was not clear and convincing, the Supreme Court reasoned that this conversation did not focus specifically on the withdrawal of artificial nutrition and hydration. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2855 (1990). The Missouri court noted that informally expressed reactions to another's medical condition could not constitute clear proof of intent. Evidence offered to prove informed consent, or the informed refusal to consent, must be stronger than remote, general, spontaneous statements made in casual circumstances. *Cruzan v. Harmon*, 760 S.W.2d at 411, 424, 443-44.

44. *Cruzan v. Harmon*, 760 S.W.2d at 423-25, 443.

45. Note that the Missouri Supreme Court goes beyond simply clarifying the evidentiary standard and actually reverses the trial court's factual findings based on that new standard. Moreover, the United States Supreme Court does not challenge this factual determination. *Cruzan*, 110 S. Ct. at 2855. One interesting and unanswered question is why both appellate courts chose to reverse the trial court's factual finding and hold that the testimony did not amount to clear and convincing evidence of Nancy's intent to have treatment withdrawn. Not only did they ignore factual evidence (see *supra* note 43), but as appellate courts, their determination was based on a "cold" record. Usually factual findings are more appropriately made by a trial court, which is in the best position to weigh evidence presented by witnesses and judge their demeanor, credibility, and so forth. Perhaps a more prudent course for the appellate courts would have been to clarify that the evidentiary standard was "clear and convincing" and remand the case to the trial court for factual findings in accordance with that standard. In effect, of course, that is what happened when Nancy's family petitioned the trial court with new evidence, which the court determined did meet that higher standard. See *infra* part II.D.

Supreme Court reversed the lower court order, refusing Nancy's parents' request to terminate her artificial nutrition and hydration.⁴⁶

The Cruzans petitioned the United States Supreme Court, which granted certiorari⁴⁷ and affirmed the Missouri Supreme Court decision on June 25, 1990.⁴⁸

B. Holding of the Court

The issue before the United States Supreme Court was whether Nancy had a right under the United States Constitution that would require the hospital to withdraw her life-sustaining treatment under the particular circumstances of her case.⁴⁹ The Court separated the issue into two subparts: (1) does the Constitution grant a right to die; and (2) does the Constitution prohibit Missouri from choosing the rule of decision that it did to effectuate that right.⁵⁰

In answering the first question, the Court noted that, at common law, touching a person without consent or legal justification is a battery.⁵¹ No right is more sacred than an individual's right to possession and control of his own person, free from restraint or interference of others.⁵² The logical corollary to this notion of bodily integrity and autonomy is that a person must give informed consent for medical treatment. Otherwise, the doctor's "touching" will be considered battery. As Justice Cardozo stated: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."⁵³ The natural counterpart of the informed consent doctrine is that a person possesses the right not to consent but to refuse treatment.⁵⁴

After examining this common law foundation, the Court found constitutional support for the doctrine of informed con-

46. *Cruzan v. Harmon*, 760 S.W.2d at 426-27.

47. 109 S. Ct. 3240 (1989).

48. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990).

49. *Id.* at 2846.

50. *Id.* at 2851.

51. *Id.* at 2846.

52. *Id.*

53. *Cruzan*, 110 S. Ct. at 2846 (quoting *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914)).

54. *Id.* at 2847.

sent in the Due Process Clause of the Fourteenth Amendment.⁵⁵ "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions."⁵⁶ As a result, the Court concluded that, at least hypothetically, "the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."⁵⁷

Nancy's parents, as petitioners, claimed that an incompetent person possesses the same right to refuse treatment as a competent person.⁵⁸ The Court, however, concluded that peti-

55. U.S. CONST. amend. XIV, § 1 (no State shall "deprive any person of life, liberty, or property, without due process of law").

56. *Cruzan*, 110 S. Ct. at 2851. See *Washington v. Harper*, 110 S. Ct. 1028 (1990) (holding forcibly injecting medication into a nonconsenting person "represents a substantial interference with that person's liberty"); *Vitek v. Jones*, 445 U.S. 480, 494 (1980) (holding mandatory behavior modification treatment combined with transfer to mental health hospital implicated liberty interests); *Parham v. J.R.*, 442 U.S. 584, 600 (1979) (holding both children and adults have a "substantial liberty interest in not being confined unnecessarily for medical treatment"); *Breithaupt v. Abrams*, 352 U.S. 432, 439 (1957) (holding individual's right that her person be held inviolable is balanced against the interests of society); *Jacobson v. Massachusetts*, 197 U.S. 11, 24-30 (1905) (holding a person's liberty interest in refusing unwanted smallpox vaccine is balanced against state's interest in disease prevention).

57. *Cruzan*, 110 S. Ct. at 2852. Prior to *Cruzan*, many state court decisions found a right to refuse medical treatment within a generalized constitutional right to privacy. In *Cruzan*, however, the Court stated that it has never held that such a right is encompassed within a right of privacy. Instead, this right "is more properly analyzed in terms of a Fourteenth Amendment liberty interest." *Id.* at 2851 n.7. For a discussion of the impact of proceeding under a liberty interest analysis versus a right of privacy analysis, see *infra* part IV.A.

58. The Court never expressly answered the question whether an incompetent has the same liberty interest in refusing treatment as a competent person. The *Cruzan*s claimed that the Court's refusal to grant an incompetent person the same liberty interest as a competent person would violate Nancy's right to equal protection under the Fourteenth Amendment. The Court rejected this claim, however, on the basis that competent and incompetent persons are not similarly situated. The difference between the choice made by a competent person and the choice made for an incompetent person is "so obviously different that the State is warranted in establishing rigorous procedures for the latter class of cases which do not apply to the former class." *Cruzan*, 110 S. Ct. at 2856 n.12.

Nevertheless, *Cruzan* does extend this liberty interest to an incompetent person as well as a competent one, at least to the extent that the Missouri rule of decision sufficiently protected that liberty interest. In other words, under the Missouri procedural rule, where probative evidence could establish by clear and convincing evidence the incompetent's intent to terminate life-sustaining treatment, the *Cruzan* court was willing to allow a surrogate to exercise that incompetent's "liberty interest" or "right" to refuse treatment. However, the Court left for a later day the decision of whether the Fourteenth Amendment *requires* that a state *must* defer to the decision of a surrogate previously appointed by the patient while competent. See *infra* text accompanying notes 79-81. Certainly a decision by the United States Supreme Court

tioners' claim begged the question. According to the Court, the crux of the matter is that an incompetent person is unable to make an informed and voluntary choice to exercise any right, including a supposed right to refuse treatment. Only a surrogate may exercise that right for her.⁵⁹

Under Missouri common law, a surrogate may exercise an incompetent's right to refuse artificial nutrition and hydration, but only if evidence of the person's intent expressed while competent is proved by clear and convincing evidence.⁶⁰ By establishing this procedural safeguard, Missouri seeks to protect not only the individual's choice, but also the state's interest in the preservation of life. Thus, in effect, Missouri balances the individual's non-absolute constitutional right to refuse treatment against the state's high interest in preserving life. In this case, these interests are advanced by adopting a clear and convincing evidentiary standard to prove the person's intent. The Supreme Court held that the state's interest promoted by this evidentiary standard was legitimate and did not impermissibly burden the individual's liberty interest. Therefore, the procedural requirement was not unconstitutional.⁶¹

The Missouri evidentiary standard was legitimate, according to the Court, because determining the existence of a due process "liberty interest" in avoiding unwanted medical treatment is only the beginning of the inquiry. A person's rights under the Due Process Clause are not absolute.⁶² Whether that person's liberty interest has been violated must be determined by balancing her right against the relevant state interests.⁶³ If the state's interests are compelling, they will outweigh her liberty interest, and her due process rights will not have been unconstitutionally infringed.

The primary state interest in this case is the preservation of life.⁶⁴ Missouri's interest in preserving life is advanced by its heightened evidentiary requirements, which seek to protect

that a state need not defer to a surrogate's decision would undercut the liberty interest that the Court extended to incompetent individuals.

59. *Cruzan*, 110 S. Ct. at 2852.

60. *Cruzan v. Harmon*, 760 S.W.2d 408, 443 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990).

61. *Cruzan*, 110 S. Ct. at 2852-56.

62. *Id.* at 2851-52. See *Mills v. Rogers*, 457 U.S. 291, 299 (1982); *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982).

63. For a discussion of the four state interests usually cited, see *infra* text accompanying note 163.

64. *Cruzan*, 110 S. Ct. at 2852.

the individual and safeguard the personal element of choice between life and death.⁶⁵ According to the Court, such a requirement would guard against potential abuses.⁶⁶ For example, a family member might be unavailable to serve as a surrogate decisionmaker or might not act to protect the patient. The proceeding might not be an adversarial one that would assure accurate factfinding.⁶⁷ Furthermore, as the Court noted, the interests at stake are "more substantial, on both the individual and societal level, than those involved in a run-of-the-mine [sic] civil dispute."⁶⁸ Therefore, the Court held that Missouri could permissibly place the increased risk of a wrong decision on the surrogate seeking to terminate an incompetent individual's treatment. The Court agreed that Missouri, by adopting such a procedural rule, could assert an unqualified interest in the preservation of human life to be weighed against the individual's constitutionally protected liberty interest in refusing medical treatment.⁶⁹

Finally, the Court held that the Due Process Clause does not require the Court to repose a right of substituted judgment.⁷⁰ The Due Process Clause only requires the state to repose judgment on choices about medical treatment with the

65. *Id.* at 2852-53.

66. *Id.* at 2853.

67. *Id.*

68. *Id.*

69. *Cruzan*, 110 S. Ct. at 2853-54.

70. *Id.* at 2855-56. In order to allow a surrogate to exercise an incompetent's right to refuse treatment, courts have adopted a number of tests to determine the patient's wishes if she never wrote down her intentions about refusing life-sustaining treatment. The first is the "substituted judgment" or subjective test. Under this legal standard, the proxy must prove that the patient would choose nontreatment if she could speak. If the patient left no written statements about her intent, the proxy must render her best judgment about whether the patient would exercise her right to refuse treatment under her particular circumstances.

Courts and commentators have criticized the substituted judgment test because, "absent a prior directive, the proxy's assessment of what the patient would want, no matter how scrupulously performed, relies to some extent upon the proxy's values in addition to the patient's." Nancy K. Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375, 377 (1988) [hereinafter Rhoden, *Litigating Life*]. For example, although the *Quinlan* court noted that most people would not want to live in Karen Quinlan's state, this was not a statement of what *Karen* would have preferred. *In re Quinlan*, 355 A.2d 647, 664 (N.J.), *cert. denied*, 429 U.S. 992 (1976). In addition, the proxy's conclusions may be highly intuitive and based not on specific statements or actions but on love and intimacy. Such analysis is often unable to meet the "clear and convincing" standard of proof that is often required in cases like *Cruzan*. Rhoden, *Litigating Life*, *supra*, at 377. This test fails most dramatically when the patient has never been competent because no one, including the patient, can ever know what he or she would want. *Id.*

patient herself.⁷¹ Because Missouri's evidentiary requirement seeks to give effect to the patient's choices, it does not violate the Due Process Clause. Thus, on the facts of this case, the Court agreed with the Missouri Supreme Court that evidence of Nancy's intent regarding the removal of artificial nutrition

at 376. See also Allen E. Buchanan, *The Limits of Proxy Decisionmaking for Incompetents*, 29 UCLA L. REV. 386 (1981).

Consequently, courts uncomfortable with the substituted judgment test have often adopted an "objective" or "best-interests" test. See, e.g., *In re Conroy*, 486 A.2d 1209 (N.J. 1985). Under this test, absent clear and convincing evidence of the patient's subjective desires, the proxy must perform a balancing test to determine the best interests of the patient: the proxy must prove that the burden of the patient's life, in terms of unavoidable pain, clearly outweighs any physical, emotional, or intellectual benefit. Rhoden, *Litigating Life*, *supra*, at 376. The "limited-objective" test includes both a subjective prong, analyzing evidence of the patient's intent, and an objective prong, weighing the benefits and burdens. In the "pure objective" test, only the benefits and burdens are weighed.

Objectivists prefer this test, arguing that one cannot invoke "the patient's values" because an unconscious or barely conscious patient no longer has higher-level interests or values. Moreover, even when an individual has clearly manifested her intent in a calm, lucid manner and drafted a living will choosing to refuse treatment, no one can be certain that what she would chose earlier is what she would choose now. For example, a person's views about what is an acceptable level of functionality may change drastically as that function declines. *Id.* at 411-12. This view also casts doubt on the evidentiary value of treatment guidelines from living wills because, at least hypothetically, the patient may now want something else. See, e.g., Rebecca Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 ARIZ. L. REV. 373 (1986). Thus, these commentators argue for a present-oriented test, in which the benefits and burdens of the patient's current situation are objectively assessed.

Other commentators, however, point out that even "objective" tests have subjective elements; in weighing the supposed burdens and benefits, the proxy's own subjective values creep into the analysis of whether something is a benefit or burden. Moreover, the analysis is skewed because, according to medical experts, many of the factors listed on the "burden" side of the equation, such as pain and suffering, do not exist for a patient in a persistent vegetative state. Finally, these commentators object to a present best-interests standard that bifurcates the now-unconscious person into a "past person," with one set of interests, and a "current person" with a different set. Rhoden, *Litigating Life*, *supra*, at 378. They argue that we cannot bifurcate people in this way. We must see them not only in the present, but also as the persons they were. "Viewing the patient only in the present divides her from her history, her values, and her relationships—from all those things that made her a moral agent." Nancy K. Rhoden, *The Limits of Legal Objectivity*, 68 N.C. L. REV. 845 (1990) [hereinafter Rhoden, *Legal Limits*]. Rather, for purposes of moral decisionmaking, we must view patients' values as extending forward in time, even if their values were not clearly expressed. Respect for the person demands that we give effect to their future choices. Otherwise, denying the right of future choice threatens the right of present choice. *Id.* at 865. Thus, these commentators bring the discussion full circle, back to the subjective standard. They contend that "the reasonableness of a choice to stop treatment should be evaluated by considering the patient as a whole, including her values, her physical and emotional interests, and her ability to experience and enjoy life." Rhoden, *Litigating Life*, *supra*, at 379.

71. *Cruzan*, 110 S. Ct. at 2855.

and hydration was not proved by clear and convincing evidence.⁷²

In summary, the Court held:

- 1) a person has a constitutionally protected liberty interest in refusing unwanted medical treatment including artificial nutrition and hydration;
- 2) the Due Process Clause requires that this right only lies with the individual; therefore, a state may protect its interest in life by requiring a surrogate to prove an incompetent's intent about exercising this right by clear and convincing evidence before exercising that person's right;
- 3) this clear and convincing evidentiary requirement represents a legitimate state interest balanced against the individual's liberty interest in avoiding unwanted medical treatment;
- 4) because the petitioners failed to prove Nancy's intent regarding medical treatment by the clear and convincing standard, Missouri could refuse to withdraw the artificial feeding tube. As a result, the judgment of the Missouri Supreme Court was affirmed.

C. *Concurrences and Dissents*

Justices O'Connor and Scalia concurred in the majority's opinion but also wrote separately. Justice Brennan wrote a dissenting opinion, in which Justices Marshall and Blackmun joined. Justice Stevens also wrote a separate dissent.

1. Concurrences.

In her concurrence, Justice O'Connor wrote separately to clarify why a protected liberty interest in refusing unwanted medical treatment could be inferred from the Court's prior decisions and why refusing artificial nutrition and hydration is encompassed within that interest.⁷³ In discussing this liberty interest in the majority opinion, Chief Justice Rehnquist had stated that "for purposes of this case, we *assume* that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."⁷⁴ Although he appears in this statement to begrudgingly acknowledge that a liberty interest exists, he couches this concession in tentative, parsimonious language,

72. *Id.* at 2854-55. See *supra* note 45.

73. *Cruzan*, 110 S. Ct. at 2856 (O'Connor, J., concurring).

74. *Id.* at 2852 (O'Connor, J., concurring) (emphasis added).

casting doubt on whether a liberty interest in fact exists or would be protected in all cases.⁷⁵ O'Connor clearly believed it necessary to elaborate on this statement, explaining why this liberty interest does in fact exist and is implicated in cases such as *Cruzan*. Justice O'Connor noted:

[T]he liberty interest in refusing medical treatment flows from decisions involving the State's invasions into the body. Because our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause. . . . The State's imposition of medical treatment on an unwilling competent adult necessarily involves some form of restraint and intrusion. A seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining measures or other medical interventions. Such forced treatment may burden that individual's liberty interests as much as any state coercion.⁷⁶

Justice O'Connor concluded that the State's provision of artificial nutrition and hydration implicates identical concerns. According to Justice O'Connor, "artificial feeding cannot readily be distinguished from other forms of medical treatment."⁷⁷ Even if it is not "medical treatment," it nevertheless clearly involves some degree of intrusion and restraint: "Requiring a competent adult to endure such procedures against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment."⁷⁸

Justice O'Connor also wrote separately to explain that the Court was not deciding the issue of whether a State *must* give

75. Justice Rehnquist states as follows: "Although we think the logic of the cases discussed above would embrace such a liberty interest, the *dramatic* consequences involved in refusal of such treatment would inform the inquiry as to *whether* the deprivation of that interest is *constitutionally permissible*." *Id.* (emphasis added). Although this language is unclear, Rehnquist appears to be saying that under certain dramatic circumstances, it would be constitutionally permissible to deny a person's liberty interest in order to prevent him or her from taking that "dramatic" action.

