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ARTIFICIAL NUTRITION AND THE TERMINALLY ILL: HOW SHOULD WASHINGTON DECIDE?

Dying is not what it used to be. Today nearly ninety percent of all Americans succumb to chronic degenerative conditions rather than to sudden death.¹ Death usually occurs in hospitals and nursing homes where life-support technology offers the ability to keep some terminally ill patients² alive almost indefinitely.³ Because of these developments, however, many people now fear dying more than death.⁴

Since the landmark decision of *In re Quinlan*⁵ in 1976, most legal authorities and health practitioners have reached a consensus that terminally ill patients possess the right to forego at least some forms of life-

1. REPORT OF THE PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 16-18 (1983) [hereinafter cited as PRESIDENT'S COMM'N]. In the early 1900's, infectious diseases were the leading causes of death. *Id.*

2. For the purposes of this Comment, terminal illness means an incurable condition caused by injury, disease, or illness from which there is no reasonable chance of recovery or cure, and which will, within reasonable medical judgment, produce death in the foreseeable future, in the absence of life-sustaining treatment. See Cohen, *Interdisciplinary Consultation on the Care of the Critically Ill and Dying: The Role of One Hospital Ethics Committee*, 10 CRITICAL CARE MED. 776, 781 (1982). See *infra* notes 22, 98, 133 for the Washington courts' interpretation of "life-sustaining treatment;" see *infra* notes 197-201 and accompanying text for the legislature's definition of "life-sustaining treatment." (Compare the term "terminal condition" used in Washington's Natural Death Act discussed *infra* note 198 and accompanying text.)

This Comment includes among the terminally ill those persons in a persistent vegetative state. The term "persistent vegetative state" refers to a form of unconsciousness arising from severe disruption of the coordinated functions of the brain caused by a physical or chemically induced injury. Ingvar, Brun, Johansson & Samuelson, *Survival after Severe Cerebral Anoxia with Destruction of the Cerebral Cortex: The Apallic Syndrome*, 315 ANNALS N.Y. ACAD. SCI. 184 (1978). Patients in a persistent vegetative state may appear wakeful and their brain stems maintain subsistence activities and reflexes, however, they suffer a complete loss of the higher functions of speech, voluntary muscular activity, directed emotions, and signs of memory. *Id.* at 202. Detectable electroencephalograph (EEG) activity may or may not occur. PRESIDENT'S COMM'N, *supra* note 1, at 175. If nutrition is supplied to persons in a persistent vegetative state, the vegetative functions of sleep/wake cycles, respiration, circulation, temperature control, and uncontrolled excretion and evacuation will continue. *Id.*

3. Childress, *Refusal of Lifesaving Treatment by Adults*, 23 J. FAM. L. 191, 194 (1984-85). Probably 80% of the deaths in the United States now occur in hospitals and long term care facilities such as nursing homes. PRESIDENT'S COMM'N, *supra* note 1, at 16-18.

4. Cassel, *Deciding to Forego Life-Sustaining Treatment: Implications for Policy in 1985*, 6 CARDOZO L. REV. 287, 288 (1984) ("[F]rom the growth of available [medical] techniques . . . [a] new public consciousness, fearful to the extreme of 'being kept alive as a vegetable,' began to demand death with dignity."). See also Cantor, Conroy, *Best Interests, and the Handling of Dying Patients*, 37 RUTGERS L. REV. 543, 556, 571, 574-75 (1985). Ethicists, too, have noted the social implications of prolonging dying by artificial means. See, e.g., Cohen, *supra* note 2, at 776: "Unless we answer such questions [regarding life-sustaining care] now, our ICU's will become the cemeteries of the future, occupied by multitudes of artificially fed and maintained human beings who are neither alive nor dead."

5. 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976).

sustaining treatment.⁶ Moreover, most agree that the decision to turn off a respirator, or to authorize a “do not resuscitate” order,⁷ can be made by a surrogate acting on the patient’s behalf.⁸ Considerable controversy exists, however, over whether artificial nutrition and hydration can be foregone.⁹ Are intravenous (IV) lines and feeding tubes different from other medical interventions that patients have a right to refuse? Do health care providers

6. See, e.g., Comment, *The Conflict Continues: Who Decides Treatment Questions for the Terminally-Ill Incompetent Patient*, 18 SUFFOLK U.L. REV. 641 (1984); Otten, *New ‘Wills’ Allow People to Reject Prolonging of Life in Fatal Illness*, Wall St. J., July 2, 1985, at 35, col. 4.

7. A “do not resuscitate” (DNR) order in a patient’s chart means that in the event of cardiopulmonary arrest or respiratory failure, the patient is not to be revived. Bedsine, *Decisions to Withhold Treatment from Nursing Home Residents*, 31 J.A.M. GERIATRICS SOC. 602, 603 (1983). For an example of the legal entanglements such an order can produce, see *In re Hamlin*, 102 Wn. 2d 810, 689 P.2d 1372 (1984); *In re Dinnerstein*, 380 N.E.2d 134, 135–36 (Mass. App. Ct. 1978).

8. E.g., *Severns v. Wilmington Medical Center*, 421 A.2d 1334, 1347 (Del. 1980) (husband authorized to request withdrawal of wife’s respirator and the entry of a DNR order in wife’s chart); *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So. 2d 921, 926 (Fla. 1984) (wife may authorize withdrawal of husband’s respirator); *In re Quinlan*, 355 A.2d at 660–61, 663 (father may authorize withdrawal of daughter’s respirator); *Leach v. Akron Medical Center*, 68 Ohio Misc. 1, 426 N.E.2d 809, 816 (1980) (husband may authorize withdrawal of wife’s respirator).

The rationale generally given by the courts for this result is that a different determination would render patients’ rights to bodily integrity and privacy worthless. See, e.g., *Quinlan*, 355 A.2d at 664 (“If a putative decision by [a patient to forego life-sustaining treatment] . . . is regarded as a valuable incident of her privacy, as we believe it to be, then it should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice.”); *In re Colyer*, 99 Wn. 2d 114, 124, 660 P.2d 738, 744 (1983) (“An incompetent’s right to refuse treatment should be equal to a competent’s right to do so.”).

Most commentators support some kind of surrogate decisionmaking process. E.g., Cantor, *Quinlan, Privacy, and the Handling of Incompetent Dying Patients*, 30 RUTGERS L. REV. 243, 252 (1977) (argument suggesting that surrogate decisionmakers cannot exercise a patient’s personal choice and autonomy is “too simplistic”; self-determination is in fact promoted by allowing a guardian to implement a patient’s wishes). The President’s Commission has suggested that the principle of “promoting patient welfare” underlies surrogate decisionmaking in the absence of any previously expressed wishes by the patient regarding terminal care. PRESIDENT’S COMM’N, *supra* note 1, at 132–36. For a similar view see Cantor, *supra* note 4, at 543, 557 (while it is presumptuous to purport to be effectuating patient choice where a patient has never articulated personal preferences about the dying process, humane handling of the dying requires that surrogates be allowed to make decisions for these patients). See Chapman, *Fateful Treatment Choices for Critically Ill Adults Part 1: The Judicial Model*, 37 ARK. L. REV. 908 (1984); *Privacy and the Family in Medical Care Decisions: A Symposium*, 23 J. FAM. L. 172, 189, 207 (1985); Rubin, *Refusal of Life-Sustaining Treatment for Terminally Ill Incompetent Patients: Court Orders and an Alternative*, 19 COLUM. J.L. & SOC. PROBS. 19 (1985); Veatch, *Limits of Guardian Treatment Refusal: A Reasonableness Standard*, 9 AM. J.L. & MED. 427 (1983). But see Smith, *In re Quinlan: Defining the Basis for Terminating Life Support Under the Right of Privacy*, 12 TULSA L.J. 150, 161 (1976) (permitting a guardian to make medical decisions for an incompetent patient actually interferes with the patient’s right of privacy); Note, *Constitutional Law—No Constitutional Basis Exists to Permit a Parent to Assert for His Adult Child a Right to Die*, 7 TEX. TECH. L. REV. 716, 722 (1976) (“To allow a guardian to make such a choice violates literally the essence of the right of self-determination,” discussing the Chancery Court’s opinion in *In re Quinlan*, 348 A.2d 801 (N.J. Super. Ct. Ch. Div. 1975)).

9. See, e.g., Note, *The Barber Decision: A Questionable Approach to Termination of Life Support Systems for the Patient in a Persistent Vegetative State*, 15 GOLDEN GATE L. REV. 371, 380 (1985); Otten, *supra* note 6.

have an obligation, or a right, to give such care despite a patient's or surrogate's decision to the contrary?