76. *Id.* at 2956-57 (O'Connor, J., concurring).

77. *Id.* at 2857 (O'Connor, J., concurring) (citing COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MEDICAL ASSOCIATION, AMA ETHICAL OPINION 2.20, WITHHOLDING OR WITHDRAWING LIFE—PROLONGING MEDICAL TREATMENT, CURRENT OPINIONS 13 (1989) [hereinafter AMA ETHICAL OPINION 2.20]; THE HASTINGS CENTER, GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING 59 (1987) [hereinafter HASTINGS GUIDELINES]).

78. *Cruzan*, 110 S. Ct. at 2857 (O'Connor, J., concurring).

effect to the decisions of a patient's duly appointed surrogate decisionmaker. Again, Chief Justice Rehnquist had raised doubts in his majority opinion about whether a State would be constitutionally mandated to implement such decisions.⁷⁹ In her concurrence, however, O'Connor points out that the Court did not in fact reach that issue in *Cruzan*; neither would the Court be precluded from finding in the future that such a duty is constitutionally required to protect a patient's liberty interest in refusing unwanted medical treatment.⁸⁰ O'Connor appears to believe that it is.

Note that, in making this statement, O'Connor is not referring to surrogate decisionmaking such as in *Cruzan*, where a surrogate makes the choice for an incompetent based on an analysis of the incompetent's previous statements about refusing medical treatment. Instead, she is referring to a situation in which a competent person appoints a proxy to make health care decisions on her behalf in the event that she becomes incapacitated. O'Connor further notes that delegating authority to make medical decisions to a family member or friend is becoming common. Several states have recognized the wisdom of this procedure by enacting durable power of attorney statutes, specifically authorizing an individual to appoint a surrogate for making medical treatment decisions. O'Connor concludes that, because most patients are likely to select a family member as a surrogate, "giving effect to a proxy's decisions may also protect the 'freedom of personal choice in matters of . . . family life.'" ⁸¹

Justice Scalia, on the other hand, believes that the federal courts have no business in this field. In his concurrence, he focuses on the State's power to prevent suicide—including suicide by refusing to take appropriate measures necessary to preserve one's life.⁸² According to Scalia, the Constitution does not designate the point at which life becomes worthless and the means preserving it become extraordinary or inappropriate. Neither do the nine Justices of the Court know any more about life-and-death than "nine people picked at random from the Kansas City telephone directory."⁸³ To Scalia, the collective citizenry of a state, through their elected representatives,

79. See *supra* text accompanying notes 70-71.

80. *Cruzan*, 110 S. Ct. at 2857-58 (O'Connor, J., concurring).

81. *Id.* at 2858 (O'Connor, J., concurring).

82. *Id.* at 2859 (Scalia, J., concurring).

83. *Id.*

should be the ones deciding whether a patient's wish to refuse life-preserving measures will be honored. In Scalia's opinion, those wishes should not be honored. He traces the history of suicide, which at common law was criminally liable, and concludes that "starving oneself to death is no different from putting a gun to one's temple."⁸⁴

2. Dissents

The dissenting Justices contest the conclusions of the majority. Justice Brennan argues that if a person has a constitutional liberty interest in avoiding unwanted medical care, that right must be fundamental. The right to be free from medical attention without one's consent is a basic civil right "deeply rooted in this Nation's history and tradition."⁸⁵ The source of this right, Brennan notes, is Anglo-American law's premise of self-determination. Thus, freedom from unwanted medical treatment is "unquestionably among those principles so rooted in the traditions and conscience of our people as to be ranked as fundamental."⁸⁶ Even though serious consequences may result from refusing medical treatment, those consequences do not vitiate the right under our common law tradition of medical self-determination. Every competent adult has the right to forego treatment "if it entails what for him are intolerable consequences or risks, however unwise his sense of values may be to others."⁸⁷ Nor does Nancy Cruzan lose this fundamental right because she is incompetent and unable to exercise that right. Brennan notes that those who are irreversibly ill with loss of brain function, like children and the insane, all retain "rights." However, those rights are only meaningful if they can be exercised by an agent on behalf of the other. "To deny [its] exercise because the patient is unconscious or

84. *Id.* at 2861 (Scalia, J., concurring).

85. *Cruzan*, 110 S. Ct. at 2865 (Brennan, J., dissenting) (quoting *Bowers v. Hardwick*, 478 U.S. 186, 192 (1986) (quoting *Moore v. East Cleveland*, 431 U.S. 494, 503 (1977))).

86. *Id.* at 2865 (Brennan, J., dissenting) (quoting *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934)).

87. *Id.* at 2866 (Brennan, J., dissenting) (quoting *Downer v. Veilleux*, 322 A.2d 82, 91 (Me. 1974)); see also *Tune v. Walter Reed Army Medical Hospital*, 602 F. Supp. 1452, 1455 (D.C. 1985). Exceptions have been made when dependent children are involved. See, e.g., *Application of President & Directors of Georgetown College, Inc.*, 331 F.2d 1000, 1008, *cert. denied*, 377 U.S. 978 (1964) (ordering blood transfusion for mother of infant); *Cruzan v. Harmon*, 760 S.W.2d 408, 422 n.17 (Mo. 1988) (citing cases in which Missouri courts ordered blood transfusions for children over their parents' religious objections).

incompetent would be to deny the right."⁸⁸

Justice Brennan concedes that the right to be free of unwanted medical treatment, like other constitutionally protected interests, may not be absolute. Nevertheless, in Justice Brennan's opinion, no state interest in this case outweighs the individual's interest in self-determination to make profound, personal choices about dying.⁸⁹

Justice Stevens also dissented. He argues that Nancy Cruzan's liberty interest in being free from medical treatment must be understood in light of her particular facts and circumstances. In his view, the Constitution requires the state to care for the patient's life in a manner that respects her own best interests.⁹⁰ Stevens argues that in this case the state has largely ignored Nancy's best interests. He concludes that the Missouri regulation is an unreasonable intrusion upon traditionally private matters encompassed within the liberty interest protected by the Due Process Clause.⁹¹

D. *Aftermath of Cruzan*

Because the Supreme Court agreed with the Missouri Supreme Court that Nancy's family lacked clear and convincing evidence of her intent regarding withdrawal of artificial nutrition and hydration, Nancy remained in the Missouri state hospital with the totality of her nutrition and hydration received through a gastrostomy tube.

On August 30, 1990, the Cruzans asked Judge Teel for a new hearing because three friends of Nancy's had come forward with additional information about Nancy's intent after hearing the publicity surrounding the Supreme Court decision.⁹² In September, the State of Missouri unexpectedly withdrew from the new proceedings, stating that Missouri no longer had "a recognizable legal interest" in the case and would no longer contest the Cruzans' attempts to take their daughter off artificial nutrition and hydration.⁹³ The State's

88. *Cruzan*, 110 S. Ct. at 2867 (Brennan, J., dissenting) (quoting Foody v. Manchester Memorial Hospital, 482 A.2d 713, 718 (Conn. 1984)).

89. *Id.* at 2871 (Brennan, J., dissenting).

90. *Cruzan*, 110 S. Ct. at 2879 (Stevens, J., dissenting).

91. *Id.* at 2882 (Stevens, J., dissenting).

92. Malcolm Gladwell, *Court Rules Woman Has Right to Die*, WASH. POST, Dec. 15, 1990, at A1.

93. *Id.* The withdrawal by the State, claiming no recognizable legal interest in the case and a willingness to accede to the Cruzans' attempts to end their daughter's life,

withdrawal left no official party with standing before the court to oppose the family's motion.

At a November hearing, the three friends testified about conversations with Nancy in which she stated that she would never want to live "like a vegetable."⁹⁴ Two of the friends, who had worked with Nancy at a school for deaf and blind children in 1978, testified that Nancy said she would not want to be force fed or kept alive by machines.⁹⁵ Nancy's doctor, James Davis, testified vividly about her deteriorating vegetative condition, including contorted limbs, red bloated face, bleeding gums, incontinence, diarrhea, seizures, and vomiting.⁹⁶ Dr. Davis originally had opposed removing Nancy from artificial nutrition, but stated that he had changed his belief. When asked if it was in Nancy's best interests for her to continue in this state, Dr. Davis responded, "No, sir. I think it would be personally a living hell."⁹⁷

On December 14, 1990, Judge Teel issued an order authorizing the Cruzans to remove Nancy's feeding tube, stating that her parents had presented evidence that Nancy would not want to continue her present hopeless existence.⁹⁸ Judge Teel's decision essentially repeated his findings of three years

seems ironic and inconsistent with the contention by the Missouri Supreme Court that the state's interest is *not* in the *quality* of life but instead is an *absolute unqualified interest* in the preservation of life. *Cruzan v. Harmon*, 760 S.W.2d 408, 420 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990). The State's willingness to drop out of the case and allow Nancy to die lends support to Judge Blackmar's dissent in *Cruzan v. Harmon* that the state does not in fact have an absolute interest in the preservation of life. *Id.* at 428. Judge Blackmar noted that Missouri's absolutist position is infirm because: 1) the support of capital punishment in Missouri demonstrates relativist values in which some lives are deemed not worthy of saving; 2) the Missouri Living Will Statute, used by the court as an expression of Missouri's policy on the sanctity of life, in fact encourages pre-planned termination of life through living wills; and 3) the state is not prepared to finance the preservation of life without regard to cost, resulting in deaths among those who cannot afford medical treatment. *Id.* at 428-29.

94. Andrew H. Malcolm, *Judge Allows Feeding-Tube Removal*, N.Y. TIMES, Dec. 15, 1990, at 10.

95. Robert Steinbrook, *Missouri Court Says Family Can Let Woman Die*, L.A. TIMES, Dec. 15, 1990, at A1.

96. Malcolm, *supra* note 94, at 10.

97. *Id.*

98. Judge Teel's order stated:

The court, *by clear and convincing evidence*, finds:

That the intent of our ward, if mentally able, would be to terminate her nutrition and hydration.

That there is no evidence of substance to cause belief that our ward would continue her present existence, hopeless as it is, and slowly progressively worsening.

earlier except that this time he called the additional evidence "clear and convincing."⁹⁹ Less than two hours after receiving the decision, Nancy's physician, Dr. Davis, removed the feeding tube from Nancy's stomach and moved her to a private room for terminally ill patients in the Missouri Rehabilitation Center.¹⁰⁰ Seven appeals by a loose coalition of anti-euthanasia and anti-abortion groups¹⁰¹ to the Missouri Court of Appeals, Missouri Supreme Court,¹⁰² Missouri Federal District Court,¹⁰³ and the United States Eighth Circuit Court of Appeals¹⁰⁴ were dismissed because the groups had no legal standing to intervene. In the early hours of December 26, 1990, eight years after the car crash, six months after the Supreme Court ruling, and twelve days after Judge Teel had the final say, Nancy Beth Cruzan, age thirty-three, died in her sleep peacefully, and apparently, without pain.¹⁰⁵

That the co-guardians, Lester L. and Joyce Cruzan, are authorized to cause the removal of nutrition and hydration from our ward, Nancy Beth Cruzan. Malcolm, *supra* note 94, at 10; Steinbrook, *supra* note 95, at 1 (emphasis added).

99. Malcolm, *supra* note 94, at 10.

100. *Anger in Hospital at a Death Order*, N.Y. TIMES, Dec. 16, 1990, at 29 [hereinafter *Anger in Hospital*]. The removal of the tube by Dr. Davis was not uniformly accepted by all of the staff at the hospital. The director, Don Lamkins, opposed the judge's order and considered ignoring it, but in the end he felt compelled to uphold the law. Paul Hendrickson, *The Mourning After: In a Small Missouri Town, the Nancy Cruzan Vigil Ends—The Debate Doesn't*, WASH. POST, Dec. 28, 1990, at B1. Some of the nurses who had previously cared for Nancy felt that they were "violated and betrayed" by her family, doctors, and the legal system. *Anger in Hospital, supra*, at 29. Although none on the staff were forced to care for Nancy after the tube was removed, some of the nurses said that they would care for her, but did not want to be around her family. *Id.* For a discussion from the point of view of medical professionals, see C. Everett Koop, *Decisions at the End of Life*, 5 ISSUES IN L. & MED. 225 (1989); Irene Prior Loftus, *I Have a Conscience, Too: The Plight of Medical Personnel Confronting the Right to Die*, 65 NOTRE DAME L. REV. 699 (1990).

101. In addition to filing appeals, some protesters were arrested after attempting to force their way into Nancy's room to reconnect her feeding tube. *20 Protestors Held in Bid to Force Feed Right-to-Die Patient*, L.A. TIMES, Dec. 18, 1990, at P2. Other protesters held prayer vigils outside the hospital. *Nancy Cruzan Dies, Outlived by Debate Over Right to Die*, N.Y. TIMES, Dec. 27, 1990, at A1 [hereinafter *Nancy Cruzan Dies*].

102. *Court Refuses to Order Life Support for Coma Patient*, L.A. TIMES, Dec. 20, 1990, at P2. Ironically, the two-sentence order dismissing the appeal to the Missouri Supreme Court was signed by Judge Edward Robertson, who wrote that court's decision in *Cruzan v. Harmon*, denying the family's original request to withdraw artificial nutrition and hydration. *Id.*

103. *A Federal Judge Scolds Protestors on Filing Petitions in Cruzan Case*, N.Y. TIMES, Dec. 22, 1990, at 11.

104. *Court Refuses to Halt Starvation of Patient*, L.A. TIMES, Dec. 25, 1990, at A35.

105. *Nancy Cruzan Dies, supra* note 101, at A1. In a statement issued by Nancy's parents, they stated that Nancy "remained peaceful throughout and showed no sign of

E. Analysis and Criticism of Cruzan

The *Cruzan* decision has received extensive analysis and criticism since it was issued.¹⁰⁶ Some commentators have sided with the majority, supporting its analysis that the right to refuse medical treatment is less than a fundamental right—a liberty interest—and that the task of safeguarding that interest may be entrusted to individual states. Others have sided with the dissenters in their belief that a fundamental right is at stake, requiring strict scrutiny analysis. Another approach is to look beyond that analysis and examine the normative values underlying the Justices' choices in their majority, concurring, and dissenting opinions. Those normative values are reflected by their use of narrative. In other words, one approach to analyzing *Cruzan* is to look at how the Court's legal narrative reflects the normative values underlying that story.

1. Narratives and Nomos

The law derives its authoritative power in part by its ability to analyze a particular set of facts and derive a more abstract, generalized rule that can be applied to later, similar sets of facts. But those abstract rules would have no meaning or justification if they did not reflect our underlying normative values. As Robert Cover has noted: "We inhabit a *nomos*—a normative universe. We constantly create and maintain a world of right and wrong, of lawful and unlawful, of valid and

discomfort or distress in any way." *Id.* The cause of her death was listed as "shock, due to dehydration, due to severe head injury." Steinbrook, *supra* note 26, at A3.