Our society attaches considerable emotional significance to providing food and water to those unable to care for themselves. Feeding is an expression of nurturing and caring;¹⁰ the intentional denial of sustenance to the dying is repugnant to widely held notions of providing proper, "ordinary" care that health care providers have a duty to give.¹¹ This attitude has led some to contend that nutrition is a basic element of human existence; it is never extraordinary, and therefore, never optional.¹²

The Washington courts have never adjudicated the right of a terminally ill patient to forego artificial nutrition and hydration. Nor does Washington's living will statute, the Natural Death Act (NDA),¹³ address this matter with specificity. Both the state supreme court¹⁴ and the legislature,¹⁵ however, have recognized the fundamental right of all adult persons to make decisions about their own medical care, including the freedom to choose nontreatment that will inevitably lead to death. Because a terminally ill patient's right to forego artificial sustenance is consistent with this broad right, Washington case law and statutory authority appear to support the right of terminally ill citizens of this state or their surrogates to decide to forego artificial nutrition and hydration.¹⁶

Nonetheless, the matter is far from settled. State lawmakers could amend Washington's NDA to prohibit the withholding or withdrawing of artificial nutrition and hydration from terminally ill patients.¹⁷ Thirteen

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

11. See *infra* note 67.

12. *Id.*

On March 16, 1986, the American Medical Association's Council on Ethical and Judicial Affairs announced a new opinion on withholding and withdrawing life-sustaining treatment. In that opinion, the Council stated, "[l]ife [sustaining] medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained." Memorandum from the American Medical Ass'n to FEDNET (Mar. 17, 1986) (discussing life-prolonging treatment) (copy on file with the *Washington Law Review*).

13. WASH. REV. CODE § 70.122 (1985). See *infra* text accompanying notes 195–203. In 1979, Washington became the ninth state to enact living will legislation. Today, 35 states and the District of Columbia have living will laws. See *infra* notes 78–83 and accompanying text.

14. *In re Colyer*, 99 Wn. 2d 114, 660 P.2d 738 (1983).

15. WASH. REV. CODE § 70.122.010 (1985).

16. See *infra* notes 123–222 and accompanying text.

17. S.S.B. 3228, 49th Leg., Reg. Sess., 1985 Washington. Introduced as S.B. 3228, this bill, which would have substantially amended Washington's NDA, originally contained no mention of nutrition. The language "[life-sustaining treatment] shall not include the provision of basic nutrition by whatever route necessary" was added on the Senate floor. This language was later rejected by the House Committee on Social and Health Services. Subsequently, however, E.S.S.B. 3228 encountered

new living will statutes enacted by other states last year included such a prohibition.¹⁸ Further, Washington courts could retreat from the broad language of *In re Colyer*¹⁹ and *In re Hamlin*²⁰ in which the supreme court held that all terminally ill patients have a common law and constitutionally based right to forego medical treatment that only prolongs their dying.²¹ Artificial nutrition and hydration were not clearly at issue in either decision: the facts in those cases establish only that patients in a persistent vegetative state can forego mechanical ventilation, antibiotics, and cardiopulmonary resuscitation.²² Recent decisions in Massachusetts²³ and Florida²⁴ have held that feeding tubes could not be withdrawn from persistently vegetative patients despite earlier decisions in those jurisdictions permitting similar patients to forego mechanical ventilation,²⁵ hemodialysis,²⁶ chemotherapy²⁷ and cardiopulmonary resuscitation.²⁸

unexpected resistance in the House Rules Committee and failed to reach the House floor. This vote was taken shortly after a Sunday Seattle newspaper headline: Powell, *Two Families' Decision: Letting Loved Ones Starve*, Seattle Times, Apr. 14, 1985, at 1, col. 1.

When the second session of the 49th Legislature convened in January, 1986, this bill resurfaced in the Senate. After passing the Senate in the same form as it had in 1985, the bill went to the House Committee on Social and Health Services which again amended the Senate version. Despite the recommendation of the Nursing Home Advisory Council—a task force assembled to review E.S.S.B. 3228 during the fall of 1985 which called for artificial nutrition and hydration to be specified as a life-sustaining procedure—the version reported out of this House committee contained the language life-sustaining treatment “does not include nutrition for comfort care in the alleviation of pain.” Once again, however, the bill failed in the House Rules Committee and was not reported out.

18. Otten, *supra* note 6.

19. 99 Wn. 2d 114, 660 P.2d 728 (1983).

20. 102 Wn. 2d 810, 689 P.2d 1372 (1984).

21. *Hamlin*, 102 Wn. 2d at 816, 689 P.2d at 1376; *Colyer*, 99 Wn. 2d at 118–19, 660 P.2d at 741.

22. *Hamlin*, 102 Wn. 2d at 814, 689 P.2d at 1375. In *Colyer* it is not clear which life-sustaining treatments were precisely at issue. Bertha Colyer's husband petitioned the court for “removal of [her] life support systems.” *Colyer*, 99 Wn. 2d at 117, 660 P.2d at 740. The court specifically mentioned “respirator” only twice in its opinion, *id.* at 116, 660 P.2d at 740; throughout the remainder of the opinion the court spoke generally of “life-sustaining treatment.” See *infra* note 133 and accompanying text. However, the court compared Bertha Colyer's medical care to that of Karen Quinlan, stating: “For Karen Quinlan, the degree of bodily invasion was great, since she required a respirator, an *intravenous feeding apparatus*, a catheter, and intensive nursing care. . . . Similar intrusive care was required for Bertha Colyer.” 99 Wn. 2d at 122–23, 660 P.2d at 743 (emphasis added). Therefore, the *Colyer* court may have included artificial sustenance in its holding. However, as artificial nutrition and hydration were not clearly at issue in *Colyer*, this Comment takes the position that *Colyer* left the artificial nutrition question unanswered.

23. *Brophy v. New Eng. Sinai Hosp.*, No. 85E0009-GI (Mass. P. Ct. Oct. 21, 1985) (copy on file with the *Washington Law Review*).

24. *Corbett v. D'Alessandro*, No. 84-5627CA-JRT (Fla. Cir. Ct. Feb. 28, 1985) (copy on file with the *Washington Law Review*).

25. *John F. Kennedy Memorial Hosp. v. Blutworth*, 452 So. 2d 921 (Fla. 1984).

26. *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980).

27. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977).

28. *In re Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978).

Society's general aversion to death²⁹ is especially pronounced in arguments that favor legislative and judicial mandates to preclude artificial nutrition and hydration from the field of patient choice.³⁰ Providing sustenance to the dying is emotionally appealing. Furthermore, many terminally ill patients are incompetent and thus unable to participate in decisions about their medical care.³¹ Some proponents of the requirement that artificial nutrition and hydration be provided to all patients question whether a surrogate should make the decision to withhold treatment on behalf of an incompetent patient.³²

Despite these sentiments, most legal and medical authorities recognize that the dying patient may be in greater need of emotional comfort and dignity than of aggressive medical intervention.³³ Modern medical ethics do not require that life be sustained in all circumstances.³⁴ Some courts and legislators have asserted specifically that artificial nutrition and hydration need not be given in all cases.³⁵

Legal decisions about the right of terminally ill patients to refuse artificial sustenance involve complex policies that are difficult to define and to develop in a society with widely differing moral philosophies. The solution must not come by picking one voice from an emotional shouting match. In order for Washington courts to resolve the issue when it arises, or for state lawmakers to enact informed legislation, they must understand the medical reality of artificial nutritional support, the right to forego artificial nutrition and hydration as it exists in other jurisdictions, the legal development in Washington of the right to forego life-sustaining treatment, and the bases supporting a right to refuse artificial sustenance that derive from the

29. See Morris, *Voluntary Euthanasia*, 45 WASH. L. REV. 239 (1970).

30. See Towers, *Irreversible Coma and Withdrawal of Life Support: is it Murder if the IV line is Disconnected?*, 8 J. MED. ETHICS 203 (1983) (discussing the pre-trial behavior of public interest groups confronted with termination-of-care issues). Consider also the titles to the following recent legal commentaries: Note, *Suicide, Euthanasia, Murder: The Line Blurs*, 15 GOLDEN GATE L. REV. 407 (1985); Note, *Withholding Food and Water From a Patient—Should it be Condoned in California*, 16 PAC. L. J. 877 (1985). But see Note, *supra* note 9, at 371.

31. PRESIDENT'S COMM'N, *supra* note 1, at 120–26; Cantor, *supra* note 4, at 557; Rubin, *supra* note 8, at 23.

32. See *supra* note 8.

33. See, e.g., PRESIDENT'S COMM'N, *supra* note 1, at 190; Lynn & Childress, *Must Patients Always Be Given Food and Water?*, 13 HASTINGS CENTER REP. 17 (Oct. 1983).

34. Wanzer, Adelstein, Cranford, Federman, Hook, Moertel, Safar, Stone, Taussig & van Eys, *The Physician's Responsibility Toward Hopelessly Ill Patients*, 310 NEW ENG. J. MED. 955, 958 (1984) [hereinafter cited as Wanzer]. See also Cantor, *supra* note 4, at 573.

35. For court decisions, see *infra* notes 62–71 and accompanying text. For legislation addressing artificial nutrition, see, for example, Arizona Medical Treatment Decision Act, 1985 Ariz. Legis. Serv. ch. 199, § 36-3201(4) (West), which states: "Life-sustaining procedure does not include the administration of medication, food or fluids or the performance of a medical procedure deemed necessary to provide comfort care." This language suggests that if artificial nutrition and hydration were not needed for comfort care, they qualify as life-sustaining procedures under the Act.

policy and rights underlying the general right to forego life-sustaining treatment.

This Comment demonstrates that artificial nutrition and hydration are life-sustaining treatments which all patients have a right to forego under Washington's common law, state constitution, and NDA. Countervailing state interests do not compel a contrary result. Moreover, artificial nutrition and hydration do not require the preclusion of surrogate decisionmaking already recognized by Washington in the life-sustaining treatment context. However, since current judicial guidelines for surrogate-made decisions are inadequate, this Comment concludes by proposing substantive guidelines for such decisions.

I. BACKGROUND

A. *The Medical Reality of Artificial Nutrition and Hydration*

Ingestion—the means by which food and water enter the gastrointestinal (GI) tract—usually occurs as the result of coordinated muscular movements: placing food and water into the mouth, chewing, and swallowing. From the GI tract, nutrients are absorbed into the blood.³⁶ For patients unable to ingest food voluntarily,³⁷ or for patients whose GI tract is nonfunctional,³⁸ water and nutrients can be mechanically placed into the GI tract for absorption, or directly into the blood stream.³⁹ Patients unable to ingest water and nutrients voluntarily, like patients unable to breathe spontaneously, will die in the absence of artificial support.⁴⁰

36. J. CROUCH, FUNCTIONAL HUMAN ANATOMY 496–98 (3d ed. 1978).

37. Comatose, severely demented, and persistently vegetative patients cannot eat and drink by themselves. See Lo & Dornbrand, *Sounding Board: Guiding the Hand that Feeds, Caring for the Demented Elderly*, 311 NEW ENG. J. MED. 402, 403 (1984); Lynn & Childress, *supra* note 33, at 17–18 (discussing the ethics and medical implications of withholding food and water); Meguid, Eldar & Wahba, *The Delivery of Nutritional Support: A Potpourri of New Devices and Methods*, 55 CANCER 279, 280 (Jan. 1 Supp. 1985) (describing the methods of supplying artificial sustenance to those unable to feed themselves).

38. Chronically debilitated patients may have a reduced ability to absorb nutrients from their GI tracts. Meguid & Williams, *The Use of Gastrostomy to Correct Malnutrition*, 149 SURG. GYN. & OBST. 27 (1979). But some debilitated patients do gain weight from artificial nutritional support. O'Hara, Kennedy & Lizewski, *Effects of Long Term Elemental Nasogastric Feeding on Elderly Debilitated Patients*, 108 CAN. MED. A. J. 977, 980 (1973).

39. Common means of artificial nutrition and hydration include: nasogastric tubes (*see infra* note 44 and accompanying text), gastrostomy tubes (*see infra* note 49 and accompanying text), intravenous lines (*see infra* note 51 and accompanying text), and hyperalimentation (*see infra* notes 53–54 and accompanying text).

40. See Lo & Dornbrand, *supra* note 37, at 402. However, death in this fashion may not be painful or uncomfortable. See Lynn & Childress, *supra* note 33, at 19; *infra* note 77. The starvation process is described in Heymsfield, Bethel, Ansley, Nixon & Rudman, *Enteral Hyperalimentation: An Alternative to Central Venous Hyperalimentation*, 90 ANNALS INTERNAL MED. 63 (1979). The natural course of dehydration is described in Zerwekh, *The Dehydration Question*, NURS. 83, Jan. 1983, at 47, 48.

Medical technology has only recently provided effective methods of artificial nutrition and hydration.⁴¹ For many, these mechanical interventions offer substantial benefit, such as the means to survive cancer treatment,⁴² or the opportunity to resume activities of daily living despite an otherwise fatal digestive disorder.⁴³ Nevertheless, serious complications may accompany each method of artificial nutrition and hydration.

The mechanical placement of nutrients into the GI tract necessarily involves tubes. Nasogastric tubes which are inserted through the nose and pass into the stomach⁴⁴ can painfully irritate the patient, causing bleeding and ulceration.⁴⁵ Tubes can be misplaced, which may lead to infection and death.⁴⁶ Aspiration-induced pneumonia is a frequent complication in disoriented patients;⁴⁷ for such patients, physical restraints may be necessary.⁴⁸ Gastrostomies, which require surgical placement of a tube directly into the patient's stomach,⁴⁹ may lead to leakage of acidic stomach contents

41. The first flexible tubing for instilling food and fluids into the stomach was developed about 100 years ago. Lynn & Childress, *supra* note 33, at 17; *see also* Torosian & Rombeau, *Feeding by Tube Enterostomy*, 150 *SURG. GYN. & OBST.* 918 (1980). The direct infusion of adequate nutrition into the veins was introduced in 1968. Ota, Imbembo & Zuidema, *Total Parenteral Nutrition*, 83 *SURGERY* 503 (1980).

42. Kokal, *The Impact of Antitumor Therapy on Nutrition*, 55 *CANCER* 273 (Jan. 1 Supp. 1985).

43. Torosian & Rombeau, *supra* note 41, at 918; Padilla & Grant, *Psychosocial Aspects of Artificial Feeding*, 55 *CANCER* 301 (Jan. 1 Supp. 1985).

44. Heymsfield, Bethel, Ansley, Nixon & Rudman, *supra* note 40, at 67.

45. Meguid, Eldar & Wahba, *supra* note 37, at 280.

46. Hand, Kempster, Levy, Rogol & Spirn, *Inadvertent Transbronchial Insertion of Narrow-Bore Feeding Tubes into the Pleural Space*, 251 *J. A.M.A.* 2396, 2397 (1984). Feeding tubes have been placed inadvertently into the brain and have perforated the esophagus, lung, and stomach; these complications most frequently occur among neurologically impaired patients. *Id.* Many terminally ill patients will fit this category. *See supra* note 2. *See also* Schorlemmer & Battaglini, *An Unusual Complication of Naso-Enteral Feeding with Small-Diameter Feeding Tubes*, 199 *ANNALS SURG.* 104 (1984). Tube misplacement can lead to infection and the presence of air in the chest cavity outside the lung. Schorlemmer & Battaglini, *supra*, at 106.

Other problems include bacterial colonization of the nutrient-rich feeding solution which can cause intestinal infection and poisoning. Anderton, *Microbial Aspects of the Preparation and Administration of Nasogastric and Nasoenteric Tube Feeds in Hospitals—A Review*, 37A *HUMAN NUTRITION: APPLIED NUTRITION* 426 (1983). Metabolic complications can arise from a patient's inability to assimilate large volume fluid and nutrient loads due to heart, liver, or kidney insufficiency. Heymsfield, Bethel, Ansley, Nixon & Rudman, *supra* note 40, at 69. Fluid overload, congestive heart failure, electrolyte imbalance, and dehydration are among other problems reported. *Id.* Adverse gastrointestinal symptoms include vomiting, bloating, cramping, and diarrhea. *Id.*

47. Aspiration-induced pneumonia arises when food or saliva is aspirated into the lungs, causing infection. Meguid, Eldar & Wahba, *supra* note 37, at 281; Torosian & Rombeau, *supra* note 41, at 921.

48. Demented or restless patients are often tied down and sedated to prevent them from pulling out their tubes. *Id.* *See also* Lynn & Childress, *supra* note 33, at 18.

49. *See* Meguid & Williams, *supra* note 38, at 27–28 (1979). Gastrostomies require local or general anesthesia; liquified food is then infused through the tube. *Id.* Other types of tube feedings include the esophagostomy (where the surgical opening is in the esophagus), the pharyngostomy (where the opening is in the pharynx), or the jejunostomy (where the opening is in the jejunal region of the intestine). Torosian & Rombeau, *supra* note 41, at 919–21.

causing sores and infection.⁵⁰

Methods which infuse fluids and nutrients directly into the circulatory system also entail significant risks. First, IV lines can provide short term support only.⁵¹ Veins become irritated and infected, and collapse.⁵² Hyperalimentation⁵³, although it can be used to administer adequate nutrients indefinitely, necessitates surgical intervention⁵⁴ and followup professional care.⁵⁵ As with other forms of artificial nutrition and hydration, resistant patients receiving this treatment must be physically restrained.⁵⁶

Nasogastric tubes, IV lines, and hyperalimentation artificially replace the natural function of ingestion. Each method is physically invasive and involves significant risk. The medical reality of artificial nutrition and hydration bears little resemblance to ordinary oral consumption of food and water.⁵⁷

B. *The Right to Forego Artificial Nutrition and Hydration: Current Status of the Law*

In the case of *In re Quinlan*,⁵⁸ the New Jersey Supreme Court became the

50. Rigdon & Kukora, *Management of Leakage from Gastrostomy Sites*, 49 AM. SURG. 531 (1983). Other complications associated with the surgical placement of enteral tubes include wound opening, herniation, fistula development, peritonitis, hemorrhage, and nerve damage. Torosian & Rombeau, *supra* note 41, at 919-21.