106. See, e.g., James Bopp, Jr. & Daniel Avila, *Perspectives on Cruzan: The Sirens' Lure of Invented Consent: A Critique of Autonomy-Based Surrogate Decisionmaking for Legally-Incapacitated Older Persons*, 42 HASTINGS L.J. 779 (1991); Norman L. Cantor, *Prospective Autonomy: On the Limits of Shaping One's Postcompetence Medical Fate*, 8 J. CONTEMP. HEALTH L. & POL'Y 13 (1992); William L. Leschensky, *Constitutional Protection of the "Refusal-of-Treatment": Cruzan v. Director, Missouri Department of Health*, 14 HARV. J.L. & PUB. POL'Y 248 (1991); Susan R. Martyn & Henry J. Bourguignon, *Perspectives on Cruzan: Coming to Terms with Death: The Cruzan Case*, 42 HASTINGS L.J. 817 (1991); Thomas J. Onusko & Patricia Casey Cuthbertson, *The Right to Refuse Medical Treatment in Ohio After Cruzan: The Need for a Comprehensive Legislative Solution*, 5 J.L. & HEALTH 35 (1990-91); George P. Smith II, *Murder, She Wrote or Was It Merely Selective Nontreatment?*, 8 J. CONTEMP. HEALTH L. & POL'Y 49 (1992); Tom Stacy, *Death, Privacy and the Free Exercise of Religion*, 77 CORNELL L. REV. 490 (1992); Ben A. Rich, *The Assault on Privacy On Healthcare Decisionmaking*, 68 DENV. U. L. REV. 1 (1991); Anne Marie Gaudin, Note, *Cruzan v. Director Missouri Department of Health: To Die or Not To Die: That is the Question—But Who Decides?*, 51 LA. L. REV. 1307 (1991); Edward J. O'Brien, Note, *Refusing Life-Sustaining Treatment: Can We Just Say No?*, 67 NOTRE DAME L. REV. 677 (1992).

void.”¹⁰⁷ One of the most powerful means by which the law reflects those values and gives meaning to abstract rules is through its use of narrative or storytelling. The attraction of narratives is that they correspond more closely “to the manner in which the human mind makes sense of experience than does the conventional, abstracted rhetoric of law.”¹⁰⁸ Narratives, with their fuller, more concrete meanings, provide a link between generalized rules and the normative values that they reflect.¹⁰⁹

Judicial opinions take conflicting stories presented by the opposing parties and fashion from them a legal narrative, the court’s version of the story. Of course, no story can include all the details, or, for that matter, determine every aspect of the truth—of what actually happened. And to some extent, no one “truth” may exist. Often parties with conflicting versions of events are each convinced that their version is right. Once that story is framed in a legal narrative, however, it becomes the official version of what happened. The power of a legal narrative, then, lies partly in its ability to satisfy the parties and the community at large with that official version of what happened and with the normative values that it reflects. However, part of its persuasive power also lies in its ability to address the normative values at stake in the broader cultural narrative of which the legal narrative is only a part.

2. *Cruzan*: The Failure of Narrative

In *Cruzan*, the legal narrative is a story about a young woman who sustained severe injuries in an automobile accident, which left her in a persistent vegetative state. But *Cruzan* is also about a broader cultural narrative. It is about the process of dying and about the freedom of individuals and their families to make choices about that process. One disturbing aspect of Rehnquist’s opinion is that his version of Nancy’s story fails to adequately embrace that broader cultural narrative or give thoughtful consideration to its conflicting normative values. His dismissive attitude of the values explored by the dissenting opinions fails to acknowledge how

107. Robert M. Cover, *The Supreme Court, 1982 Term—Forward: Nomos and Narrative*, 97 HARV. L. REV. 4 (1983).

108. Steven Winter, *The Cognitive Dimension of the Agon Between Legal Power and Narrative Meaning*, 87 MICH. L. REV. 2225, 2228 (1989).

109. *Id.* See also JAMES BOYD WHITE, *HERACLES’ BOW: ESSAYS ON THE RHETORIC AND POETICS OF THE LAW* 168 (1985).

the normative values within the broader cultural narrative are changing. As a result, his opinion has a narrowness, a sort of brittleness, that makes it ill-suited to assist the thousands of people who will find themselves or their family members in the same situation as Nancy Cruzan.

In Rehnquist's narrowing and shaping of the legal narrative, much is left out. Most of the emotional content of the narrative is lost: the anguish of Nancy's family and friends, and of the hospital nurses, doctors, and administrators, all of whom must cope with their emotional response to Nancy's condition and their personal feelings about when life ends and death begins. The legal narrative focuses very narrowly on Nancy's situation and even downplays that situation. For example, the Court's choice of language describes her story in a perfunctory manner and relegates to a footnote the detailed description of her persistent vegetative state. Although the Court notes that she is legally an incompetent, the tone of the legal narrative gives the impression that she is a cognitive, competent adult asking to commit suicide by starving herself to death. The Court thus treats her situation the same as a person asking for the right to jump off a bridge or to go on a hunger strike.

Certainly, in a case, a Court is presented with only one set of facts, and to an extent, the Court should address only those facts briefed. But when the Court is construing a possible Constitutional right, the effects of that decision will ripple far beyond the facts of that one case into the broader cultural narrative. In *Cruzan*, the Court fails to acknowledge this effect. But even if the Court does acknowledge this effect, it draws little distinction between the infinitely varied situations in which a person may be confronted with the process of dying.

In contrast, the two dissenting narratives of Justices Brennan and Stevens go into great detail about Nancy's condition, concluding that she is in a "twilight zone of suspended animation where death commences while life, in some form, continues."¹¹⁰ Moreover, both legal narratives broaden their stories to include the cultural narrative beyond Nancy's individual situation. *Cruzan* is not an isolated or unusual case; many

110. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2863 (1990) (Brennan, J., dissenting). See *Rasmussen v. Fleming*, 741 P.2d 674, 678 (Ariz. 1987); Daniel D. King et al., *Where Death Begins While Life Continues*, 31 S. TEX. L. J. 145, 146 (1990).

thousands of people are in situations similar to hers. As Justice Brennan notes, of those who die each year in this country, most will die in hospitals or long-term care facilities and many of those after a decision to forego life-sustaining treatment is made.¹¹¹ Thus, the Court's decision has a much broader ramification than the wording of the majority decision would seem to acknowledge.

Another disturbing feature of the majority's legal narrative is that it ignores much of the factual evidence about Nancy's intentions regarding removal of life-support treatment. The only evidence that the Court includes in its narrative is a "somewhat serious conversation with a housemate friend that if sick or injured [Nancy] would not wish to continue her life unless she could live at least halfway normally."¹¹² In the Court's eyes, such an off-the-cuff statement is unreliable for purposes of determining Nancy's intent. The Court concludes that this evidence is insufficient to meet the clear and convincing evidence standard. The trial court, however, concluded that the evidence *was* sufficient, a conclusion based on a great deal of testimony *in addition* to this "somewhat serious conversation." Besides her friend's testimony about their conversations, Nancy's sister, mother, and another friend testified about Nancy's wishes regarding artificial life-support.¹¹³

3. The Failure of Narrative to Reflect Nomos

The Court does acknowledge several normative values underlying its legal narrative. In that narrative, the Court frames the issue as whether the United States Constitution forbids Missouri from establishing a procedural rule that requires clear and convincing evidence of a patient's intent about withdrawing treatment. According to the Court, the normative value underlying this high evidentiary rule is the protection of the individual's intent. In other words, the Court wants to protect Nancy's choice and ensure that her intent is accurately determined and effectuated. But if the normative value that the Supreme Court wished to advance was truly protecting the intent of the individual, why did the Court ignore much of the factual evidence in its legal narrative?

111. *Cruzan*, 110 S. Ct. at 2864 (Brennan, J., dissenting).

112. *Id.* at 2846.

113. See *supra* notes 36, 43-45 and accompanying text.

Why did it impose a markedly asymmetrical evidentiary burden that discounted much of that evidence? Certainly the state has a legitimate interest as *parens patriae* in providing Nancy, as an incompetent, with "as accurate as possible a determination of how she would exercise her rights under these circumstances."¹¹⁴ Once the individual's intent to continue treatment has been determined, the state may assert a legitimate interest in providing that treatment. It seems likely that most people in Nancy Cruzan's situation would want their families, friends, and doctors to determine carefully their intent regarding treatment and carry out that intent. But *before* the state can assert an interest in providing treatment according to the individual's choice, the only state interest that may be advanced is safe-guarding the accuracy of that determination. Therefore, as Justice Brennan notes, accuracy should be the touchstone of the Court's proceeding. Yet the Court ignored much of the evidence that would seemingly go to the heart of an accurate determination of Nancy's intent. What was really going on in this opinion?

Ultimately, one is forced to conclude that the Justices were disingenuous. Although they pay lip-service to the normative value of protecting Nancy's choice, the Court was really promoting another normative value: the state's interest in preserving human life. Certainly this interest is a legitimate normative value. One of our country's core values is a belief in the value of human life, and one of the state's key roles is protecting the lives of its citizens. The state demonstrates that commitment to life by treating homicide as a serious crime and passing laws against suicide. But is *Cruzan* truly about suicide, as Justice Scalia would have us believe in his concurring opinion? The Court acts as if Nancy's case is the same as a competent adult who decides one day to starve herself,¹¹⁵ but are those cases really the same? Probably not.

The problem is that, in lumping all these cases together and asserting an unqualified interest in preserving life, the Court begs the ultimate question: What is life? According to the Court, in the face of doubt about Nancy's intent, the Court errs on the side of "life." The Court notes that an erroneous decision not to terminate results in maintenance of the status

114. *Cruzan*, 110 S. Ct. at 2871 (Brennan, J., dissenting).

115. A state need not "remain neutral in the face of an informed and voluntary decision by a physically-able adult to starve to death." *Id.* at 2852.

quo, whereas an erroneous decision to withdraw life-sustaining treatment “is not susceptible of correction”—the patient has died.¹¹⁶ Certainly Nancy was “alive” in a physiological sense at the time of the Court’s decision, but was her situation “life” as we know it, accept it, or want it to be defined? The Court chooses to view this issue as a judgment about “quality” of life and responds that a state may decline to make such judgments and simply assert an unqualified interest in the preservation of human life. But by asserting that unqualified interest and by keeping Nancy on life-support, the Court is in fact making an unstated conclusion that life equals biological persistence. As Justice Stevens notes,

for patients like Nancy Cruzan, who have no consciousness and no chance of recovery, there is a serious question as to whether the mere persistence of their bodies is “life” as that word is commonly understood, or as it is used in both the Constitution and the Declaration of Independence. The State’s unflagging determination to perpetuate Nancy Cruzan’s physical existence is comprehensible only as an effort to define life’s meaning, not as an attempt to preserve its sanctity.¹¹⁷

This definition of life is disturbing. Not only does it fail to provide any guidance in situations similar—or different—from Cruzan’s, but it dooms thousands to become prisoners of every advance in medical science or technology. At the heart of this concern lies another normative value rejected by the majority: the individual’s right to self-determination. In this country, our ideas of physical freedom and self-determination are inextricably entwined with our notions of liberty. “The duty of the State to preserve life must encompass a recognition of an individual’s right to avoid circumstances in which the individual himself would feel that efforts to sustain life demean or degrade his humanity.”¹¹⁸ Medical decisions should be guided by the individual patient’s interests and values. “Allowing persons to determine their own medical treatment is an important way in which society respects persons as individuals.”¹¹⁹

This normative value, which is embraced by the *Cruzan* dissent, is in tension with the majority’s normative value, the

116. *Id.* at 2854.

117. *Id.* at 2886 (Stevens, J., dissenting) (emphasis in original).

118. *Id.* at 2868 (Brennan, J., dissenting).

119. *Cruzan*, 110 S. Ct. at 2876 (Brennan, J., dissenting).

State's interest in preserving life. In the majority's legal narrative, the State's interest prevails. Unless people's intent about withdrawing life-sustaining treatment is clear and convincing—a burden that can likely be met in only a small minority of cases—most will have no choice in determining their fate. They will be forced to accept the Court's definition of life as biological persistence, subject to the "constantly increasing power of science to keep the human body alive for longer than any reasonable person would want to inhabit it."¹²⁰ By adopting this normative value of preserving life at all costs, the Court evinces a disdain for individuals' right to choose and transforms them into passive subjects of medical technology.

This result is unacceptable. The majority's normative value, with its definition of life as biological persistence, seems to be an old-fashioned view of life and death that fails to provide any guidance to our modern technological society. The majority clings to the old notion that death should be beyond human choice, decided by fate when the body can no longer sustain itself. That notion, however, no longer accurately reflects medical reality. Whereas the timing of death was once a matter of fate, it is now often a matter of choice.¹²¹ Moreover, one is suspicious that the majority is trying to impose on society its own Judeo-Christian religious view of life-and-death decisions.

For example in his concurring opinion, Justice Scalia goes into great detail about the history of suicide. He notes that in *Blackstone* and old common law cases suicide was considered criminally liable:

The life of those to whom life has become a burden—of those who are hopelessly diseased or fatally wounded—nay even the lives of criminals condemned to death, are under the protection of the law, equally as the lives of those who are in the full tide of life's enjoyment, and anxious to continue to live.¹²²

Scalia uses this historical analysis as evidence that suicide was never "so rooted in our tradition that it may be deemed 'fundamental' or 'implicit in the concept of ordered liberty.'"¹²³

120. *Id.* at 2859 (Scalia, J., concurring).

121. *Id.* at 2864 (Brennan, J., dissenting).

122. *Id.* at 2860 (Scalia, J., concurring) (quoting *Blackburn v. State*, 23 Ohio St. 146, 163 (1873)).

123. *Id.* at 2860 (Scalia, J., concurring) (citing Thomas J. Marzen et al., *Suicide: A*

Therefore, to Scalia, Nancy Cruzan has no basis for claiming a *fundamental* right to remove life-support. However, he uses *Blackstone* and cases from the 1800's when medical technology was vastly different than today. Furthermore, he merely cites the common law of 1800 as support without ever examining the normative values underlying that law or how those values are changing. Scalia seems to forget that the common law is, in essence, an embodiment of the societal values by which the community wants to be governed. In the 1800's, those values had strong religious overtones, reflecting the predominant view that suicide was a sin against God and that human beings must persevere on this mortal plain until God chooses to take them away. But those values are changing, in part because of changes in medical technology that have blurred the line between life and death, and in part because of the splintering of society's religious views. Nevertheless, for the Justices to incorporate their own religious view of the definition of life into constitutional decision-making is unprincipled. As Justice Stevens commented,

it would be possible to hypothesize such [a state interest in defining and preserving life] on the basis of theological or philosophical conjecture. But even to posit such a basis for the State's action is to condemn it. It is not within the province of secular government to circumscribe the liberties of the people by regulations designed wholly for the purpose of establishing a sectarian definition of life.¹²⁴

The ultimate problem with the majority's normative value is two-fold: (1) it does not acknowledge that society's views about preserving life are changing, and (2) it fails to provide any framework for accommodating that change. Rather, the predominant normative value in the broader cultural narrative today is that of individual self-determination, and more specifically, the right of the individual to chose when life is no longer worth living. Of course, even this statement is too black-and-white; people are much less comfortable with the Kevorkian death-machine than with the notion of allowing a terminally ill, comatose person to die by stopping artificial life-support when no chance of recovery exists.

Nevertheless, who are we to say what a person's choice

Constitutional Right?, 24 DUQ. L. REV. 1, 76 (1985) (quoting *Palko v. Connecticut*, 302 U.S. 319, 325 (1937)).

124. *Cruzan*, 110 S. Ct. at 2888 (Stevens, J., dissenting).

should or should not be if confronted with a situation such as Nancy Cruzan's? What state's interest can justify the government intruding into some of the most personal and profound choices facing a person or their family and friends? Certainly the State serves a role in protecting life and should safeguard our society's normative value that life is precious. The law should never become a vehicle reflecting disdain for life, where it would be a routine matter to say, "Oh, Uncle is failing, and we can't afford the hospital bills, so let's just pull the plug." To the extent that the law serves a role in preserving our attitudes about the sanctity of life, it should continue to serve that function. But as Justice Stevens notes,

the only apparent *secular* basis for the State's interest in life is the policy's persuasive impact upon people other than Nancy and her family. Yet, "[a]lthough the State may properly perform a teaching function," and although that teaching may foster respect for the sanctity of life, the State may not pursue its project by infringing constitutionally protected interests for "*symbolic effect*."¹²⁵

Cruzan sends a symbolic message about the sanctity of life, but at the expense of the individual's choice about that life.

By embracing only the normative value of preserving life, without adequately addressing the conflicting value of self-determination, the majority's legal narrative fails to reflect the tension of these changing normative values or provide any flexibility for dealing with the thousands of situations like Nancy Cruzan's that will arise each year. Thus, the Court's opinion is too rigid and brittle; it is like a crystal that captures and attempts to hold onto old normative values to prevent them from changing. But if a "word is not a crystal," neither is the law a crystal, "transparent and unchanged." Rather, as Justice Holmes noted, it is the "skin of a living thought, varying greatly in color and content according to the circumstances and the time in which it is used."¹²⁶ If legal narratives are in fact normative, then for that narrative to be embraced by society, it must adequately reflect those normative values underlying those "living thoughts"—the values and standards by which our society wants to be governed. Certainly the law has an inherent tension as both a guardian for preserving our cul-

125. *Id.* at 2889 (Stevens, J., dissenting) (quoting *Carey v. Population Services Int'l*, 431 U.S. 678, 715 (1977)) (emphasis in original).

126. *Towne v. Eisner*, 245 U.S. 418, 425 (1918).

tural values and a vehicle by which those values change. But when the law ceases to provide a flexible mechanism for reflecting those changing values and only holds on to preserving old values, the law becomes as brittle as Holmes' crystal.

This result suggests a further danger. When a legal narrative fails to reflect the normative values of its larger cultural narrative, people sense this failure and will not accept its result. In other words, the opinion fails to have weight within the community that it seeks to govern. For example, in *Cruzan*, because the legal narrative was inadequate, it was not accepted by much of its community as authoritative. In particular, the Cruzan family refused to accept the result of the Court and found additional evidence to take back to the trial court judge, who originally ruled in their favor. Based on this new evidence, the trial court held that the evidence was now clear and convincing, and granted the family's petition.