51. Meguid, Elder & Wahba, *supra* note 37, at 284. In peripheral IV therapy, fluid and nutrient solutions are infused directly into the body's circulatory system by way of small, temporary steel or plastic needles commonly inserted into the superficial veins of a patient's arms and hands. *Id.*

52. Even with frequent site rotation, venous inflammation, pain, and discomfort may occur. Tomford, Hershey, McLaren, Porter & Cohen, *Intravenous Therapy Team and Peripheral Venous Catheter-Associated Complications*, 144 ARCH. INTERNAL MED. 1191, 1194 (1984). During prolonged hospitalizations, repeated episodes of inflammation cause veins to harden and collapse, resulting in the need for more invasive procedures. *Id.* Inflammation may also lead to infection and death. *Id.*

53. Hyperalimentation involves the infusion of high-density nutrient-rich solutions directly into a large diameter, high flow blood vessel by the placement of a plastic catheter into the vessel or into the heart's right atrium by inserting a right atrial catheter. Meguid, Eldar & Wahba, *supra* note 37, at 286-87; Ota, Imbembo & Zuidema, *supra* note 41, at 511. Catheters used to administer hyperalimentation can remain in the body for longer periods than can IV needles. Meguid, Eldar & Wahba, *supra* note 37, at 286.

54. Meguid, Eldar & Wahba, *supra* note 37, at 286-87; Ota, Imbembo & Zuidema, *supra* note 41, at 511.

55. Ota, Imbembo & Zuidema, *supra* note 41, at 512-14. Central venous clotting and infection are common problems. *Id.* Frequent dressing changes and insertion site wound care are required. *Id.* Potential for metabolic complications demands daily monitoring. *Id.* See also Thompson, Madison & Hodges, *The Incidence and Complications of Total Parenteral Nutrition*, 68 NEB. MED. J. 321 (1983).

56. Lynn & Childress, *supra* note 33, at 18.

57. As one ethicist commented, "[i]f withdrawal of IV fluids from a deeply comatose patient is considered equivalent to denying food and water to a conscious patient and thereby 'starving him to death' . . . then we might as well be with Alice in Wonderland, playing crazy croquet with the red queen." Towers, *supra* note 30, at 205.

58. 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

first appellate tribunal to assert that all patients possess a federal constitutional right to privacy that includes a right to refuse life-sustaining treatment.⁵⁹ The court also held that the patient's father, as surrogate decision-maker, could request the withdrawal of Quinlan's respirator.⁶⁰ Subsequently, other cases have recognized a common law right to freedom from nonconsensual invasions of bodily integrity as an alternative basis for the right to refuse treatment.⁶¹

Since then, seven courts have decided cases involving requests for authorization to withhold or withdraw artificial nutrition and hydration. The right to forego artificial sustenance was affirmed in five of these decisions. In 1980, a Delaware chancery court followed the state's supreme court direction to authorize withdrawing a nasogastric tube from a patient rendered comatose in an automobile accident.⁶² In 1983, a California appellate court dismissed criminal charges against two physicians who withdrew IV hydration from a post-operatively brain damaged patient.⁶³ In 1984, a Massachusetts appellate court refused to overturn a lower court determination that a gastrostomy tube should not be placed in a terminally ill patient for whom the burdens of gastrostomy feeding would outweigh any reasonably expected benefit;⁶⁴ and a New York trial court held that a competent, elderly nursing home patient could refuse all means of medical nutrition.⁶⁵ Finally, in 1985, the New Jersey Supreme Court held that a semiconscious, seriously ill nursing home patient had the right to forego artificial feeding under certain circumstances.⁶⁶ The courts in these cases generally equated artificial nutrition and hydration with other forms of

59. 355 A.2d at 663-64.

60. *Id.*

61. See *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417, 424 (1977) (existing law recognizes the interest of the individual in preserving the inviolability of the person); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209, 1223 (1985) (the right to decline medical treatment is embraced within the common law right to self-determination); *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, 272-73, *cert. denied*, 454 U.S. 858 (1981) (common law recognizes right of patient to control personal medical treatment); *In re Colyer*, 99 Wn. 2d 114, 121-22, 660 P.2d 738, 743 (1983) (the common law right to be free from bodily invasion is one basis for the right to forego life-sustaining treatment) (see discussion *infra* notes 84-111, 123-37 and accompanying text).

62. *Severns v. Wilmington Medical Center*, 425 A.2d 156 (Del. Ch. 1980) (following 421 A.2d 1334 (Del. 1980)).

63. *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

64. *In re Hier*, 18 Mass. App. 200, 464 N.E. 2d 959, *appeal denied*, 392 Mass. 1102, 465 N.E. 2d 261 (1984). The lower court later received more medical information and changed its initial determination that a gastrostomy tube should not be implanted. See Annas, *The Care of Mary Hier: When Substituted Judgment Becomes Sleight of Hand*, 14 HASTINGS CENTER REP. 23, 25 (1984).

65. *In re Plaza Health* (N.Y. Sup. Ct., Cty. of Onandaga, Feb. 6, 1984) (copy on file with the *Washington Law Review*).

66. *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).

life-sustaining treatment that patients already possessed the established right to forego.⁶⁷ While acknowledging that the state had interests that might weigh against the patient's right to refuse treatment,⁶⁸ the courts considered the procedures invasive⁶⁹ and the patient's prognosis poor⁷⁰ in

67. *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484, 490 (1983); *Severns v. Wilmington Medical Center*, 425 A.2d 156, 157 (Del. Ch. 1980); *Corbett v. D'Alessandro*, No. 84-5627CA-JRT, slip op. at 2 (Fla. Cir. Ct. Feb. 28, 1985); *Brophy v. New Eng. Sinai Hosp.*, No. 85E0009-G1, slip op. at 13-15 (Mass. P. Ct. Oct., 21, 1985); *In re Heir*, 18 Mass. App. 200, 464 N.E.2d 959, 961-62, *appeal denied*, 392 Mass. 1102, 465 N.E. 2d 261 (1984); *Conroy*, 486 A.2d at 1236; *In re Plaza Health*, slip op. at 3-4 (N.Y. Sup. Ct., Cty. of Onandaga Feb. 6, 1984). Courts have specifically noted that artificial nutrition and hydration are analogous to mechanical ventilators (respirators) in that each treatment replaces a biological function, and neither addresses the patient's underlying condition. *E.g.*, *Barber*, 195 Cal. Rptr. at 490.

Still it has been argued that since nutrition is basic to life, artificial nutrition and hydration is "ordinary," and therefore obligatory care that health care providers have a duty to give. *Cantor*, *supra* note 4, at 552; *Callahan*, *supra* note 10. *See also* Micetich, Steinecker & Thomasma, *Are Intravenous Fluids Morally Required for a Dying Patient?* 143 ARCH. INTERNAL MED. 975 (1983) (some clinicians consider IV fluids ordinary care, as opposed to extraordinary care, and therefore, believe themselves required to provide such care). *But see* Strong, *Can Fluids and Electrolytes be 'Extraordinary' Treatment?*, 7 J. MED. ETHICS 83 (1981) (even if the ordinary/extraordinary distinction is used, "ordinariness" falls along a continuum: any distinction should be made in the context of particular case). When first defined in the literature, ordinary care included all medicines, treatments, and operations which offered the patient a reasonable hope of benefit, and which could be used without excessive pain, expense, or inconvenience to the patient. *Comment*, *supra* note 6, at 650 n.43. According to this scheme, only care that constitutes "extraordinary" care is medical treatment that health care personnel may opt not to provide and patients may opt not to accept. *E.g.*, McCormick, *The Quality of Life, The Sanctity of Life*, 8 HASTINGS CENTER REP. 30, 1978; *Rubin*, *supra* note 8, at 36 & 36 n.95. As originally defined, extraordinary care was treatment that could not be obtained without excessive expense, pain, or other inconvenience, or that if used, would not offer the patient a reasonable hope of benefit. *Comment*, *supra* note 6, at 650 n.43.

Most legal authorities, however, now reject the ordinary/extraordinary care distinction and favor its replacement by a case-by-case evaluation of whether the burdens of a proposed treatment outweigh, or are disproportionate to, its benefits to the patient. *Note*, *supra* note 9, at 379. *See also* *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. at 491. Modern usage of the distinction is confusing: It ignores the benefit component of "ordinary" care, and fails to recognize that individual patient circumstances determine whether care is required or optional. *See id.* PRESIDENT'S COMM'N, *supra* note 1, at 82-90. Moreover, what for one patient is ordinary care, such as mechanical ventilation for a curable patient, may be extraordinary for another. *See generally id.* at 88-89; Micetich, Steinecker & Thomasma, *supra* at 975; Towers, *supra* note 30, at 203-05; Veatch, *supra* note 8, at 433; *Note, I.V. Withdrawal: The Severance of Medicine's or Society's Umbilical Cord?*, 63 NEB. L. REV. 941, 960-91 (1984).

68. *E.g.*, *Conroy*, 486 A.2d at 1223-26. *See* Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 FORDHAM L. REV. 1, 1 (1975). *See also infra* notes 100-10, 170-94 and accompanying text.

69. *E.g.*, *Barber*, 195 Cal. Rptr. at 491 (court's approach to surrogate decisionmaking included a consideration of intrusiveness, but even if the treatment is minimally invasive it need not be provided if the patient's prognosis is hopeless); *In re Plaza Health*, slip op. at 4-5 (N.Y. Sup. Ct., Cty. of Onandaga Feb. 6, 1984) ("I will not, against his wishes, in effect order this 85 or 86 year old person to be operated upon and/or to be force fed in any manner, or to be restrained for the rest of his natural life."). Courts have also noted that artificial sustenance entails significant risk of complications. *Hier*, 464 N.E.2d at 961-62; *Conroy*, 486 A.2d at 1236. *But see* *Brophy v. New England Sinai Hosp.*, No. 85E0009-G1, slip op. at 13-14 (Mass. P. Ct. Oct. 21, 1985) (though the surgical placement of a gastrostomy tube subjects a

concluding that the patient's right to self-determination should prevail.⁷¹

In contrast, a Florida trial court refused to authorize withdrawing a nasogastric tube from a patient in a persistent vegetative state,⁷² despite prior Florida decisions asserting that such patients had a constitutional right to forego mechanical ventilation and antibiotics.⁷³ Similarly, a Massachusetts probate court recently held that a persistently vegetative patient's gastrostomy tube could not be withdrawn at his family's request, even though the judge believed the patient, if competent, would have wanted the tube removed.⁷⁴ The court did not find the patient's gastrostomy tube especially invasive,⁷⁵ nor did it view the patient's persistent vegetative state as a terminal illness.⁷⁶ The court also expressed concern with the patient's potential for experiencing pain as a result of the withholding of fluids.⁷⁷

patient to risks of hemorrhage and infection, once the opening heals, the risk of infection is remote).

70. *E.g.*, *Conroy*, 486 A.2d at 1218–19 (elderly nursing home resident suffering from serious and permanent mental and physical impairments would probably die within one year).

71. *See* *Severns v. Wilmington Medical Center*, 425 A.2d 156, 159 (Del. Ch. 1980) (incompetent patient's privacy right increases as prognosis dims); *Conroy*, 486 A.2d at 1225–27 (incompetent patient retains right to self-determination); *In re Plaza Health* (N.Y. Sup. Ct., Cty. of Onandaga Feb. 6, 1984) (competent patient's right to refuse artificial nutrition prevails).

72. *Corbett v. D'Alessandro*, No. 84-5627CA-JRT (Fla. Cir. Ct. Feb. 28, 1985). The trial court relied on Florida's Life Prolonging Procedure Act which states, in part, that "life-prolonging procedure" shall not include the provision of sustenance, even while recognizing that "[i]t may be that medical procedures to provide sustenance are more similar to other medical procedures than to typical human ways of providing sustenance." *Id.*

73. *John F. Kennedy Hospital. v. Bludworth*, 452 So. 2d 921 (Fla. 1984).

74. *Brophy v. New Eng. Sinai Hosp.*, No. 85E0009-G1 (Mass. P. Ct. Oct. 21, 1985).

75. *Id.*, slip op. at 17–18.

76. *Id.*, slip op. at 41. The *Brophy* court's finding that Mr. Brophy's persistent vegetative state did not constitute a terminal illness is inconsistent with the findings of other courts on this issue, that construe a persistent vegetative state as a terminal illness in that without the application of life-sustaining treatment, the patient will die. *See, e.g.*, *In re Colyer*, 99 Wn. 2d 114, 116–17, 660 P.2d 739, 740 (1983). Compare Uniform Rights of the Terminally Ill Act, § 1 (9) (which uses the term "terminal condition.") Under the Uniform Act, persistent vegetative state qualifies as a terminal condition in that a patient in a persistent vegetative state would die in a "relatively short period" in the absence of life-sustaining treatment. *Id.*

77. *Brophy v. New Eng. Sinai Hosp.*, No. 85E0009-G1, slip op. at 29 (Mass. P. Ct. Oct 21, 1985). The court ignored several considerations in reaching this result. First, foregoing artificial nutrition and hydration will not always cause pain, especially for a comatose or persistent vegetative patient. *Severns v. Wilmington Medical Center*, 425 A.2d 157 (Del. Ch. 1980); *Lynn & Childress, supra* note 33, at 19; *Zerwekh, supra* note 40, at 51. Moreover, the pain and discomfort that may accompany clinical dehydration and malnutrition can be controlled. PRESIDENT'S COMM'N, *supra* note 1, at 19, 278–86. For patients unable to sense hunger and thirst, withholding feeding devices may not result in more pain than the termination of any other medical treatment. *See Lynn & Childress, supra* note 33, at 19, 20. Finally, for many terminally ill patients, the alternative, mechanical administration of nutrients and fluids, will increase discomfort. *Id.* at 19; *Zerwekh, supra* note 40, at 51.

The *Conroy* court also considered the prospect that foregoing artificial sustenance might cause pain. *In re Conroy*, 98 N.J. 321, 486 A.2d 1209, 1217–18, 1232 (1985). However, the court also realized that the pain of a prolonged life with artificial nutrition and hydration may be greater than the pain of a

Thirty-five state legislatures and the District of Columbia also have addressed the right of terminally ill patients to forego life-sustaining treatment.⁷⁸ Some state statutes provide only the means for a competent adult to execute a written directive stating that, in the event he or she becomes terminally ill and incompetent, life-sustaining treatment is to be withheld or withdrawn.⁷⁹ Nine states include additional procedures for

shorter life without. *Id.* at 1232, 1236. The court also noted that dehydration may not be distressing or painful to a dying patient. *Id.* at 1236.

78. Alabama Natural Death Act, Ala. Code §§ 22-8A-1 to -10 (1981); Arizona Medical Treatment Decision Act, 1985 Ariz. Legis. Serv. ch. 199 (West) (to be codified as ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210); Arkansas Death with Dignity, ARK. STAT. ANN. §§ 82-3801 to -3804 (1977); California Natural Death Act, CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West 1976); Colorado Medical Treatment Decision Act, COLO. REV. STAT. §§ 15-18-101 to -113 (*see also* § 12-36-117) (1985); Connecticut Death with Dignity Act, 1985 Conn. Acts 85-606 (Reg. Sess.); Delaware Death with Dignity Act, DEL. CODE ANN. tit. 16, §§ 2501-2509 (1982); District of Columbia Natural Death Act of 1981, D.C. CODE ANN. §§ 6-2421 to -2430 (1982); Florida Life Prolonging Procedure Act, FLA. STAT. ANN. §§ 765.01-.15 (1984); Georgia Living Wills Act, GA. CODE ANN. §§ 31-32-1 to -12 (1984); Idaho Natural Act, IDAHO CODE §§ 39-4501 to -4508 (1977); Illinois Living Will Act, ILL. ANN. STAT. ch. 110 1/2 §§ 701-710 (Smith-Hurd 1984); Indiana Living Wills and Life-Prolonging Procedures Act, IND. CODE ANN. §§ 16-8-11-1 to -22 (Burns 1985); Iowa Life-Sustaining Procedures Act, 1985 Iowa Legis. Serv. 144A.1-144A.11 (West); Kansas Natural Death Act, KAN. STAT. ANN. §§ 65-28,101 to -109 (1980); Louisiana Life-Sustaining Procedures, LA. REV. STAT. 40:1299.58.01 to -.10 (1984); Maine Living Will Act, ME. REV. STAT. ANN. tit. 22, ch. 710a (1985); Maryland Life-Sustaining Procedures Act, MD. HEALTH GENERAL CODE ANN. §§ 5-601 to -614 (1985); Mississippi Act, MISS. CODE ANN. §§ 41-41-101 to -121 (1984); Missouri Death Prolonging Procedures Act, 1985 Mo. Legis. Serv. Senate Bill No. 51 (Vernon); Montana Living Will Act., MONT. CODE ANN. §§ 50-9-101 to -104, § 50-9-111, §§ 50-9-202 to -206 (1985); Nevada Withholding or Withdrawal of Life-Sustaining Procedures, NEV. REV. STAT. §§ 449.540-.690 (1977); New Hampshire Living Wills Act, N.H. REV. STAT. ANN. § 137H:1-16 (1985); New Mexico Right to Die Act, N.M. STAT. ANN. §§ 24-7-1 to -11 (1977); North Carolina Right to Natural Death Act, N.C. GEN. STAT. §§ 90-320 to -322 (1977, amend. 1979, 1981, 1983); Oklahoma Natural Death Act, OKLA. STAT. tit. 63, §§ 3101-3111 (1985); Oregon Rights with Respect to Terminal Illness, OR. REV. STAT. §§ 97.050-.090 (1977, amend. 1983); Tennessee Right to a Natural Death Act, 1985 Pub. Acts ch. 355; Texas Natural Death Act, TEX. STAT. ANN. art. 4590h (Vernon 1977, amend. 1983); Utah Personal Choice and Living Will Act, UTAH CODE ANN. §§ 75-2-1101 to -1118 (1985); Vermont Terminal Care Document, VT. STAT. ANN. tit. 18, §§ 5251-5262 and tit. 13 § 1801 (1982); Virginia Natural Death Act, VA. CODE §§ 54-325.8:1 to -13 (1983); Washington Natural Death Act, WASH. REV. CODE §§ 70.122.010-.905 (1985); West Virginia Natural Death Act, W. VA. CODE. ch. 16, art. 30 §§ 1-10 (1984); Wisconsin Natural Death Act, WIS. STAT. ANN. §§ 154.01-.11 (1984); Wyoming Act, WYO. STAT. §§ 33-26-144 to -152 (1984).