If the legal narrative in a case such as *Cruzan* is inadequate, it undermines the power of the court to speak authoritatively and resolve disputes according to a consensus of community values. Of course, the failure of legal narratives may motivate people to change the law legislatively, thereby better reflecting the community's values. On the other hand, people may become disenchanted, jaded. They may begin to view the law as not representative of their values and ignore those laws, or believe that "the system" does not work. Such a result undermines the ability of the law to provide an authoritative resolution as people begin to circumvent or ignore the law.

In conclusion, the *Cruzan* legal narrative is unsatisfactory. It fails to address adequately all the facts of its own narrative, the broader cultural narrative, or the normative values at stake in such a case. To the extent that our culture has not resolved these conflicting normative values, perhaps the law cannot not resolve them either. But the law should reflect that tension, and if it is not resolvable, then leave that resolution to the individual and her family. Ultimately, the Rehnquist narrative leaves many readers angry. They are angered because the Court fails to take seriously the enormity of a situation in which a person wants to make choices about life and death in private with some semblance of dignity. Finally, the Court fails to provide a framework for effectuating those choices.

F. The Effect of Cruzan

The above criticisms focused on the failure of the *Cruzan* narrative to provide a flexible legal framework that adequately reflects the conflicting normative values of our society. But beyond this failure, what impact does the decision have on the state's ability to provide such a framework on its own accord? To some extent, the effect of the *Cruzan* decision is uncertain because the decision appears to be a narrow holding limited to Missouri law. The Court held that Missouri's rule of decision requiring a clear and convincing evidentiary standard did not violate the Due Process Clause of the Fourteenth Amendment. Nevertheless, *Cruzan* does have broad implications that may have a significant impact on every state, including Washington.

In *Cruzan*, the United States Supreme Court acknowledged for the first time that a competent person has a constitutionally protected liberty interest in refusing medical treatment.¹²⁷ Because of *Cruzan*, people now have a constitutional due process right to refuse medical treatment. More importantly, that protected liberty interest encompasses a right to refuse artificially delivered food and water. Justice O'Connor, in her concurring opinion, noted that "artificial feeding cannot readily be distinguished from other forms of medical treatment."¹²⁸

Another important development is the Court's acknowledgment that a state could allow a person's right to refuse medical treatment to be exercised by a surrogate on behalf of the now-incompetent person. Certainly the Cruzans and many groups such as the Society for the Right to Die would have preferred the Court find that the Due Process Clause *required* a state to give effect to the decisions of a patient's duly appointed surrogate decisionmaker.¹²⁹ Just as important, however, the Court did not block the development of state laws to deal with situations such as Nancy Cruzan's. In fact, the Court's decision allows each state to develop its own approach for protecting an incompetent person's liberty interest in refusing medical treatment.¹³⁰ As Justice O'Connor pointed out in

127. *Cruzan*, 110 S. Ct. at 2852.

128. *Id.* at 2857 (O'Connor, J., concurring).

129. See *supra* text accompanying notes 79-81.

130. The Chief Judge of the State of New York noted that the actual holding of *Cruzan* may be narrow, but the message is clear: "This is an area in which the Court intends to defer to the states. In other words: Don't call us, we'll call you." Sol

her concurrence, "the more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the 'laboratory' of the States."¹³¹

Thus, the importance of *Cruzan* to states such as Washington is two-fold: First, the case finds a constitutionally protected liberty interest in refusing unwanted medical treatment, including artificial hydration and nutrition. Second, the case allows each state to develop its own approach for protecting that liberty interest. However, before we can explore these implications in detail and assess the direct effect of *Cruzan* on Washington state, we must first examine the current status of Washington law.

III. WASHINGTON STATE LAW

A. *The Natural Death Act*

In *Cruzan*, the first area of state law to which the United States Supreme Court turned for guidance was Missouri's Living Will Statute, which the Court found to reflect that state's strong interest in life. Washington, like Missouri, has a living will statute.

In the 1970's, Washington, like many states, began to recognize the dilemma created by advances in medical science that increasingly blur the line between life and death. State legislatures responded by passing so-called living will statutes, under which an adult could execute a directive that would require the withholding or withdrawal of life-sustaining procedures under certain conditions. In 1979, Washington passed its version of a living will statute, the Natural Death Act (NDA).¹³² In 1992, the Washington legislature amended the NDA¹³³ in response to a statewide referendum proposing numerous changes to the NDA.¹³⁴ Despite the amendments to

Wachtler, *Life and Death Decisions: The Patient's Choice*, N.Y.L.J., Jan. 23, 1991, at 39.

131. *Cruzan*, 110 S. Ct. at 2859 (O'Connor, J., concurring).

132. WASH. REV. CODE ch. 70.122 (1989).

133. 1992 Wash. Laws ch. 98 (to be codified at WASH. REV. CODE ch. 70.122).

134. Citizens' Initiative Measure No. 119, a state-wide referendum proposing extensive changes to the NDA, appeared on the general ballot in November 1991. Some of the initiative's provisions that would clarify language, such as refusing artificial nutrition and hydration, were generally supported by the health care community. Lou Cannon, *Assisted Killing of Fatally Ill on State Ballot—Wash. Measure Spurs Intense Debate*, WASH. POST, Nov. 3, 1991, at A6; Robert O'Boyle, *Life and Death Look A Lot Different Now*, THE SEATTLE TIMES, Oct. 27, 1991, at K3. However, other language, called "aid-in-dying," would specifically allow a competent,

the statute, however, the NDA still only applies to a person who has executed a written directive indicating her preferred course of medical treatment. Thus, the NDA does not directly apply to the thousands of people like Nancy Cruzan who have not executed a living will. Nevertheless, the changes to the NDA do help to clarify Washington state's underlying policy on the use of artificial nutrition and hydration for people in a persistent vegetative state.

In the NDA, the legislature stated that adult persons have a fundamental right to control decisions relating to their health care, including a decision to withhold or withdraw life-sustaining treatment in instances of a terminal condition or permanent unconscious condition.¹³⁵ Because medical technology may now artificially prolong life beyond its natural limits, such prolonging may cause a person suffering from a terminal or permanent unconscious condition to lose personal dignity or undergo unnecessary pain and suffering. Yet such treatment provides "nothing medically necessary or beneficial to the patient."¹³⁶ In the interest of protecting individual autonomy, dignity, and privacy, the legislature passed the Natural Death Act. Under the NDA, an adult with the capacity to make health care decisions has the right to execute a written directive, which would require the withholding or withdrawal of life-sustaining treatment in the event of a terminal or permanent unconscious condition.¹³⁷

conscious patient to request medical aid by a physician to end the patient's life. See Wash. Initiative Measure No. 119 (on file with the *University of Puget Sound Law Review*). This controversial aid-in-dying provision would authorize what to some had previously been considered euthanasia and statutorily defined as homicide. Strong opposition to the aid-in-dying provision by some members of the health care community and by the Catholic archdiocese resulted in defeat of the referendum. To persuade voters to defeat the initiative, the archdiocese promised to support legislative amendments to the NDA that would include the initiative's less-controversial language clarifications. These amendments had previously been proposed in the legislature but defeated partly because of the Catholic archdiocese's opposition. *Natural Death Act Gives Patients Right to Decide on Feeding Tubes*, THE SEATTLE TIMES, Mar. 8, 1992, at A14 [hereinafter *Natural Death Act*]; *Senate GOP Majority Kills House—Ok'd Right-to-Die Bill*, THE OREGONIAN, Mar. 4, 1992, at B4; see Engrossed Substitute Senate Bill (ESSB) 3228, 49th Leg., 1985 Reg. Sess.; ESSB 5401, 50th Leg., 1987 Reg. Sess.; H.B. 1965, 50th Leg., 1988 Reg. Sess. The archdiocese kept its promise to support the amendments, which resulted in the passage of S.H.B. 1481 by the legislature on March 5, 1992. See 1992 Wash. Laws ch. 98; *Natural Death Act, supra*, at A14.

135. 1992 Wash. Laws ch. 98, § 1.

136. *Id.*

137. The revised NDA states:

In recognition of the dignity and privacy which patients have a right to expect, the legislature hereby declares that the laws of the state of Washington shall

A Washington court confronted with a case such as Cruzan's might turn to the NDA for guidance, just as the Missouri and United States Supreme Courts turned to the Missouri Living Will Statute in *Cruzan*. The Missouri Living Will Statute specifically excluded artificial nutrition and hydration from the list of procedures that could be withdrawn in accordance with a living will. From that exclusion, the Missouri and United States Supreme Courts inferred a policy in favor of the preservation of life. Unlike Missouri, however, the 1992 revisions to the Washington NDA added "artificially provided nutrition and hydration" to the "life-sustaining treatment"¹³⁸ that may be withheld or withdrawn from a person under certain conditions. The revised NDA also clarified those conditions under which artificial nutrition and hydration could be removed. Whereas the statute previously allowed removal only when the person was in a "terminal condition,"¹³⁹ the revised NDA now allows removal when the patient is in a "permanent unconscious condition,"¹⁴⁰ including an "irrevers-

recognize the right of an adult person to make a written directive instructing such person's physician to withhold or withdraw life-sustaining treatment in the event of a terminal condition or permanent unconscious condition.

Id.

138. *Id.* § 2(5). The revisions change the term "life-sustaining procedure" to "life-sustaining treatment." *Id.* Changes to the definition are interesting; deletions from the definition are indicated below in brackets and new language is indicated in italics:

"Life-sustaining [procedure] *treatment*" means any medical or surgical [procedure or intervention which utilizes] *intervention that uses* mechanical or other artificial means, *including artificially provided nutrition and hydration*, to sustain, restore, or [supplant] *replace* a vital function, which, when applied to a qualified patient, would serve only to [artificially] prolong the [moment of death and where, in the judgment of the attending physician, death is imminent whether or not such procedures are utilized] *process of dying*. "Life-sustaining [procedure] *treatment*" shall not include the administration of medication or the performance of any medical [procedure] *or surgical intervention* deemed necessary *solely* to alleviate pain.

Id.

139. The legislature also clarified the definition of "terminal condition." Deletions from the definition are indicated by brackets and additions are indicated by italics:

"Terminal condition" means an incurable *and irreversible* condition caused by injury, disease, or illness, [which, regardless of the application of life sustaining procedures, would] *that*, within reasonable medical judgment, [produce] *will cause* death *within a reasonable period of time in accordance with accepted medical standards*, and where the application of life-sustaining [procedures] *treatment* serves only to [postpone the moment of death of the patient] *prolong the process of dying*.

1992 Wash. Laws ch. 98, § 2(9).

140. The revised NDA defines "permanent unconscious condition" as "an incurable and irreversible condition in which the patient is medically assessed within

ible coma" or a "persistent vegetative state."¹⁴¹

Moreover, the new revisions to the Washington NDA reflect a change in policy underlying the NDA. Unlike the Missouri Living Will Statute, which evinced a policy to preserve life at all costs, the Washington State Legislature's 1992 revisions specifically changed the NDA's language from the "prolongation of life" to the "prolongation of the process of dying."¹⁴² Although the shift in emphasizing prolonging "life" to the "process of dying" may only be one of semantics, it arguably denotes a policy shift reflecting competing normative values. By using the term "prolongation of life," such as in the Missouri statute, the legislature reflects a normative value in which life is viewed as precious, and doctors should use whatever measures necessary to preserve that life at all costs. The language "process of dying" does not challenge that normative value about life. Instead, it reflects the realization that all life eventually ends and that health care professionals have a competing normative value to ease the patient's suffering and allow the process to run its course when prolonging it will not be beneficial to the patient. Significantly, the legislature added language to support this competing normative value. In the language immediately following the discussion of "the process of dying," the legislature instructs that "physicians and nurses should not withhold or unreasonably diminish pain medication for patients in a terminal condition where the primary intent of providing such medication is to alleviate pain and maintain or increase the patient's comfort."¹⁴³

Several key provisions of the NDA, however, limit its applicability to many situations such as that of Nancy Cruzan. First, the person must actually execute a written directive stating her intentions before the terminal or permanent unconscious condition ensues.¹⁴⁴ Nancy Cruzan, like the vast

reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or persistent vegetative state." *Id.* § 2(6).

141. Although the revised NDA does not define "irreversible coma" or "persistent vegetative state," a patient suffering from those conditions is not "qualified" for removal of life-sustaining treatment unless two physicians diagnose in writing that the patient is in a permanent unconscious condition "in accordance with accepted medical standards." *Id.* § 2(8). One physician must be the patient's attending physician, and both must have personally examined the patient. *Id.*

142. *Id.* § 1; see also § 2(5), in which "moment of death" is redefined as the "process of dying."

143. 1992 Wash. Laws ch. 98, § 1.

144. *Id.* § 1, 3 (to be codified at WASH. REV. CODE § 70.122.010, -.030).

majority of Americans, had not executed such a directive prior to entering a persistent vegetative state; in fact, the statute did not even exist at the time of her accident. Thus, in her case, the Missouri Living Will Statute was not directly applicable. Likewise, the Natural Death Act would not be applicable to a person in Nancy Cruzan's situation in Washington because the Act only covers people who have executed a written directive before becoming incompetent.

Not only must the person have executed a written living will, but that person must also be an "adult," one who has attained the age of majority and who has the capacity to make health care decisions.¹⁴⁵ Thus, the Washington NDA would not cover situations involving minors suffering from a persistent vegetative state.¹⁴⁶ Likewise, the statute would not provide for individuals, regardless of their age, who do not have the capacity to make health care decisions. This exception would apply to individuals like Nancy Cruzan who did not execute a living will before she suffered injury in the car accident and no longer had the capacity to make her own health care decisions afterwards. This exception would also apply to those disabled individuals who have never had the capacity to make health care decisions.¹⁴⁷

The Act does add language that a person's right to control his or her health care may be exercised by an authorized representative holding that person's durable power of attorney for health care.¹⁴⁸ Again, the person must have executed a written durable power of attorney; many people, especially young adults like Nancy Cruzan who do not anticipate injury in a car accident, will not have taken that action. Furthermore, the statute only authorizes the representative to exercise the health care choices of the person as indicated in the written directive drafted according to the NDA.

In conclusion, the Washington Natural Death Act, unlike the Missouri Living Will Statute, evinces a policy that artificial nutrition and hydration are life-sustaining treatments that may be withdrawn from individuals suffering from a persistent vegetative state. Nevertheless, the Washington statute, like the Missouri law, would not be applicable to a person in Nancy

145. *Id.* § 1, 2(1).

146. *See In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983).

147. *See In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

148. 1992 Wash. Laws ch. 98, §§ 1, 3(1)(b).

Cruzan's situation because the NDA only covers people who have executed a written directive before becoming incompetent. Thus, a Washington court deciding a case like *Cruzan* must turn to common law solutions for cases not covered by the Natural Death Act.

*B. Common Law Solutions: Colyer, Hamlin, and Grant.*¹⁴⁹

In a series of cases decided before *Cruzan*, the Washington Supreme Court dealt with situations similar to that of Nancy Cruzan.

1. *In re Colyer*

The first case, *In re Colyer*,¹⁵⁰ was one of first impression in Washington that addressed the issue of an incompetent's right to have life-sustaining treatment withheld or withdrawn in appropriate circumstances. The case dealt with the plight of Bertha Colyer, who suffered a heart attack at age sixty-nine. Like Nancy Cruzan, Bertha was deprived of oxygen for approximately ten minutes, which resulted in massive brain damage. Afterwards, Bertha could only breathe with the assistance of a respirator and remained in a persistent vegetative state, with zero prognosis for recovery to "any sort of meaningful existence."¹⁵¹ Bertha's husband, as guardian over Bertha's person and estate, petitioned the court for authorization to remove her life support systems. The court appointed a guardian ad litem to represent Bertha's interests.¹⁵² The trial

149. For additional discussion of these cases, see Jacquelyn A. Beatty, Comment, *Artificial Nutrition and the Terminally Ill: How Should Washington Decide?*, 61 WASH. L. REV. 419 (1986); Stephen P. VanDerhoef, Note, *In re Grant: Where Does Washington Stand On Artificial Nutrition and Hydration?*, 13 U. PUGET SOUND L. REV. 197 (1989).

150. 99 Wash. 2d 114, 660 P.2d 738 (1983).

151. *Id.* at 116, 660 P.2d at 740. The court does not define "meaningful existence," but goes on to describe Bertha's condition as follows:

Weeks elapsed without any signs of neurological improvement or lightening of her coma. Two physicians, a cardiologist and a neurologist, agreed that the likelihood of Bertha Colyer recovering any significant amount of brain function was extremely small. They also agreed that she would probably expire within a short period if removed from the respirator. Even their most optimistic prognosis was that she might be able to breathe on her own, but would persist in a very infantile state, unable to speak or communicate and requiring maintenance of all bodily functions.

Id.