79. Following *Quinlan*, discussed *supra* text accompanying notes 58-60, California enacted the first "living will" legislation. Since then, most other states have passed similar laws. *See supra* note 78. No two are precisely alike. *See* SOCIETY FOR THE RIGHT TO DIE, THE PHYSICIAN AND THE HOPELESSLY ILL PATIENT: LEGAL, MEDICAL AND ETHICAL GUIDELINES 39-41 (1985). In August 1985, the National Conference of Commissioners on Uniform State Laws approved the Commissioner's final draft of the Uniform Rights of the Terminally Ill Act [URTIA]. *See* Minutes, National Conference of Commissioners on Uniform State Laws: Rights of the Terminally Ill Act, Aug. 2-9, 1985, at 384 (copy on file with the *Washington Law Review*).

Some states, such as California, Colorado, and Pennsylvania, also have enacted Durable Power of Attorney for Health Care laws (DPAHC) which permit appointment of an agent for medical decision-making if the appointing person becomes incapacitated. SOCIETY FOR THE RIGHT TO DIE, *supra*, at 43, 46, and 72. The President's Commission recommended that more states adopt DPAHC's because

decisionmaking on behalf of incompetent patients who have not executed a declaration.⁸⁰ Living will statutes in eighteen states explicitly provide for nutrition and hydration.⁸¹ Ten of these living will laws clearly mandate providing artificial nutrition and hydration in all circumstances.⁸² Eight of these statutes may require the provision of artificial sustenance only when needed for patient comfort.⁸³

II. COMMON LAW AND CONSTITUTIONAL BASES FOR THE RIGHT TO FOREGO ARTIFICIAL NUTRITION AND HYDRATION IN WASHINGTON

A. *The Cases*

In two recent decisions, the Washington Supreme Court affirmed the right of all adult persons to make decisions about their own medical care, including the freedom to choose nontreatment when death will result. Absent countervailing state interests, which may outweigh an individual's right to forego treatment in some circumstances, neither opinion suggested that artificial nutrition and hydration is excluded from patient choice.

1. *In re Colyer*

*In re Colyer*⁸⁴ provided the first opportunity for the Washington Supreme Court to affirm that all terminally ill patients have a fundamental right to refuse medical care that merely prolongs their dying.⁸⁵ There, a cardiopulmonary arrest had left sixty-nine year old Bertha Colyer in a persistent vegetative state, her body supported by artificial means.⁸⁶ As his

"[p]roxy directives allow patients to control decisionmaking in a far broader range of cases than the instruction directives authorized by most existing natural death acts." PRESIDENT'S COMM'N, *supra* note 1, at 145. Washington's Durable Power of Attorney law does not, on its face, apply to medical matters. WASH. REV. CODE § 11.94 (1983).

80. Arkansas, Florida, Iowa, Louisiana, New Mexico, North Carolina, Oregon, Utah, and Virginia. For statutory citations, see *supra* note 78.

81. Arizona, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Maine, Maryland, Missouri, New Hampshire, Oklahoma, Oregon, Tennessee, Utah, Wisconsin, and Wyoming. For statutory citations, see *supra* note 78.

82. Colorado, Connecticut, Georgia, Indiana, Maine, Maryland, Missouri, Oklahoma, Oregon, and Wisconsin. For statutory citations see *supra* note 78. For an example, see Wisconsin's Natural Death Act, WIS. STAT. ANN. § 154.01(5)(b): "Life-sustaining procedure" does not include "[t]he provision of fluid maintenance and nutritional support."

83. Arizona, Florida, Illinois, Iowa, New Hampshire, Tennessee, Utah, and Wyoming. For example, see text of Arizona's statute, *supra* note 35. For statutory citations, see *supra* note 78.

84. 99 Wn. 2d 114, 660 P.2d 738 (1983).

85. *Id.* at 118-19, 660 P.2d at 741.

86. *Id.* at 116-17, 660 P.2d at 740.

wife's guardian, Mr. Colyer brought a declaratory judgment action seeking authorization to remove Bertha Colyer's life support systems.⁸⁷ Even though Bertha Colyer's condition precluded her participation in the decision to terminate care and she had never executed a directive under Washington's NDA, her family believed her to be a very independent woman who would have refused medical care had she been able to do so.⁸⁸ Accordingly, despite the personal nature of the right to forego life-sustaining intervention,⁸⁹ the court elected to permit exercise of the right by a surrogate decisionmaker, rather than foreclose its assertion altogether.⁹⁰

The *Colyer* court based its recognition of the right to forego life-sustaining treatment on alternative grounds. First, the court concluded that a federal constitutional right to privacy encompassed the right of terminally ill patients to forego life-sustaining treatment.⁹¹ The court relied on previous decisions in other states⁹² and Justice Douglas' statement in *Doe v. Bolton*⁹³ that privacy included the "freedom to care for one's health and person."⁹⁴ The court then carefully articulated its findings of state action,

87. *Id.*

88. *Id.* at 127, 660 P.2d at 745.

89. The right to privacy and the right to be free from nonconsensual invasions of bodily integrity are individual rights. *See id.* at 124, 660 P.2d at 744. It has been argued that because these rights are attributed to the individual, they are personal and nontransferable, and cannot be exercised by someone else. *See supra* note 8.

90. *Colyer*, 99 Wn. 2d at 124, 660 P.2d at 744, states:

An incompetent's right to refuse treatment should be equal to a competent's right to do so. No court has denied an individual this right because of incompetency to exercise it: '[H]er right of privacy . . . should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice.' (quoting *Quinlan*, 70 N.J. 10, 355 A.2d at 664). 'The recognition of that [privacy] right must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both.' (quoting *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417, 427).

In re Hamlin subsequently modified *Colyer*, eliminating the need for guardianship appointment if family members are available to act for the patient. 102 Wn. 2d 810, 818, 689 P.2d 1372, 1377 (1984). *See infra* notes 112–22 and accompanying text.

91. *Colyer*, 99 Wn. 2d at 119–20, 660 P.2d at 741–42. The *Colyer* court cited the two leading U.S. Supreme Court decisions that established U.S. Constitutional protection for a right of privacy: *Griswold v. Connecticut*, 381 U.S. 479 (1965) (holding that a right of privacy emanates from the penumbra of the specific guarantees of the Bill of Rights which protects the use of contraceptives by married persons); and *Roe v. Wade*, 410 U.S. 113 (1973) (holding that the fourteenth amendment gives rise to the right of privacy which protects a woman's decision whether or not to have an abortion). Other Supreme Court rulings on privacy have also attributed its constitutional source to the fourteenth amendment. *E.g.*, *Paul v. Davis*, 424 U.S. 693 (1976).

92. *E.g.*, *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E. 417, 424 (1977) (unwritten constitutional right of privacy encompasses right of incompetent person to refuse life-sustaining treatment); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, 663, *cert. denied*, 429 U.S. 922 (1976) (Privacy is "broad enough to encompass a patient's decision to decline medical treatment under certain circumstances.").

93. 410 U.S. 179 (1973) (Douglas, J., concurring).

94. *Id.* at 213. *See Colyer*, 99 Wn. 2d at 119–20, 660 P.2d at 742.

as required by the fourteenth amendment,⁹⁵ in (1) the nexus between the state and prohibitions against foregoing life-sustaining treatment in Washington's criminal code as well as its licensing requirements for physicians, (2) the judiciary's participation in the guardianship process, and (3) the state's *parens patriae* responsibility to supervise the affairs of the incompetent.⁹⁶ The court also stated that article 1, section 7 of Washington's state constitution supported a patient's privacy right to refuse treatment.⁹⁷

Second, the *Colyer* court asserted that the common law protection of freedom of choice with respect to medical treatment included the right of all terminally ill patients to forego treatment that only prolonged their dying.⁹⁸ "Freedom of choice," the court noted, derived from the common law right of all persons to be free from nonconsensual invasion of bodily integrity.⁹⁹

The *Colyer* court cautioned, however, that whether founded on the common law or a constitutional right of privacy, the right to refuse treatment was not absolute.¹⁰⁰ Recognizing the state's responsibility to protect the well-being of its citizens,¹⁰¹ the court identified four "state interests:"¹⁰² (1) preserving life, (2) protecting innocent third parties,

95. U.S. CONST. amend. XIV. See *Colyer*, 99 Wn. 2d at 120–21, 660 P.2d at 742, (quoting *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 351 (1974)):

[Privacy], if founded on the federal constitution and applied to the states through the Fourteenth Amendment, extends only to situations where state action exists. . . . The existence of "state action" for constitutional purposes depends on "whether there is a sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself."

96. *Colyer*, 99 Wn. 2d at 121, 660 P.2d at 742.

97. *Id.* at 120, 660 P.2d at 742. The court's one reference to art. 1, § 7 was placed at the end of a discussion dealing with federal constitutional privacy.

98. *Colyer*, 99 Wn. 2d at 121–22, 660 P.2d at 743. Nowhere did the court expressly define "life-sustaining treatment;" however, the court did distinguish between life-saving treatment and treatment that only postponed the moment of death. *Id.* at 127, 660 P.2d at 745.

99. *Id.* at 122, 660 P.2d at 743.

100. *Id.*

101. *Id.*

102. Courts use the term "state interests" in several ways. Here, *Colyer's* use of the term "state interests" is consistent with the pattern of judicial approaches in cases involving the refusal of treatment since the *Quinlan* decision, see, e.g., *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417, 425 (1977). However, the courts may have employed a misnomer. In cases involving the rights of terminally ill patients to forego life-sustaining treatment, the interests the court calls "state interests" do not arise from the need to validate specific state regulations or statutes—as has been the situation in Supreme Court decisions where the Court has weighed an individual's privacy right against the interest of the state in regulating, for example, abortion (*Roe v. Wade*, 410 U.S. 113, (1973) and narcotics traffic (*Whalen v. Roe*, 429 U.S. 589 (1977)). In *Roe v. Wade* the Court stated that an individual's right to privacy is not absolute: "A State may properly assert important interests in safeguarding health, in maintaining medical standards, and in protecting potential life." 410 U.S. at 154. In cases like *Colyer*, what the courts have called "state interests" instead seem to describe *society's* concerns and values that might be compromised by the assertion of an individual's right to forego

(3) preventing suicide, and (4) maintaining the integrity of the medical profession.¹⁰³ These state interests are to be balanced, on a case by case basis,¹⁰⁴ against the patient's right to refuse treatment and the burdens that the treatment would impose.¹⁰⁵

In applying these criteria, the court found that the state's interest in preserving Bertha Colyer's life was outweighed by the degree of bodily invasion occasioned by the treatment required to sustain her life.¹⁰⁶ The court asserted that the state's interest in preserving life diminished when continued treatment served only to sustain a life afflicted with a terminal condition.¹⁰⁷ Next, the court dismissed the state's interest in protecting innocent third parties, since Bertha Colyer had no minor children and her family had agreed that life-sustaining treatment should be withdrawn.¹⁰⁸ The *Colyer* court also dismissed the state's interest in preventing suicide, stating that death following the removal of life-sustaining treatment resulted from natural causes.¹⁰⁹ Finally, the court asserted that the state's

medical care. However, to be consistent with courts and commentators on this issue, this Comment employs the term state interests, though it should be understood the term probably refers to social interests the courts have said the state has a duty to protect.

103. *Colyer*, 99 Wn. 2d at 122, 660 P. 2d at 743.

104. *Colyer* does not expressly state that a patient's right to refuse treatment must be balanced against these state interests in every case. However, the court did review each interest as it pertained to the particular circumstances of Bertha Colyer's case. Also, in concluding its review of countervailing state interests, the court stated: "[T]here were no compelling state interests opposing the removal of life sustaining mechanisms from Bertha Colyer that outweighed her right to refuse such treatment." *Id.* at 123, 660 P. 2d at 743.

105. *Id.* at 122-23, 660 P. 2d at 743; *accord* *Severns v. Wilmington Medical Center*, 425 A.2d 156, 159 (Del. Ch. 1980); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.3d 417, 425-26 (1977); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, 663-64, *cert. denied*, 429 U.S. 922 (1976).

106. *Colyer*, 99 Wn. 2d at 123, 660 P.2d at 743. This position rejects the view that life, whatever its quality, must be preserved at all cost. Many courts, *see supra* notes 62-71 and accompanying text, and ethicists agree. *See, e.g.*, Lynn & Childress, *supra* note 33, at 18; Wanzer, *supra* note 34, at 955-59.

107. *Colyer*, 99 Wn. 2d at 122, 660 P.2d at 743; *accord* *Saikewicz*, 370 N.E.2d at 425; *Quinlan*, 355 A.2d at 664.

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

109. *Id.* at 123, 660 P.2d at 743 ("A death which occurs after the removal of life sustaining systems is from natural causes, neither set in motion nor intended by the patient.").

Courts confronted with cases presenting the issue of foregoing life-sustaining treatment have consistently ruled that suicide is not involved even though death follows the termination of care. *E.g.*, *Saikewicz*, 370 N.E.2d at 426 n.11 ("The interest in protecting against suicide seems to require little if any discussion. . . . What we consider here is a competent, rational decision to refuse treatment when death is inevitable [from the underlying terminal condition] and the treatment offers no hope of cure or preservation of life."); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209, 1226 (1985) (withdrawing patient's artificial means of feeding would not constitute attempted suicide, "as the decision would probably be based on a wish to be free of medical intervention rather than a specific intent to die, and her death would result, if at all, from her underlying medical condition, which included her inability to swallow").

Suicide is no longer a crime in Washington, although promoting a suicide attempt is a class C felony. *See* WASH. REV. CODE § 9A.36.060 (1985). At common law, suicide required the presence of two elements: (1) the individual set in motion a death producing agent with (2) the specific intent of effecting

interest in maintaining the integrity of the medical profession was not at odds with a decision to forego life-sustaining treatment.¹¹⁰ Thus, unless the state can show an overwhelming interest in the protection of innocent third parties,¹¹¹ the court's analysis suggests that state interests, as a matter of law, cannot prevail when the patient asserting the right to forego treatment is terminally ill.

2. In re Hamlin

*In re Hamlin*¹¹² both modified and extended *Colyer*. Forty-two year old Joseph Hamlin, severely retarded since birth, had suffered a cardiopulmonary arrest which left him in a persistent vegetative state.¹¹³ Like Bertha Colyer, Hamlin had never executed an NDA directive. Unlike Bertha Colyer, however, Hamlin had never expressed any wishes regarding medical treatment. The hospital in which he was a patient petitioned the court for termination of his life support systems. In granting the petitioner's request, the court authorized the termination of mechanical ventilation and antibiotics, and the entry of a "no-code" order in Joseph Hamlin's chart.¹¹⁴

Hamlin again affirmed that "[a]n incompetent patient does not lose his right to consent to termination of life supporting care by virtue of his incompetency."¹¹⁵ The court reexamined its position with respect to language in *Colyer* which suggested that a guardian would always have to be appointed for patients who had never been competent.¹¹⁶ The court also

his or her own destruction. See Byrn, *supra* note 68, at 16–24 for an excellent discussion of this issue generally.

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

111. Two situations where third party interests might be considered overwhelming are (1) the patient's family is economically or emotionally unprepared for the patient's death, and (2) the family's religious beliefs mandate medical intervention. However, a family's inability to accept a patient's death should prevail, if at all, only for the period necessary to meet the family's immediate emotional needs. See, e.g., Lynn & Childress, *supra* note 33, at 20–21; Zerwekh, *supra* note 40, at 50–51. A family's economic need to keep a patient alive, for example in order to collect employment benefits, presents a difficult question beyond the scope of this Comment. The issue was addressed, however, by the court in Brophy v. New Eng. Sinai Hosp., No. 85E0009-GI, slip op. at 27 (Mass. P. Ct. Oct. 21, 1985). See generally PRESIDENT'S COMM'N, *supra* note 1, at 95–100; Byrn, *supra* note 68, at 33–34; Cassel, *supra* note 4; Mehlman, *Rationing Expensive Lifesaving Medical Treatments*, 1985 Wis. L. REV. 239.

Modern religious tenets generally do not require that the life of a terminally ill patient be sustained in all circumstances. See the courts' discussions of this issue in *Brophy*, slip op. at 26–27; *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, 658–60, cert. denied, 429 U.S. 922 (1976). See also Supplemental Brief of Respondent, Harborview Medical Center at 25–27, *In re Hamlin*, 102 Wn. 2d 810, 689 P.2d 1372 (1984).

112. 102 Wn. 2d 810, 689 P.2d 1372 (1984).

113. *Id.* at 812–13, 689 P.2d at 1374. See *supra* note 2 for discussion of persistent vegetative state.

114. 102 Wn. 2d at 814, 824, 689 P.2d at 1375, 1380. See *supra* note 7 for an explanation of a "no-code" (DNR) order.

115. 102 Wn. 2d at 816, 689 P.2d at 1376.

116. *Id.* at 817, 689 P.2d at 1376–77.

outlined new procedures for surrogate decisionmaking. In *Colyer*-type situations, where the patient has once been competent and a family member is available to act on the patient's behalf, the decision to forego life-sustaining treatment can be reached only after the patient's attending physician has diagnosed the patient to be in a persistent vegetative state with no reasonable chance of recovery, and life support systems are maintaining the patient's life.¹¹⁷ A prognosis board must unanimously confirm this diagnosis.¹¹⁸ The decision then devolves upon the patient's immediate family, which consults with the attending physician and the prognosis committee. If family members all agree that the patient's best interests would be advanced by withholding or withdrawing life-sustaining treatment, such treatment could be foregone.¹¹⁹ In evaluating the patient's best interests, family members are to consider the patient's previously expressed wishes regarding life-sustaining treatment and his or her general attitude toward medical care.¹²⁰

In *Hamlin*-type situations, where the patient is incompetent and has no available family, a guardian must be appointed to represent the patient's best interests.¹²¹ Then, as in the family situation, if the attending physician, prognosis committee, and the guardian all agree that the incompetent patient's best interests are served by foregoing life-sustaining treatment, the decision can be made to request cessation of such care.¹²²

117. *Id.* at 819, 689 P.2d at 1378.