152. Under Washington law, a guardian ad litem is appointed under various circumstances to represent and protect the interests of the incompetent person, thus providing an important safeguard function. For example, when a petition has been

court granted the husband's request, and the Washington Supreme Court affirmed. The court held that an incurably and terminally ill adult has a constitutional right to refuse life-sustaining treatment that only prolongs the dying process, absent countervailing state interests.¹⁵³ A guardian, exercising his best judgment¹⁵⁴ that the patient, if competent, would choose to

filed to appoint a guardian for an incompetent, the court will first appoint a guardian ad litem to represent the best interests of the incompetent until a permanent guardian is appointed. WASH. REV. CODE § 11.88.090 (1989). The guardian ad litem must be a person "free of influence from anyone interested in the result of the proceeding." *Id.* § 11.88.090(2)(a). While a guardianship petition is pending, the guardian ad litem has authority to consent to emergency lifesaving medical procedures for the incompetent. *Id.* § 11.88.090(5). Once a permanent guardian has been appointed, authority to act on the incompetent's behalf shifts to the guardian, and the guardian ad litem is dismissed. *See id.* § 11.88.090(6). The guardian then has the power "to care for and maintain the incompetent or disabled person, assert his or her rights and best interests, and provide timely, informed consent to necessary medical procedures." *Id.* § 11.92.043(4)-(5) (Supp. 1992).

However, if judicial intervention is subsequently required to resolve a dispute regarding life sustaining treatment decisions, a guardian ad litem would again be appointed to protect the best interests of the incompetent during that proceeding. *Colyer*, 99 Wash. 2d at 136-37, 660 P.2d at 750. According to the *Colyer* court, the guardian's function in this context is to discover and present to the court all the facts relevant to the decision to withdraw life sustaining treatment. Such facts would include, but are not limited to:

(a) facts about the incompetent: i.e., age, cause of incompetency, relationship with family members and other close friends, attitude and prior statements concerning life sustaining treatment; (b) medical facts: i.e., prognosis for recovery, intrusiveness of treatment, medical history; (c) facts concerning the state's interest in preserving life: i.e., the existence of dependents, other third party interests; and (d) facts about the guardian, the family, and the petitioner: i.e., their familiarity with the incompetent, their perceptions of the incompetent's wishes, any potential for ill motives. Thus, the guardian ad litem would not necessarily play a true adversarial role, but would serve as an investigator and a reporter of relevant facts to the court.

Id. at 133, 660 P.2d at 748-49. For a comparison of the guardian ad litem's role in other jurisdictions requiring routine judicial intervention in the substantive decision making process, *see, e.g.*, Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977); Charles H. Baron, *Assuring "Detached But Passionate Investigation and Decision": The Role of Guardians Ad Litem in Saikewicz-type Cases*, 4 AM. J.L. & MED. 111 (1978).

153. *Colyer*, 99 Wash. 2d at 120, 660 P.2d at 742. The usual four countervailing state interests were cited. For a discussion of these interests, *see infra* note 163 and accompanying text.

154. Under the guardianship statute, a guardian has a duty to assert the "rights and best interests" of the incompetent person. WASH. REV. CODE § 11.92.040(3) (1989). *See supra* note 152. This treatment may be different from the "best-interests" test used by some courts to decide if treatment should be withdrawn when the patient's intent cannot be determined. *See supra* note 70. The *Colyer* court uses the "substituted judgment" test, but takes a less stringent, more realistic approach than some courts. Rhoden, *Litigating Life*, *supra* note 70, at 391. In *Colyer*, the proxy simply exercises her best judgment about whether the patient would want treatment

remove treatment, could assert that patient's right to refuse such treatment.¹⁵⁵

The court noted that the Washington Natural Death Act was not applicable, but as with the Missouri statute in *Cruzan*, the Act established a general policy that served as the foundation for the court's holding. The court cited the legislative findings from the Act, which acknowledged a person's right to control medical decisions and the right to privacy as grounds for withholding treatment.¹⁵⁶

In addition to the policy behind the NDA, the court found a constitutional and common law basis for a right to refuse life-sustaining procedures. According to the court, this right flows from a constitutional right to privacy, as identified by the United States Supreme Court in the penumbras of the Bill of Rights,¹⁵⁷ and as specifically guaranteed in the Washington State Constitution.¹⁵⁸ An alternative basis for the right to refuse life-sustaining procedures is the common law right to be free from bodily invasion.¹⁵⁹ The court noted that, historically, medical treatment without patient consent constituted battery and malpractice.¹⁶⁰ This common law right led to the doctrine of informed consent, which encompassed the right to refuse consent to medical treatment, including life-saving procedures.¹⁶¹

Acknowledging that a right to refuse treatment is not absolute, the court stated that the right must be balanced by the state's interest in protecting the sanctity of its citizens' lives.¹⁶² Courts have usually identified four state interests: (1) the preservation of life, (2) protection of innocent third parties

withheld. *Id.* Subsequently, in the *Grant* decision, the court clarifies that if the proxy cannot determine the patient's intent, a "best-interests" test may then be used to determine the best treatment choice for the patient. *In re Grant*, 109 Wash. 2d 545, 567-68, 747 P.2d 445, 456-57 (1987).

155. *Colyer*, 99 Wash. 2d at 127-28, 660 P.2d at 746.

156. *Id.* at 119, 660 P.2d at 741.

157. *Id.* at 119-20, 660 P.2d at 741 (citing *Roe v. Wade*, 410 U.S. 113 (1973); *Doe v. Bolton*, 410 U.S. 179, 213 (1973) (Douglas, J., concurring); and *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965) (freedom to care for one's health and person falls within the purview of the right of privacy)).

158. WASH. CONST. art. I, § 7 ("No person shall be disturbed in his private affairs, or his home invaded, without authority of law").

159. *Colyer*, 99 Wash. 2d at 121, 660 P.2d at 743.

160. *Id.*; see *Physicians' & Dentists' Business Bureau v. Dray*, 8 Wash. 2d 38, 111 P.2d 568 (1941).

161. *Colyer*, 99 Wash. 2d at 121-22, 660 P.2d at 743.

162. *Id.* at 122; 660 P.2d at 743.

such as children, (3) prevention of suicide, and (4) maintenance of the ethical integrity of the medical profession.¹⁶³ Of the four, the most significant interest is the preservation of life, which has prevailed over the individual's rights in cases where life-sustaining treatment could save the life of a nonconsenting patient.¹⁶⁴ On the other hand, when lifesaving treatment only prolongs a life inflicted with an incurable condition, this state interest weakens considerably.¹⁶⁵ If the condition is hopeless, or if there is "no reasonable possibility of returning to a cognitive, sapient state," the patient's privacy rights outweigh the state's interest in preserving life.¹⁶⁶

Applying a balancing test, the court compared the degree of bodily invasion under such circumstances to the state's interest in life.¹⁶⁷ Bertha required a respirator, intravenous feeding equipment, a catheter, and intensive nursing care, which the court found to be extremely invasive. As a result, the court concluded that Bertha Colyer's privacy right to refuse treatment outweighed the state's interest in preserving her life.¹⁶⁸

Likewise, the other three state's interests did not prevail over Bertha's right to refuse treatment. No third party interests needed protection because Bertha had no children, and her family agreed that the life-sustaining treatment should be stopped.¹⁶⁹ The court was not concerned about preventing suicide, stating that death after the removal of life-sustaining treatment would be from natural causes.¹⁷⁰ Last of all, the court did not find the ethical integrity of the medical profession at odds with this outcome. "The prevailing ethical prac-

163. *Id.*; Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 425 (Mass. 1977). In a recent decision, the Nevada Supreme Court found a fifth state interest: The encouragement of "charitable and humane care of those whose lives may be artificially extended under conditions that have the prospect of providing at least a modicum of quality living." McKay v. Bergstedt, 801 P.2d 617, 628 (Nev. 1990).

164. *Colyer*, 99 Wash. 2d at 122, 660 P.2d at 743.

165. *Id.*

166. *Id.* at 122, 660 P.2d at 749 (quoting *Saikewicz*, 370 N.E.2d at 435).

167. This test of balancing the degree of bodily invasion with the state's interest in life was first used by the New Jersey courts in the landmark *Quinlan* case. *In re Quinlan*, 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976).

168. *Id.* at 123, 660 P.2d at 743.

169. *Id.*

170. "A death which occurs after the removal of life sustaining systems is from natural causes, neither set in motion nor intended by the patient." *Id.* See *Saikewicz*, 370 N.E.2d at 417; Robert M. Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 FORDHAM L. REV. 1 (1975).

tice seems to be to recognize that the dying are more often in need of comfort than treatment. Recognition of the right to refuse necessary treatment in certain circumstances is consistent with existing medical mores"¹⁷¹ Because none of the state's four interests outweighed the patient's interest, Bertha, as a terminally ill patient, could assert a right to forego treatment.

The court also addressed the question of who could exercise an incompetent's right to refuse life-sustaining treatment when the person has not executed a directive and is no longer competent to do so.¹⁷² First, the court stated that an incompetent's right to refuse treatment should be equal to that of a competent person and should not be discarded solely because her condition prevents her conscious assertion of that right.¹⁷³ As a result, a surrogate must exercise her rights for her.¹⁷⁴ In cases to date, surrogates have been either a family member¹⁷⁵ or the court, requiring judicial intervention.¹⁷⁶ The Washington court concluded that as a general practice, these types of decisions should be handled primarily within the patient-doctor-family relationship.¹⁷⁷ The court noted that the judicial process is a cumbersome, unresponsive mechanism for these sorts of decisions.¹⁷⁸

In the *Colyer* case, Bertha's husband had been appointed as her guardian. Under Washington law, a guardian has a duty to assert the "rights and best interests" of the incompetent per-

171. *Colyer*, 99 Wash. 2d at 123, 660 P.2d at 743-44 (citing *Saikewicz*, 370 N.E.2d at 417). Note, however, the court's somewhat sloppy use of the term "necessary" in the statement that refusing "necessary treatment in certain circumstances is consistent with existing medical mores." One would hope that refusing *necessary* treatment will never be consistent with medical mores. Presumably the court meant "necessary" to the extent that, for example, a respirator may be necessary to keep alive a patient whose lungs have failed. However, if the prognosis is that the patient's condition is not curable by that respirator and if the patient has declined into a terminal, incurable condition with no cognitive consciousness, then it is not unethical for medical personnel to implement the surrogate's decision to follow the patient's wishes and allow the natural process of death to follow its inevitable course.

172. *Id.* at 124, 660 P.2d at 744.

173. *Id.*; but see *supra* note 58, discussing the Supreme Court's rejection of this equal protection argument, and *infra* note 185, discussing problems with exercising an incompetent's right.

174. See *supra* notes 13 and 70.

175. See, e.g., *In re Quinlan*, 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976).

176. See, e.g., *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977).

177. *Colyer*, 99 Wash. 2d at 124-28, 660 P.2d at 744-46.

178. *Id.* at 127, 660 P.2d at 746.

son.¹⁷⁹ As a result, the court held that a guardian did not need a court order. Instead, he could use his best judgment about whether the patient, if competent, would want treatment withheld, and exercise an incompetent's right to refuse such treatment.¹⁸⁰

2. *In re Hamlin*

Shortly after handing down the *Colyer* decision, the Washington Supreme Court had an opportunity to clarify the *Colyer* holding in *Hamlin*.¹⁸¹ This case involved a blind adult who had been severely retarded, and thus incompetent, since birth. As a result, Mr. Hamlin had never exercised a directive or expressed his wishes about terminating life support. After being admitted to Harborview Medical Center suffering from pneumonia, Joseph Hamlin had a heart attack. The resulting lack of oxygen completely destroyed any cerebral cortical activity.¹⁸² Hamlin was placed on a respirator to maintain his breathing, without which he would be unable to breath and would die naturally. The physicians treating Hamlin petitioned the court for an order authorizing termination of the respirator after Hamlin's guardian claimed he lacked authority to consent.

The issue in *Hamlin* was whether the guardian, as part of his duty to care for the ward, could terminate the patient's life support systems given the diagnosis that he was in a persistent vegetative state with no prospect for regaining cognitive functions. Previously, in *Colyer*, the court stated in dicta that in certain instances the judiciary must intervene to make substantive decisions about withholding treatment, such as when a patient has always been incompetent so that his wishes cannot be known.¹⁸³ The *Hamlin* court held that the guardian did have the authority to consent to withdrawing life support systems.¹⁸⁴ The guardian's duties include asserting the ward's rights and best interests, including his right to have medical treatment withdrawn. The court noted that an incompetent patient like Hamlin does not lose his right to consent to termi-

179. WASH. REV. CODE § 11.92.040(3) (1989). For a discussion of the duties of a guardian versus guardian ad litem, see *supra* note 152.

180. *Colyer*, 99 Wash. 2d at 129-30, 660 P.2d at 746-47.

181. *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

182. *Id.* at 813, 689 P.2d at 1374.

183. *Colyer*, 99 Wash. 2d at 136, 660 P.2d at 738.

184. *Hamlin*, 102 Wash. 2d at 815, 689 P.2d at 1376.

nating life support because of his incompetency.¹⁸⁵ Furthermore, the guardian may determine what is in the best interests of the ward. "Just as medical intervention is, in the majority of cases, clearly in the best interests of the ward, nonintervention in some cases may be appropriate and, therefore, in the ward's best interest."¹⁸⁶ Thus, a guardian exercising his duty to assert his ward's best interests¹⁸⁷ has the authority to consent to withdrawal of life-sustaining treatment.¹⁸⁸ The court emphasized that "these decisions must be made on a case-by-case basis, with particularized consideration of the best interests and rights of the specific individual . . . [distinguishing] between treatment which is expected to result in some measure of recovery and that which merely postpones death."¹⁸⁹

In dicta, the *Hamlin* court went on to clarify the portion of *Colyer* that could be construed as requiring appointment of a guardian to decide any treatment decisions for incompetents. The court outlined two sets of procedures: one for *Colyer*-type situations and one for *Hamlin*-types. In the *Colyer* situation, where the patient has family members, guardianship proceedings are not a necessary predicate to making a decision about using life-support systems. First, a prognosis committee, consisting of the treating physician and at least two other doctors with relevant qualifications, must unanimously agree that the

185. *Id.* at 816, 689 P.2d at 1376. Some courts and commentators have questioned how incompetent persons can exercise their right to consent to withdrawing medical treatment if they are incompetent and do not have the capacity for consent. "An incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right." *Cruzan v. Director, Missouri Dep't of Health*, 110 S. Ct. 2841, 2852 (1990). Their rights must be exercised for them by a surrogate or guardian. *Id.*

Obviously, one concern in allowing a surrogate to exercise an incompetent's right to consent is whether the surrogate can determine the incompetent's wishes about consenting. Would the patient want treatment withdrawn or not? Unlike Nancy Cruzan, who had a normal life before her injury and made statements from which the court could infer her wishes, an incompetent like Mr. Hamlin had no period of competence at all. The same would be true of Bertha Colyer, who became incompetent before reaching the age of majority. Thus, the guardian or surrogate has no basis for determining the incompetent person's intent. In these cases, the courts are allowing the guardian to use the best-interests test for determining how to exercise the incompetent's rights as opposed to the substituted judgment test, in which the guardian attempts a subjective determination of the patient's intent. For a more thorough discussion of the best-interests test versus substituted judgment, see *supra* note 70.

186. *Hamlin*, 102 Wash. 2d at 815, 689 P.2d at 1375.

187. *Id.* See *supra* notes 154, 185.

188. *Id.* at 815, 689 P.2d at 1376.

189. *Id.* at 814-16, 689 P.2d at 1375-76.

patient's condition is incurable with "no reasonable medical probability of returning to a cognitive, sapient state."¹⁹⁰ If the incompetent patient's immediate family, treating physician, and a prognosis committee consisting of two other physicians agree that the patient's best interests would be advanced by withdrawing life-sustaining treatment, the family may assert the incompetent's personal right to refuse such treatment without seeking appointment of a guardian or a court order to withdraw the treatment.¹⁹¹

In *Hamlin*-type situations, where the patient has always been incompetent and has no family members to serve as guardian, the court must appoint a guardian¹⁹² to act as surrogate decision-maker and ensure that the patient's best interests are represented.¹⁹³ As in *Colyer*-type cases, a prognosis board must first reach the same diagnosis as outlined above. If the treating physician, along with the prognosis committee and the guardian, are unanimous that life-support equipment should be withheld or withdrawn in the patient's best interests, the guardian may exercise the incompetent's right without prior judicial approval.¹⁹⁴ The court noted that in either situation, if conflicts arose between family members, the physicians, committee, or guardian, any participant could petition the court for intervention.¹⁹⁵

3. *In re Grant*

In *Grant*,¹⁹⁶ the Washington Supreme Court extended *Colyer* and *Hamlin* to cover incompetent patients in an advanced stage of terminal, incurable illness that had not yet degenerated into an irreversible coma or persistent vegetative state. Barbara Grant suffered from an incurable neurological disorder¹⁹⁷ that causes degeneration of the central nervous system

190. *In re Colyer*, 99 Wash. 2d 114, 137, 660 P.2d 738, 751 (1983); *Hamlin*, 102 Wash. 2d at 819, 689 P.2d at 1378. Note that if the prognosis board is unable to agree, they may petition the court for a decision; the court will then use a clear and convincing evidentiary standard. *Colyer*, 99 Wash. 2d at 137, 660 P.2d at 751.

191. *Hamlin*, 102 Wash. 2d at 819, 689 P.2d at 1377.

192. The appointment of the guardian is governed by WASH. REV. CODE § 11.88.010 (1986). See *supra* notes 152, 154.

193. *Hamlin*, 102 Wash. 2d at 820, 689 P.2d at 1378.

194. *Id.*

195. *Id.* at 821, 689 P.2d at 1378-79.

196. 109 Wash. 2d 545, 747 P.2d 445 (1987), *modified*, 757 P.2d 534 (1988).

197. Batten's Disease, a genetic, neurological condition, causes degeneration of the central nervous system and, ultimately, death. No cure is known. Victims start life as normal children. First symptoms include blurred vision and epileptic seizures and

and eventually death. In 1978, at age fourteen, Barbara was declared legally incompetent, with her mother appointed guardian. As an incompetent, Barbara was unable to execute a living will or indicate her wishes regarding life-sustaining treatment.¹⁹⁸ By 1987, Barbara's physicians estimated that she was at the terminal stage of the disease, with no hope of improvement. She had not yet reached a vegetative state, however. Because the state facility in which she was treated had a policy of always using every measure possible to sustain life, Mrs. Grant applied to the court for an order authorizing, in advance, the withholding of life-sustaining equipment when Barbara's vital organs failed.

The trial court ruled that the motion was premature because Barbara was not yet in a vegetative state or in need of life-sustaining treatment. The Washington Supreme Court, however, disagreed. Extending its holding in *Colyer* and *Hamlin*, the court held that a person has a right to withhold life-sustaining procedures when the person (1) is in an advanced stage of a terminal, incurable illness, and (2) is suffering severe, permanent, mental, and physical deterioration.¹⁹⁹ Such a right would be balanced against countervailing state interests.²⁰⁰ As in *Colyer* and *Hamlin*, the state's interests did not outweigh Barbara Grant's right because the treatment would be highly invasive, and the terminally ill patient had no possibility of returning to a cognitive sapient life.²⁰¹

Moreover, for the first time, the Washington Supreme Court concluded that artificial nutrition and hydration was a medical means of life support by which a vital bodily function was performed by artificial means. As a result, the court extended its definition of life-sustaining treatment to cover all

speech difficulties. Later the child becomes blind and severely retarded. Voluntary muscle control is lost, followed by loss of involuntary muscle function such as control of heart and breathing. Ultimately, these vital functions fail, and the child dies. *Id.* at 547-48, 747 P.2d at 446.

198. Barbara's IQ was that of a normal child at age 5; by the time she was 21, her mental age was estimated between 2 weeks and 1 1/2 months. *Id.* at 548, 747 P.2d at 447.

199. *Id.* at 556, 747 P.2d at 451.

200. Again the usual four state interests were cited. *See supra* note 163 and accompanying text.

201. The court also held that the requested order was not premature because the family anticipated that life-sustaining treatment would be required soon, and Barbara had a right to have such treatment withheld as well as withdrawn. *Grant*, 109 Wash. 2d at 559, 747 P.2d at 452.

artificial procedures that serve only to prolong life.²⁰² The court concluded that a terminally-ill person in Washington has a right to have withheld or withdrawn artificial life-sustaining procedures, including nasogastric tubes, intravenous feeding, and any other means of artificial nutrition and hydration.²⁰³

Finally, the *Grant* court again clarified the procedure by which life-sustaining treatment could be withheld without prior court approval:

(1) the incompetent patient's physician and two other qualified physicians must determine within reasonable medical judgment that the patient is in an advanced stage of a terminal, incurable illness and is suffering from severe, permanent, mental and physical deterioration;

(2) the patient's legal guardian or immediate family²⁰⁴ must determine that the patient would choose to refuse life-saving treatment if competent,²⁰⁵ or, if the patient's choice cannot be determined, the guardian or family concludes that withholding the treatment would be in the best interests of the patient;²⁰⁶

202. *Id.* at 563, 747 P.2d at 454. This definition of artificial nutrition and hydration would not include procedures such as pain medication, which addresses the patient's comfort level.

203. *Id.* at 565, 747 P.2d at 455 (Note that this part of the court's holding was modified a year later. See *infra* text accompanying notes 208-213).

204. Usually, the immediate family will make any decision about withholding life-sustaining treatment. As in *Hamlin*, however, if no family is available and the patient has always been incompetent, a guardian must be appointed. *Id.* at 566-67, 747 P.2d at 456, n.4 and 5.

205. In determining what the patient's choice would be if competent, the guardian or family should consider the following criteria: the patient's general character and personality, attitude towards medical treatment, and prior statements regarding life-sustaining procedures. The probative value of such statements will depend on the context in which the statements were made, the age and maturity of the patient at the time, and the connection between the statements and the debilitating event. When the patient has clearly expressed her wishes about withholding life-sustaining treatment, even if incompetent at the time, those wishes must be given strong consideration. *Id.* at 567-68, 747 P.2d at 457.

206. When the patient's wishes cannot be ascertained, the following types of factors should be considered to determine the best interests of the patient:

evidence about the patient's present level of physical, sensory, emotional, and cognitive functioning; the degree of physical pain resulting from the medical condition, treatment, and termination of treatment, respectively; the degree of humiliation, dependence, and loss of dignity probably resulting from the condition and treatment; the life expectancy and prognosis for recovery with and without treatment; the various treatment options; and the risks, side effects, and benefits of each of those options.

Grant, 109 Wash. 2d 567-68; 747 P.2d at 457 (quoting *In re Conroy*, 486 A.2d 1209, 1249 (N.J. 1985) (Handler, J., concurring in part and dissenting in part)). Note that the

- (3) no immediate family members object to withholding treatment; and
- (4) neither the patient's physicians nor the health care facility object to the decision.²⁰⁷

If all of the above criteria are met, a patient's right to refuse treatment, including artificial hydration and nutrition, may be exercised for her by her guardian or immediate family without prior court authorization.

C. Problems with Washington's Common Law Solutions

Following the issuance of the *Colyer*, *Hamlin*, and *Grant* decisions, Washington law seemed clearly set on a course to allow individuals and their families to decide these types of health care decisions privately in conjunction with their doctors. In particular, individuals now had a right to refuse life-sustaining medical treatment including artificial nutrition and hydration in the event they became incurably and terminally ill. Several events that occurred shortly after *Grant* was issued, however, have only served to confuse the state of Washington law on this matter.

At about the same time the court rendered *Grant*, the Washington State Legislature changed the Washington Informed Consent Law²⁰⁸ to establish a procedure for making

Grant court is using a substituted judgment test, followed by a best-interests test if a substituted judgment cannot be made. See *supra* notes 70, 154.

207. *Grant*, 109 Wash. 2d at 567, 747 P.2d at 456.

208. WASH. REV. CODE § 7.70.065 (1989):

(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:

- (a) The appointed guardian of the patient, if any;
- (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;
- (c) The patient's spouse;
- (d) Children of the patient who are at least eighteen years of age;
- (e) Parents of the patient; and
- (f) Adult brothers and sisters of the patient.

(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 person in the next class in 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

health care decisions for incompetent patients. In contrast to *Grant*, in which the court required a consensus between a guardian, immediate family, and the doctors, the informed consent law provided a hierarchical list of persons who are authorized to make informed consent decisions for incompetent patients. The *Grant* court was informed of the change in a letter from Assistant Attorney General Steve Milam.²⁰⁹ In response, the court issued an order changing its decision so as to conform with the new law, but a month later rescinded that change and reverted to the original language.²¹⁰

On July 15, 1987, six months after issuing the original opinion, the court modified *Grant*.²¹¹ The court was silent about the new Informed Consent Law. Instead, Justice Durham withdrew her support from the majority opinion by Justice Callow and appended her name to Justice Andersen's concurring and dissenting opinion. Justice Andersen agreed with the majority decision that a terminally ill, incompetent person such as Barbara Grant had the right to refuse life-sustaining treatment. Thus, that aspect of the majority decision was not affected. However, Justice Andersen vehemently dissented on the issue of withholding artificial nutrition and hydration, calling it "pure, unadorned euthanasia."²¹² As a result, in the modified *Grant* decision, a new five-to-four majority now opposed granting a guardian or family the right to withhold artificial nutrition and hydration from an incompetent patient.²¹³

This modification has caused much confusion over the exact state of Washington law. Under the modified *Grant* deci-

(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.

209. Letter to the Washington Supreme Court from Assistant Attorney General Steve Milam, *In re Grant* (No. 52609-5) (Dec. 22, 1987). For a detailed discussion of this event, see VanDerhoef, *supra* note 149, at 204-06.

210. VanDerhoef, *supra* note 149, at 205-06.

211. *In re Grant*, 757 P.2d 534 (1988). No reason was given by Justice Durham for the switch.

212. *Grant*, 109 Wash. 2d at 570, 747 P.2d at 458 (Andersen, J., concurring in part and dissenting in part) (joined by Brachtenbach, J. and Durham, J.).

213. *In re Grant*, 5 ISSUES IN L. & MED. 247 (1989).

sion, a guardian or family may *not* withdraw artificial nutrition or hydration from a terminally-ill person. Nonetheless, other courts around the country appear confused over the exact holding in *Grant*. Many courts have cited *Grant* as supporting the proposition that artificial nutrition and hydration are life-sustaining treatments that may be withheld or withdrawn.²¹⁴ Most importantly, the Supreme Court in *Cruzan* incorrectly cited *Grant* as supporting the withdrawal of artificial nutrition and hydration.²¹⁵

Clearly, doctors and families need to know whether they can withdraw artificial nutrition and hydration as one means of artificial life-support if they meet the remainder of the court's criteria outlined in *Grant*. Because the state of the law is unclear, they may be forced to obtain a court order, defeating the very purpose of *Grant*, which strove to establish a procedure that would circumvent the need to go to court. This confusion must be clarified.

IV. ANALYSIS OF CRUZAN'S IMPACT: A COMPARISON OF CRUZAN WITH WASHINGTON STATE LAW

Before turning to any proposals for resolving the problems created by the Washington Supreme Court's actions subsequent to rendering the *Grant* decision, we must first examine the effect of *Cruzan* on Washington state law and on *Grant* in particular. As discussed above,²¹⁶ *Cruzan*'s impact should be at least two-fold: (1) the case finds a constitutionally protected liberty interest in refusing unwanted medical treatment including artificial nutrition and hydration; and (2) the case allows each state to develop its own procedural mechanism for protecting that liberty interest balanced against its state interests. We shall examine each of these two impacts in turn.

214. See *Conservatorship of Drabick*, 245 Cal. Rptr. 840, 841 n.1., cert. denied, 109 S. Ct. 399 (1988); *In re Browning*, 543 So. 2d. 258, 267 (Fla. 1990); *In re Longway*, 549 N.E.2d 292, 294 (Ill. 1989). For additional discussion of this confusion, see VanDerhoef, *supra* note 149, at 206-08.

215. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2850-51 n.6 (1990).

216. See *supra* text accompanying notes 127-131.

A. *Cruzan's First Impact: A Constitutionally Protected
Liberty Interest in Refusing Artificial Nutrition and
Hydration Under the the Fourteenth
Amendment Due Process Clause*

In *Cruzan*, as a predicate to holding that Missouri's rule of decision does not violate the Due Process Clause, the Supreme Court acknowledged for the first time the existence of a constitutionally protected liberty interest in refusing unwanted medical treatment, including artificial nutrition and hydration. As Justice Rehnquist stated, in common parlance, this will be construed as a right to die.²¹⁷ However, many lower courts had previously assumed that a more fundamental interest was at stake, subject to a high level of judicial scrutiny and protection. They based their decisions on a fundamental right of privacy, flowing from *Roe v. Wade* and its progeny.²¹⁸ The Court rejected that basis, however, noting that "this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest."²¹⁹ Significantly, the Court explicitly referred to *Bowers v. Hardwick*,²²⁰ a case that narrowed the Court's definition of a fundamental right of privacy and allowed a general moral objection to serve as the justification for prohibiting certain homosexual activities. Thus, rather than finding a fundamental privacy interest broad enough to encompass a right to refuse treatment, the Court found at best only a liberty interest, subject to minimal judicial protection.²²¹ Rather than a strict scrutiny analysis in which the Court would provide a high level of judicial protection for a right-to-die, the Court established only a rationality standard. A state could meet such a minimal standard by claiming, as in *Cruzan*, "no more than a general interest in promoting life or, as in *Bowers*, a general moral objection to the activity that it is attempting to regulate or prohibit."²²²

The impact of this limited liberty interest is two-fold. First, this finding of a liberty interest may erode, to some extent, the prior right-to-die cases that based their decisions on

217. *Cruzan*, 110 S. Ct. at 2851.

218. See, e.g., *In re Quinlan*, 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976) and other cases cited, *supra*, note 8.

219. *Cruzan*, 110 S. Ct. at 2851 n.7.

220. 478 U.S. 186 (1986).

221. Kenneth R. Wing, *The Supreme Court's Spring Term: Abortion, the Right to Die, and the Decline of Privacy Rights*, 15 J. HEALTH POL., POL'Y & L. 919, 924 (1990).

222. *Id.* at 925.

a fundamental constitutional right of privacy. To the extent that the United States Supreme Court held that a right to refuse treatment is not based on a fundamental right of privacy, the Court knocked out the constitutional underpinnings for most of these previous cases. The question of whether they are still good law may result in additional litigation in numerous states. Of course, by finding a liberty interest, the Court has in effect replaced the right of privacy with another constitutional right that must be protected. But, as noted above, this right is not subject to as high a level of judicial scrutiny as a "fundamental" right. Thus, "under such a standard the courts, particularly the federal courts, have little role in evaluating that claim or in assessing the impact of the state law on individuals."²²³

Second, the Court's recognition of only a liberty interest subject to minimal procedural due process protection will force states to turn to their own constitutions if they want to provide more protection. Many states have a more explicit privacy guarantee in their state constitutions than is found in the United States Constitution. Thus, even if the United States Constitution does not include a right of privacy covering medical decisions, states may rely on their own constitutions as the basis for a right of privacy that encompasses the right to refuse life-sustaining treatment. This strategy has already been adopted since *Cruzan* was decided. The Florida Supreme Court based its recent decision allowing the withdrawal of artificial nutrition and hydration from an incompetent, incurable patient on its own state constitutional right of privacy.²²⁴ The court did not even mention a federal right of privacy or liberty interest.²²⁵ Although issued before *Cruzan*, the Washington Supreme Court's decision in *Colyer* recognized a constitutional right of privacy not only in the United States Constitution, but also in the Washington State Constitution.²²⁶ Certainly the Washington court's finding of a federal constitutional right of privacy is questionable after *Cruzan*, but the court's finding of a right of privacy under the Washington Constitution is still

223. *Id.*

224. *In re Browning*, 568 So. 2d 4 (Fla. 1990).

225. *Id.* at 9.

226. WASH. CONST. art. I, § 7 ("No person shall be disturbed in his private affairs, or his home invaded, without authority of law"). *In re Colyer*, 99 Wash. 2d 114, 120, 660 P.2d 738, 742 (1983); *In re Grant*, 109 Wash. 2d 545, 553 n.1, 747 P.2d 445, 449 n.1 (1987).

valid. Thus, the constitutional underpinnings of Washington state law on this issue should be secure.

An equally important result of *Cruzan* is that the Supreme Court, in the majority opinion, recognized that the right to refuse medical treatment includes the right to refuse artificial nutrition and hydration. The Court stated that "for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse *lifesaving hydration and nutrition*."²²⁷ Unfortunately, the Court's language is less than crystal clear in this passage. Some commentators may argue that the Court only hypothetically acknowledges that the right to refuse treatment includes nutrition and hydration, but does not actually hold that it is included.²²⁸ Justice O'Connor, however, thought that it was part of the holding. According to her, the majority held that a protected liberty interest in refusing unwanted medical treatment could be inferred from prior Court decisions, and "that the refusal of artificially delivered food and water is encompassed within that liberty interest."²²⁹ Thus, the Washington Supreme Court's modified decision in *Grant*, denying the right to terminate such treatment, may now be unconstitutional.

Moreover, the Supreme Court is correct in concluding that artificial nutrition and hydration should be encompassed within a liberty interest and that people should have a right to

227. *Cruzan*, 110 S. Ct. at 2852 (emphasis added).

228. Note also that the Court in the above passage only specifically extends this right to refuse nutrition and hydration to a *competent* adult. Whether this right would extend to an incompetent person is less clear. See *supra* note 58 and text accompanying notes 85-89. Nevertheless, the Supreme Court did uphold Missouri's evidentiary rule, which would allow artificial nutrition and hydration to be withdrawn if clear and convincing evidence of the incompetent's intent was ascertained. Thus, the Court, by inference, was including artificial nutrition and hydration within the liberty interest that Missouri was ostensibly protecting with its high evidentiary standard.

Since *Cruzan* was decided, other courts have continued to extend the incompetent's right to refuse treatment to a surrogate decisionmaker so that the individual will not lose the right to have life-sustaining treatment withheld on account of her incompetency. See, e.g., *In re Browning*, 568 So. 2d 4, 13 (Fla. 1990). Furthermore, the Washington Supreme Court in *Grant* was less concerned than the United States Supreme Court with the issue of whether to extend a right to refuse life-sustaining treatment to an incompetent. The Washington court was willing to extend such a right and allow it to be exercised by a surrogate decisionmaker. *In re Grant*, 109 Wash. 2d 545, 566-68, 747 P.2d 445, 449, 456-57 (1987). Rather, the dilemma for the Washington Justices in *Grant* was whether artificial nutrition and hydration should be deemed life-sustaining medical treatment.

229. *Cruzan*, 110 S. Ct. at 2856 (O'Connor, J., concurring).

withhold or withdraw that type of treatment. A liberty interest in refusing medical treatment flows from decisions concerning the state's invasions of the body.²³⁰ The Supreme Court has repeatedly deemed such incursions to be repugnant to the Due Process Clause. An individual's liberty interests are as burdened by forced medical treatment as by any other form of state coercion.²³¹ Artificial nutrition and hydration implicate this same concern for burdening an individual's liberty interest because artificial feeding cannot be distinguished from other forms of medical treatment.²³² According to Justice O'Connor, artificial nutrition and hydration are medical treatments that "bears little resemblance to ordinary oral consumption of food and water."²³³

The ability to directly infuse adequate nutrition into a patient through artificial means has been available through medical technology only since 1968.²³⁴ The medical technique for implanting a feeding tube involves sophisticated, invasive procedures by which nutrients are mechanically placed into the patient's digestive system. A nasogastric tube is passed through the patient's nose, throat, esophagus and into the person's stomach.²³⁵ A gastrostomy, or jejunostomy tube, is surgically implanted into the stomach or intestine through an incision in the abdominal wall.²³⁶ An IV line infuses nutrients directly into the blood stream.²³⁷

These artificial procedures are accompanied by significant risks. The tubes may cause pain, bleeding, ulceration of the stomach, infection, pneumonia, or leakage of acidic stomach contents into the abdominal cavity.²³⁸ Intravenous lines cause veins to become irritated and infected, or collapse.²³⁹ The patient must be monitored daily as to weight, fluid intake, and fluid output²⁴⁰ to avoid intestinal infection, poisoning, fluid

230. *Id.* at 2856-57 (O'Connor, J., concurring).

231. *Id.*

232. *Id.* ("Artificial feeding cannot readily be distinguished from other forms of medical treatment") (citing AMA ETHICAL OPINION 2.20, *supra* note 77, at 13; HASTINGS GUIDELINES, *supra* note 77, at 59).

233. Beatty, *supra* note 149, at 426.

234. *Id.* at 425 n.41.

235. *Id.* at 425.

236. *Id.*

237. *Id.* at 425-26.

238. Beatty, *supra* note 149, at 425-26.

239. *Id.*

240. *Id.*

overload, and other serious metabolic complications.²⁴¹

The medical profession regards artificial nutrition and hydration as medical treatment.²⁴² The formulas used are commercially prepared and regulated by the Federal Drug Administration as "medical foods"; the feeding tubes are likewise regulated as medical devices.²⁴³ The position of the American Academy of Neurology states:

The artificial provision of nutrition and hydration is a form of medical treatment . . . analogous to other forms of life-sustaining treatment, such as the use of the respirator. When a patient is unconscious, both a respirator and an artificial feeding device serve to support or replace normal bodily functions that are compromised as a result of the patient's illness.²⁴⁴

If use of a respirator and a feeding tube are analogous medical treatments, then no difference exists between a mechanical device that artificially allows a person to breathe and a mechanical device that artificially gives a person nourishment.²⁴⁵ If a person has a legal right to turn off a respirator, then that person should have an equal right to decline a feeding tube.²⁴⁶

People who are opposed to withdrawing artificial nutrition and hydration often emotionally claim that this withdrawal is tantamount to starvation. Nevertheless, courts and society have previously accepted the withdrawal of a respirator, which could be considered suffocation. Both the idea of starvation and suffocation evoke strong emotions. Yet many will allow the removal of respirators, but will not condone removing nutrition and hydration.²⁴⁷ The notion seems to be that remov-

241. *Id.* at 425 n. 46.

242. See AMA ETHICAL OPINION 2.20, *supra* note 77, at 13 ("Life-prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition, or hydration"); HASTINGS GUIDELINES, *supra* note 77, at 59; PRESIDENT'S COMM'N, *supra* note 4, at 88 (life-sustaining treatment includes respirators and special feeding procedures).

243. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2867 (1990) (Brennan, J., dissenting).

244. *Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient*, 39 NEUROLOGY 125 (Jan. 1989).

245. *Gray v. Romeo*, 697 F. Supp. 580, 586-87 (D.R.I. 1988).

246. *Id.*

247. Kevin O'Rourke, *Should Nutrition and Hydration Be Provided to Permanently Unconscious and Other Mentally Disabled Persons?*, 5 ISSUES IN L. & MED. 181, 196 (1989).

ing nutrition and hydration will "cause" a painful death.²⁴⁸ Death will not occur immediately, but only after a period of days to several weeks. The process is viewed as painful and dehumanizing, as "dying from thirst and starvation."²⁴⁹

Removal of artificial nutrition and hydration, however, is not necessarily painful. Patients who are near death and not receiving nourishment may be more comfortable than comparable patients receiving conventional nourishment.²⁵⁰ Patients in a persistent vegetative state are not believed to register pain in any cognitive fashion.²⁵¹ Furthermore, if they do suffer pain, it may be reduced to reasonable levels, usually without unacceptable sedation.²⁵²

A crucial distinction exists between starving (or suffocating) a person and withdrawing artificial nutrition. When, as the result of an incurable disease, a patient cannot chew or swallow and a feeding tube is withdrawn, the ultimate agent of death is the patient's underlying illness and not the withdrawal of the tube.²⁵³ As one commentator states:

Grasping the distinction between causing death and allowing a pathology to take its natural course because there is no benefit to the patient in circumventing or removing the

248. *Id.* Of course, removal from a respirator also might be painful.

249. *Id.* at 195.

250. See Joanne Lynn & James F. Childress, *Must Patients Always Be Given Food and Water?*, 13 HASTINGS CTR. REP. 17, 19 (1983).

251. Rhoden, *Litigating Life*, *supra* note 70, at 398-99. "Indeed, the answer to the question, "What is currently beneficial or burdensome to a comatose patient?" is "Nothing." *Id.* at 399. Nancy Cruzan's family stated, after her death, that Nancy died peacefully and apparently without pain in her sleep. Lewin, *supra* note 26, at A1.

Of course, we do not actually *know* whether Nancy, or any other patient in a persistent vegetative state, is in any pain. In an existential world, we must make medical judgments that a patient is not in pain based on deductions about deterioration of the brain or external indicia such as the patient's lack of physical reaction to a stimulus that we, as cognitive people, would find painful. But doctors are not all-knowing, and such external indicia may or may not be reliable. As doctors and scientists grope for an answer about what is actually taking place within comatose patients, one is reminded of the story of the three blind men who touched different parts of the elephant and then were asked to report what kind of animal they believed was present. As one might imagine, all three had vastly different theories. Unfortunately, at present, medical science has no equivalent of a "seeing" individual who can state the actual truth, i.e., that it is an elephant which is present, or that comatose patients actually do not register pain, or any other awareness of self, in a cognitive fashion. *But see* PRESIDENT'S COMM'N, *supra* note 4, and PLUM & POSNER, *supra* note 23, which contend that patients in a persistent vegetative state do not in fact have any awareness of self.

252. PRESIDENT'S COMM'N, *supra* note 4, at 50-51.

253. *In re Greenspan*, 558 N.E.2d 1194, 1197 (Ill. 1990).

pathology, is a fine distinction. Yet it is a real and firm distinction, as those who have experienced clinical decision-making will avow.²⁵⁴

In 1957, when Pope Pius XII stated that respirators could be removed if they were of no benefit to the patient, he did not expect patients to live after removal of the respirators. Foreseeing an event that is beyond the power of the original intention is not the same as causing the unintended event.²⁵⁵

Not everyone agrees, however, that artificial nutrition and hydration are "medical treatment" that burden a person's liberty interest. Certainly the average person-on-the-street may view artificially provided food and water differently from the medical community. Opponents of withdrawing life-support treatment argue that artificial nutrition and hydration are different from other medical procedures. At the heart of this position is the perception that food and water are basic necessities of life that carry tremendous emotional significance.²⁵⁶ "The feeding of . . . [those who] are physically unable to feed themselves, is the most fundamental of all human relationships."²⁵⁷

Regardless of whether the procedure is called "medical treatment," artificial nutrition and hydration are clearly invasive and involve some degree of restraint and serious risk of medical complications. Requiring such a person to endure such procedures against her will certainly burdens her liberty, dignity, and freedom to determine her own medical treatment. "Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water."²⁵⁸

Moreover, the issue here is not really whether artificial nutrition and hydration are "medical treatment." That is too superficial and simplistic. Underlying this debate are the normative values that are in tension within the *Cruzan* decision. On the one hand, are the fundamental normative values of our

254. O'Rourke, *supra* note 247, at 196.

255. *Id.*

256. *In re Grant*, 109 Wash. 2d 545, 559-60, 747 P.2d 445, 453 (1987), *modified*, 757 P.2d 534 (1988).

257. *Id.* (quoting Daniel Callahan, *On Feeding the Dying*, 13 HASTINGS CTR. REP. 22 (1983)).

258. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2857 (1990) (O'Connor, J., concurring).

society such as preserving life, and providing food and water for the sick and injured. These are some of the values which we want our society to reflect and respect, the values that make us moral agents. But as discussed above in Part II.E., these values are in tension with the equally fundamental normative value of self-determination. Concepts of physical freedom, autonomy, and self-determination are inextricably entwined with our country's notions of liberty.²⁵⁹ And integral part of that self-determination is the right to make autonomous choices about one's healthcare treatment. "We can conceive of few more personal or private decisions concerning one's body that one can make in the course of a lifetime . . . [than] the decision of the terminally ill in their choice of whether to discontinue necessary medical treatment."²⁶⁰

In addition to notions of self-determination, the concept of "liberty interest . . . [h]as always . . . been thought to encompass freedom from bodily restraint."²⁶¹ Imposing medical treatment on an unwilling person inevitably involves some sort of restraint and intrusion. Many patients must be sedated or forcibly restrained with their hands tied or placed in mittens to prevent removal of the tube.²⁶² "A seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining measures."²⁶³ Requiring a patient to remain on life-sustaining treatment forces the patient, in effect, to give one's body to medical science without consent²⁶⁴ and became a passive prisoner of technological

259. *Id.* at 2856 (O'Connor, J., concurring). Traditional Anglo-American law places a high degree of value on the individual and that person's right to self-determination. Thus, the traditional definition of liberty encompasses at a minimum physical liberty. *Flores v. Meese*, 913 F.2d 1315 (9th Cir. 1990). "Bills of rights give assurance to the individual of the preservation of liberty . . . In the beginnings of constitutional government, the freedom that was uppermost in the minds of men was freedom of the body . . . There went along with this, or grew from it, a conception of a liberty that was broader than the physical." Benjamin N. Cardozo, *Paradoxes of Legal Science*, in *SELECTED WRITINGS OF BENJAMIN NATHAN CARDOZO* 311 (M.E. Hall ed., 1947).

260. *In re T.W.*, 551 So. 2d 1186, 1192 (Fla. 1989).

261. *Ingram v. Wright*, 430 U.S. 651, 673-74 (1977).

262. *Cruzan*, 110 S. Ct. at 2856-57 (O'Connor, J., concurring).

263. *Id.* at 2856 (O'Connor, J., concurring).

264. *Cruzan v. Harmon*, 760 S.W.2d 408, 434 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990) (Higgins, J., dissenting). In fact, there is a certain irony in the Supreme Court's allusion to the "laboratory of the States" as the experimental ground upon which the parameters of this liberty interest in refusing medical treatment will be explored. By allowing the "laboratory of the states" to limit a patient's ability to refuse new advances in medical science, including

advances. "We could then sing, less fervently of the land of the free, but as medical science advances to new horizons, much more fervently of the land of the brave."²⁶⁵

In conclusion, conflicting normative values are at the heart of decisions such as *Cruzan* and *Grant*. By treating artificial nutrition and hydration as "medical treatment" that can be withheld or withdrawn because it burdens a person's liberty interest, courts are acknowledging individuals' right to self-determination in decisions about their care at the end of life. A number of courts, including the United States Supreme Court in *Cruzan*, have now acknowledged that a person has a constitutional right to refuse medical treatment, including artificial nutrition and hydration, in certain situations such as Nancy Cruzan's.²⁶⁶

Thus, either the Washington Supreme Court or Legislature should overrule the modified holding in *Grant* and declare that artificial nutrition and hydration are life-sustaining medical treatment that may be withheld or withdrawn.

B. Cruzan's Second Impact: Each State May Develop Its Own Procedural Mechanism for Protecting This Liberty Interest Balanced Against Its Own State Interests

In its second major impact, the *Cruzan* decision allows each of the fifty states to develop its own procedures to protect this new-found liberty interest in refusing medical treatment. The Court sanctioned Missouri's surrogate decisionmaking procedure as one way to ostensibly protect that interest. But the majority opinion does not endorse Missouri's or any other standard; neither does it mandate that a state give some weight to an individual's preferences or provide a means for asserting them.²⁶⁷ On the contrary, as Justice O'Connor noted, the Court simply states that "[t]oday's decision . . . does [not] prevent States from developing other approaches for protecting an incompetent individual's liberty interest in refusing medical treatment . . . [T]he more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests

life-sustaining treatment, the Court in effect makes the patient a "laboratory for medical science."

265. *Id.* at 434 (quoting Judge Teel's lower court order granting the Cruzans' petition to remove Nancy's surgically implanted life support device).

266. For a list of such cases, see *supra* note 8.

267. Wing, *supra* note 221, at 925.

is entrusted to the 'laboratory' of the States."²⁶⁸

The impact of this holding is to leave the states with broad discretion. A state may recognize patient autonomy and implement it in virtually any way that it chooses.²⁶⁹ But likewise, nothing in *Cruzan* requires that a state recognize patient autonomy to refuse medical treatment. If a state decides that its interests, such as preserving life, outweigh that liberty interest, it may refuse to recognize the patient's treatment choice. And, its decision will be subject only to a minimal "rationality" standard of judicial scrutiny. Indeed, since *Cruzan* was decided, some states have adopted precisely the *Cruzan* formulation, whereas other states have clarified that they do not require clear and convincing evidence of a patient's intent before withdrawing treatment.²⁷⁰

By entrusting the protection of this liberty interest to the states, the Court has reaffirmed the primacy of the states' police powers, by which they may promote or protect the public's health and welfare.²⁷¹ But those decisions are made in the legislative branch of government, again, subject to minimal court scrutiny. Thus, decisions to terminate medical treatment after *Cruzan* will be subject to legislative control and, consequently, tied to the whims of political sentiment.²⁷²

Given this broad discretion granted by the Court in *Cruzan*, Washington is free to follow whatever course it chooses. But what course should that be? Washington should follow the procedure outlined by the Washington Supreme Court in the original *Grant* decision and extend it to include artificial nutrition and hydration.²⁷³ The *Grant* procedure is acceptable not only under the minimal scrutiny provided by *Cruzan*, but also under the Washington Constitution's stricter right of privacy requirement. Moreover, the *Grant* procedure adequately reflects the conflicting normative values of self-determination versus preservation of life. The *Grant* proce-

268. *Cruzan*, 110 S. Ct. at 2858-59 (O'Connor, J., concurring).

269. *Wing*, *supra* note 221, at 925.

270. Martha Minow, *The Role of Families in Medical Decisions*, 1991 UTAH L. REV. 1, 19.

271. *Id.* at 927.

272. *Id.*

273. This recommendation of the *Grant* procedure is based on the first *Grant* decision from the Washington Supreme Court, which allowed the withdrawal of artificial nutrition and hydration, rather than the modified *Grant* holding. Given the Supreme Court's holding, *see supra* text accompanying notes 227-66, the first *Grant* procedure should be followed.

cedure gives effect to an individual's right to self-determination about medical treatment; at the same time, it protects the accuracy of the patient's choice about treatment by providing a procedure that uses a substituted judgment test, followed by a best-interests test, to determine that intent.²⁷⁴ Finally, *Grant* embraces yet another traditional value of our society: family decisionmaking. The *Grant* procedure is preferable because it allows family members to make medical treatment decisions in private on behalf of an incompetent person. As several commentators have argued, families should be entrusted with treatment decisions on behalf of a comatose or incompetent relative "absent a specific showing of their conflicting interests because the alternative of a state decision-maker is not presumptively better."²⁷⁵ As one commentator noted, the only real alternative to the family is to give the power to the state to be the decision-maker. But who in the state would decide? A judge? The patient's nurses or doctors? Whichever real, living person would express the decision refusing the parents' request to terminate treatment, it would not be someone who knew the patient better than her family or cared specifically more about her.²⁷⁶

This family decisionmaking approach was adopted by the Washington Supreme Court. Under the procedure established in *Colyer*, *Hamlin*, and *Grant*, either the members of an incompetent's immediate family, or a guardian when the patient has no family, may act as surrogate decisionmakers to exercise the incompetent's right to refuse treatment.²⁷⁷ In addition, the incompetent person's doctors must be in agreement with the family or guardian about the course of treatment. This procedure adequately safeguards that person's liberty interest while protecting against potential conflicts of interest or abuses.

The *Grant* procedure has numerous safeguards to protect against abuse. Certainly, a guardian or family asserting a patient's liberty interest in refusing medical treatment might act on the basis of unworthy motives, i.e., gaining an interest in

274. See *supra* notes 70, 205-06 and accompanying text.

275. Minow, *supra* note 270, at 23. See also Rhoden, *Litigating Life*, *supra* note 70, at 375, 445-46 (advocating that courts should draw on the special qualifications of families as decisionmakers and recognize a presumptive right of families to exercise discretion over treatment decisions).

276. Minow, *supra* note 270, at 17.

277. See *supra* text accompanying notes 202-07.

an estate, alleviating the financial cost of treatment, or ridding the family of the hated "black-sheep."

In the case of a guardian, the laws controlling appointment of guardianships protect against such dangers without requiring court intervention. A guardian is appointed by the court and is at all times under the court's supervision.²⁷⁸ The guardian is an officer of the court under a duty to uphold the best interests of the patient as well as the law.²⁷⁹ Finally, a guardian ad litem is appointed during formal guardianship proceedings; the purpose of such proceedings is to ensure that an acceptable guardian will be appointed and that the interests of the incompetent are protected during the proceedings.²⁸⁰ These formal procedures should protect against a precipitous decision or the appointment of a guardian with improper motives.

Where the immediate family is acting as a surrogate decisionmaker, the protection of the guardianship proceedings are not available. Nonetheless, this system should protect against abuse as well as the guardianship procedure. A decision by the family to withhold life-sustaining treatment can only be reached after a minimum of three doctors have diagnosed that the incompetent person is in an advanced stage of a terminal, incurable illness and is suffering from severe, permanent, mental and physical deterioration. The doctors and all family members must unanimously agree to the treatment decision. Furthermore, the doctors are under "an ethical, moral, and legal duty to treat the patient so as to advance his recovery and alleviate his suffering."²⁸¹ *Grant's* procedure, which requires concurrence by at least two additional qualified physicians who understand the patient's condition, will protect against an erroneous diagnosis or questionable motives by the family or guardian.²⁸²

The only remaining uncertainty under Washington law is whether the procedure outlined in *Grant*, requiring consensus of the doctors and guardian or family, should control, or whether the procedure outlined in the Washington Informed

278. WASH. REV. CODE §§ 11.88.010, 11.92.010 (1989).

279. *In re Colyer*, 99 Wash. 2d 114, 128-31, 660 P.2d 738, 746-47 (1983); *Seattle-First Nat'l Bank v. Brommers*, 89 Wash. 2d 190, 570 P.2d 1035 (1977).

280. WASH. REV. CODE § 11.88.090 (1989); *Colyer*, 99 Wash. 2d at 130-31, 660 P.2d at 747.

281. *In re Hamlin*, 102 Wash. 2d 810, 819, 689 P.2d 1372, 1378 (1984).

282. *Colyer*, 99 Wash. at 134, 660 P.2d at 749.

Consent Law²⁸³ should control decisions made by surrogates for incompetent patients. Some may argue that the procedure established in the Informed Consent Law should be followed. They would argue that this procedure was adopted by the legislature, which is better equipped to make law than the courts and more accurately reflects the views of the people.

The Washington Informed Consent Law also follows that of our sister state, Oregon, which adopted this procedure directly into its Natural Death Act to deal with situations where a person has not executed a written directive indicating her wishes about life-sustaining treatment.²⁸⁴ Furthermore, the Informed Consent Law provides more flexibility by allowing a single surrogate decisionmaker to decide private medical decisions without seeking a court order.

Despite these advantages of the Informed Consent procedure, the Washington legislature should adopt the *Grant* procedure instead for decisions involving withdrawal or withholding of life-sustaining treatment. The *Grant* procedure is preferable because the Informed Consent Law does not contain as many safeguards as the *Grant* procedure for protecting against abuse. First, the Informed Consent Law is silent on the issue of consent to withholding or withdrawing of life-sustaining treatment. As a result, the law is unclear as to whether its provisions about "proposed health care" apply to decisions on withholding life-sustaining treatment. Second, the law requires a surrogate to use a best-interests test, but it does not give any guidelines for making that decision. *Grant*, on the other hand, specifies a substituted judgement test to determine the patient's intent. Only if that intent cannot be determined does the surrogate use a best-interests test, and *Grant* gives guidelines for analyzing what treatment would be in the patient's best interest. Third, the Informed Consent Law does not require the unanimous decision of an incompetent's immediate family. Instead, the Informed Consent Law allows certain individuals, ranked in a prioritized scheme, to singlehandedly make life and death decisions for an incompetent person. One individual could decide the nature and timing of an incompetent person's death.²⁸⁵ Presumably for this rea-

283. WASH. REV. CODE § 7.70.065 (1989). For the text of the Washington Informed Consent Law, see *supra* note 208.

284. OR. REV. STAT. § 127.635-40 (1989).

285. VanDerhoef, *supra* note 149, at 205 n.49.

son, the Washington Supreme Court rejected a motion for reconsideration to adopt the Informed Consent law into its *Grant* procedure.²⁸⁶ The court was concerned that substantial conflicts could arise between family members, with one person making a decision to which the remainder of the family was opposed.²⁸⁷

The *Grant* procedure, requiring a unanimous consensus between family members, would provide more protection against abuse while still allowing these kinds of personal decisions to be made within the privacy of the family without court intervention. Requiring unanimity between the family and doctors should avoid the black sheep scenario in which the family wants to get rid of an unwanted member. It is highly unlikely that three doctors would agree to withdrawal of treatment for this type of reason. Likewise, the need for consent of family members prevents doctors or hospitals from "playing God" and deciding that a patient would be "better off dead" even though the family knows the patient expressed a clear intent to fight to the finish before lapsing into a comatose state.²⁸⁸

The above scenario raises the concern that "the 'right-to-die' could become a license to kill."²⁸⁹ Concerns that some people will decide to pull the plug because the patient is better off dead are legitimate. In this century alone, the world has seen the extermination of economically disadvantaged, retarded, and mentally disturbed persons for whom a government decided that death was the proper prescription.²⁹⁰ To guard

286. *Id.* at 205-06.

287. *Id.* at 206 n.53.

288. This scenario is all-too real. Doctors in a Minneapolis medical center attempted an unprecedented, disturbing step: they sought court permission to end life support for a woman in a vegetative state, *despite* her husband's refusal to give consent. Susan Tiffit, *Life and Death After Cruzan*, TIME, Jan. 21, 1991, at 67. Her husband claimed that his spouse firmly believed that "only God should make such a determination" and that "if anything happened to her, she didn't want anything done to shorten her life." *Id.* The doctors on the other hand, did not "feel physicians should be forced by the family to provide inappropriate medical care." *Id.* In light of our Anglo-American tradition of self-determination, the courts in this type of case should certainly give effect to the patient's prior expressed intent. Given the patient's clear intent in the Minneapolis case, the doctors' proposed action approaches euthanasia or even homicide. To guard against this kind of paternalistic behavior by the medical profession, one commentator has recommended a legal presumption in favor of family decisionmaking, with the burden falling on the doctor to challenge the impropriety of the family's choice. Rhoden, *Litigating Life*, *supra* note 70, at 445-46.

289. *In re Browning*, 568 So. 2d 4, 13 (Fla. 1990).

290. *Id.*

against such behavior, legislatures and courts must provide specific guidance for the limited circumstances in which a surrogate will be allowed to exercise an incompetent's choice to withhold or withdraw life-sustaining treatment.²⁹¹ The *Grant* court outlined this type of specific procedure that will allow families to make private, personal decisions without court intervention, yet will guard against a slide into wholesale euthanasia.²⁹²

Finally, the *Grant* procedure is preferable because it allows for private family decisionmaking²⁹³ for an incompetent person. Decisions about medical treatment have traditionally been dealt with in privacy by a patient, her family, and physician.²⁹⁴ Until recently, dying was considered a part of "the life which characteristically has its place in the home."²⁹⁵ That is no longer the case. Of the approximately two million people that die each year in the United States, eighty percent die in hospitals or long-term care facilities.²⁹⁶ About seventy percent

291. As noted by Justice Blackmar in his dissent to the Missouri Supreme Court *Cruzan* decision, court decisions will not open the door to wholesale euthanasia of persons considered to be defective because a court's holding is precedent only for the facts of its particular case. *Cruzan v. Harmon*, 760 S.W.2d 408, 429 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990) (Blackmar, J., dissenting). "The courts are open to protect incompetents against abuse." *Id.*

292. See *supra* text accompanying notes 202-07.

293. Although *Grant* allows private family decisionmaking, the particular procedure may have several drawbacks. For example, the *Grant* procedure requires unanimity among immediate family members. *In re Grant*, 109 Wash. 2d 545, 566-67, 747 P.2d 445, 456 (1987). Presumably if any one family member objected, the parties would be forced to turn to the courts for resolution of the impasse. One advantage of the Informed Consent Law is that it would circumvent this problem by allowing the decision to be made by one family member, with that family member designated according to a hierarchical ranking, i.e., spouse, followed by adult children, followed by parents, followed by adult brothers and sisters. See *supra* note 208. On the other hand, unanimity provides an additional safeguard against abuse and better assurance that the wishes of the patient are in fact known by more than one person and thus will be effectuated.

Another problem with the *Grant* procedure, however, is that it fails to define "immediate family members." Who are these immediate family members? Should the definition include only blood relatives and spouses? What about situations where the incompetent patient has severed ties with the natural family and is closest to a "spouse" or partner that is not given legal status under our current laws? If this scenario arose, the parties would have to turn to the courts to define who would be "immediate family members" for purposes of *Grant*. Given the current furor over "family values" and the definition of "family," this problem is not easily resolved. However, a discussion of how to define "family" is beyond the scope of this Comment.

294. Rhoden, *Litigating Life*, *supra* note 70, at 437-38.

295. *Poe v. Ullman*, 367 U.S. 497, 551 (1961) (Harlan, J., dissenting).

296. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2864 (1990) (Brennan, J., dissenting).

of those deaths occur after a decision to forgo life-sustaining treatment was made. To a large extent, "the timing of death—once a matter of fate—is now a matter of human choice."²⁹⁷

Many people believe that this choice should be made by family members functioning as surrogate decisionmakers if patients cannot make the decision themselves.²⁹⁸ "In short, there is a deep-rooted and almost instinctual sense that a close family member should make such decisions."²⁹⁹ Courts should not be involved in this traditional area, limiting these personal decisions that should be made by a patient or the patient's family and her doctor. People should be free to carry out their medical decisions as they wish. The preferences of a majority of individuals,³⁰⁰ as well as society's deeply rooted history and tradition, lend far more support to family decisionmaking as the favored way to make these difficult choices, rather than forcing every family of Cruzans to drag these personal decisions through the courts over a period of years. As Justice Stevens stated, the meaning of respect for the personhood of a gravely ill or incapacitated patient is not easily defined:

Choices about life and death are profound ones, not susceptible of resolution by recourse to medical or legal rules. It may be that the best we can do is to ensure that these choices are made by those who will care enough about the patient to investigate her interests with particularity and caution.³⁰¹

In conclusion, the Washington State Legislature should specify whether the Informed Consent Law or the *Grant* procedure controls in a situation involving choices about withdrawing artificial nutrition and hydration from noncompetent

297. *Id.* (quoting OFFICE OF TECHNOLOGY ASSESSMENT TASK FORCE, LIFE-SUSTAINING TECHNOLOGIES AND THE ELDERLY 41 (1988)).

298. Rhoden, *Litigating Life*, *supra* note 70, at 438.

299. *Id.*

300. *See id.* Fifty-seven percent of people polled by a President's Commission would want a family member to make medical decisions for them in the event they were incapacitated. *Id.* at 438 n.273. Likewise, the New Jersey Supreme Court noted that recent surveys strongly supported the societal belief that families should function as surrogate decisionmakers for patients. *Id.* (citing *In re Jobes*, 529 A.2d 434, 446 n.11 (N.J. 1987)). The Stanford University Medical Center Committee on Ethics expressed the unanimous view that substantial deference should be given to family decisionmaking. *Id.* at 438 n.275. *See* John Edward Ruark et al., *Initiating and Withdrawing Life Support: Principles and Practice in Adult Medicine*, 318 NEW ENG. J. MED. 25, 30 (1988).

301. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2891 (1990) (Stevens, J., dissenting).

patients. Clarification is needed so that families, doctors, and health care facilities may know the proper procedure to follow. The legislature should adopt the *Grant* procedure, which will protect against potential abuses while providing for private family decisionmaking. Furthermore, this process should be undertaken by the legislature, which is better equipped to make law than the courts. The legislature can draw on its extensive resources to make a broad policy of law based on the direct input of its constituents, health care officials, and advocacy groups through public hearings.³⁰² At the same time, the legislature should clarify that life-sustaining treatment under this procedure includes artificial nutrition and hydration, as determined by the Supreme Court in *Cruzan*.

V. CONCLUSION

The Nancy *Cruzan* case was one small step by the United States Supreme Court toward clarifying right-to-die issues. For the first time, the Court acknowledged that individuals have a liberty interest in refusing unwanted medical treatment, including artificial nutrition and hydration. The procedures for protecting that interest, however, have been delegated to the states.

In Washington state, the procedures for protecting this right to refuse treatment are outlined in a series of cases, *Colyer*, *Hamlin*, and *Grant*. Although the cases are probably in accord with *Cruzan*, the procedures need refinement. The Washington Supreme Court and Legislature should embrace artificial nutrition and hydration as a life-sustaining procedure, as did the United States Supreme Court. In addition, the legislature should clarify whether the procedure under the Informed Consent Law or under *Grant* governs consent decisions made on behalf of incompetent patients. Because the *Grant* procedure provides more protection against abuse while allowing a family to make private medical decisions without seeking a court order, the legislature should adopt *Grant* as the procedure of choice.

As right-to-die issues continue to arise, both sides will refine their arguments and emotions will continue to run high. The director and some of the nurses in the Missouri Rehabilitation Center believed that withdrawing Nancy's feeding tube

302. *In re Grant*, 109 Wash. 2d 545, 574, 747 P.2d 445, 460 (1987), *modified*, 757 P.2d 534 (1988).

was immoral and should not be done. Some of the nurses expressed concern about whether their names would still "be on the Lord's slate" if "her blood [is] on our hands."³⁰³ On the other hand, Nancy's family fervently believed that it was doing the right thing in carrying out its daughter's wishes. "*Knowing Nancy as only a family can*, there remains no question that we made the choice she would want."³⁰⁴

Against the background of this emotional debate, the United States Supreme Court has found that the right to refuse medical treatment, including artificial nutrition and hydration, is encompassed within a "liberty interest" of the Due Process Clause of the Fourteenth Amendment to the Constitution. In the case of an incompetent person who is in a persistent vegetative state, however, that person is unable to exercise this right to refuse treatment. Because these types of medical decisions have traditionally been dealt with in the intimacy of the family circle, that person's family should be able to step in and exercise her right for her without interference by the courts.

In the case of Nancy Cruzan, her "loving and caring" family³⁰⁵ should have been free to carry out what it believed were Nancy's wishes without three years of litigation. In the case of Washington law, our procedure should enable families or a qualified guardian to make those private decisions, with adequate safeguards to ensure that the wishes of the patient are investigated with particularity and caution. Now the task is up to the legislature to clarify that procedure. Future incompetent patients and their families in Washington should not have to endure suffering like that of Nancy Cruzan and her family.

303. *Anger in Hospital*, *supra* note 100, at 29.

304. Steinbrook, *supra* note 26, at A17.

305. The words are those of Justice Rehnquist. *Cruzan*, 110 S. Ct. at 2855.