118. *Id.* at 818-19, 689 P.2d at 1377-78.

119. *Id.* If there is disagreement among the parties involved in the decisionmaking process, court intervention is appropriate. *Id.* at 821, 689 P.2d at 1379.

120. *Id.* at 816-17, 689 P.2d at 1376. *See also Colyer*, 99 Wn. 2d at 131, 660 P.2d at 747.

121. *Hamlin*, 102 Wn. 2d at 819-21, 689 P.2d at 1378.

122. *Id.* The *Hamlin* dissent questioned whether surrogate decisionmakers ought to be free from judicial involvement:

The majority adopts [its] position without exploring the ramifications of its rule or the wisdom of waiving court intervention. . . . First, the majority's decision to circumvent court-appointed guardian proceedings negates the safeguards inherent in the guardian statutes and authorizes, illegally, a person other than the patient to exercise the patient's right to refuse treatment.

Id. at 825, 689 P.2d at 1381 (Rosellini, J., dissenting).

See Comment, *The Right to Die—A Current Look*, 30 LOYOLA L. REV. 139, 177 (1984) (suggesting that the traditional patient/family/physician relationship remains a viable model for decisionmaking responsibility). *But see* Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977) (requiring judicial intervention in every case involving the withholding or withdrawing of life-sustaining treatment from an incompetent patient). *Colyer* explicitly rejected the *Saikewicz* approach. 99 Wn. 2d at 127, 660 P.2d at 745-46. *See generally* Comment, *supra* note 6, at 653-74 (reviewing the divergent approaches of different courts; recommending that, at minimum, courts be involved in appointing a guardian to make the decision).

B. *Analysis: Applying the Principles of Colyer and Hamlin to Artificial Nutrition and Hydration*

In re Colyer and *In re Hamlin* characterized a broad set of principles upon which terminally ill patients or their surrogates may assert a right to forego life-sustaining medical treatment, but neither decision addressed the emotionally sensitive issue of artificial sustenance. Since artificial nutrition and hydration was not in controversy in *Colyer* or *Hamlin*, Washington courts may be asked in the future whether artificial nutrition and hydration are among the treatments patients may refuse. Certainly patients, hospitals, and attorneys will ask the question. The principles set down in *Colyer* and *Hamlin* indicate that a patient's right to forego life-sustaining treatment is not dependent on the specific nature of the intervention. Only when countervailing state interests outweigh a particular patient's right to forego treatment, will that patient's fundamental rights be circumscribed.

1. *The Common Law*

In *Colyer*, the Washington Supreme Court adopted the common law right to bodily integrity as one source for the right of terminally ill patients to forego life-sustaining treatment. The law has long recognized individuals' interests in preserving the inviolability of their persons.¹²³ In 1891, the United States Supreme Court, applying this interest to protect the right of a personal injury plaintiff to refuse a medical examination, stated: "no right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person" ¹²⁴ This common law principle eventually found expression in the judicially created doctrine of informed consent.¹²⁵ Under this doctrine, competent patients who are not terminally ill may refuse surgery or other medical treatment, even though the treatment is necessary to save the

123. See Warren & Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890).

124. *Union Pac. Ry. v. Botsford*, 141 U.S. 250, 251 (1891).

125. See Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632, 1633-34 (1974) (examining the underpinnings of the doctrine of informed consent, beginning with Judge Cardozo's opinion in *Schoendorf v. Society of N. Y. Hosp.*, 211 N. Y. 125, 105 N.E. 92 (1914)). The Note argues that the doctrine of informed consent includes the right to nontreatment. Both Washington's legislature and judiciary concur. See *ZeBarth v. Swedish Hosp. Medical Center*, 81 Wn. 2d 12, 499 P.2d 1 (1972); WASH. REV. CODE §§ 7.70.050(3)(d), -.060(1)(d) (1985).

Informed consent involves three basic prerequisites: (1) the patient must have the capacity to reason and make judgments; (2) the decision must be made voluntarily and without coercion; and (3) the patient must have a clear understanding of the nature of the disease and the prognosis. Wanzer, *supra* note 34, at 957. Additionally, the patient must also understand his or her right to make choices about the type of medical care to be received. *Id.*

patient's life.¹²⁶ Today, most jurisdictions acknowledge that unauthorized medical treatment constitutes assault and battery¹²⁷ or a basis for claiming medical malpractice.¹²⁸

Historically, a right to forego treatment that sustains a dying patient's life was never made explicit in the common law.¹²⁹ Nonetheless this right follows logically from judicial reliance on the common law to uphold the individual's right to refuse treatment, even when the probable outcome is death, and even though the person is not terminally ill.¹³⁰ The informed consent doctrine, however, by definition applies only to competent persons.¹³¹ As in *Hamlin*, many terminally ill patients are incompetent and cannot make informed decisions about their own medical care. Still, underlying the doctrine of informed consent is the general common law right of all persons to physical inviolability.¹³² Just as this right leads to the notion that a medical practitioner cannot decide a course of treatment affecting a person's physical integrity without that person's full understanding and agreement, the right also leads to the notion that a person may be spared physical intrusion of any kind, whatever the medical consequences.

Artificial nutrition and hydration were not directly at issue in *Colyer* or *Hamlin*, but in both cases the court used broad, unqualified language in discussing life-sustaining treatment.¹³³ The court balanced three factors: the invasive nature of the procedure, the prognosis of the patient, and the presence of state interests that might outweigh the patient's right to refuse treatment.¹³⁴

Artificial nutrition and hydration are invasive, in the same way that the *Colyer* and *Hamlin* decisions found mechanical ventilation, antibiotics,

126. See, e.g., *In re Brooks' Estate*, 32 Ill. 2d 361, 205 N.E.2d 435 (1975) (Jehovah's witness may refuse blood transfusion even though death may follow such refusal); *Petition of Nemser*, 51 Misc. 2d 616, 273 N.Y.S. 2d 624 (Sup. Ct. 1966) (eighty year-old suffering from gangrene may refuse surgery); *In re Yetter*, 62 Pa. D. & C. 2d 619 (C.P., Northampton County Ct. 1973) (sixty year-old resident of state nursing home may refuse cancer surgery).

127. E.g., *Physicians' and Dentists' Bureau v. Dray*, 8 Wn. 2d 38, 111 P.2d 568 (1941) (an unauthorized operation constitutes an assault and battery). See also Note, *supra* note 125, at 1635-36.

128. Note, *supra* note 125, at 1635-36. See also WASH. REV. CODE § 7.70.030(3) (1985).

129. This is not surprising given the recent nature of the development of life-sustaining treatment. See PRESIDENT'S COMM'N, *supra* note 1, at 1.

130. E.g., *In re Brooks' Estate*, 32 Ill. 2d 361, 205 N.E. 2d 435. See generally Byrn, *supra* note 68, at 3-16.

131. Wanzer, *supra* note 34, at 955.

132. Note, *supra* note 125, at 1633-34.

133. For example, in *Colyer*, the following language was used: "life support systems," 99 Wn. 2d at 117 and 660 P.2d at 740; "life sustaining mechanisms," *id.* at 123, 660 P.2d at 743; "life sustaining treatment," *id.* at 125, 660 P.2d at 745. In *Hamlin*, similar language was used: "life support systems," 102 Wn. 2d 810, 812, 689 P.2d 1372, 1374; "life sustaining treatment," *id.* at 814, 818, 689 P.2d at 1375, 1377.

134. *Colyer*, 99 Wn. 2d at 122-23, 660 P.2d at 743.

and cardiopulmonary resuscitation to be invasive.¹³⁵ They only postpone inevitable death in the terminally ill. While *Colyer* would require that state interests be balanced against the patient's right to refuse artificial nutrition and hydration, these interests will rarely prevail.¹³⁶ Therefore, by extension of the *Colyer* court's analysis, a terminally ill patient's right to forego artificial nutrition and hydration falls within the area of medical decision-making protected by the common law.¹³⁷

2. Washington's State Constitution

Opponents not only of the right to forego artificial nutrition and hydration, but also of the right to refuse life-sustaining treatment in general, demand that the common law foundation for these rights be overturned. Washington lawmakers, however, should not disregard this state's strong tradition favoring individual autonomy,¹³⁸ especially in light of the subject's constitutional overtones.

A constitutional right to privacy in medical care decisionmaking embodies many of the same values protected by the common law: the sanctity of individual freedom of choice, self-determination, personal autonomy, and human dignity.¹³⁹ The *Colyer* court held that article 1, section 7 of the Washington constitution supported its holding that an incurable, terminally ill adult had a right of privacy that encompassed the right to forego life-sustaining treatment.¹⁴⁰ This provision states: "No person shall be

135. See *supra* notes 36–56, 67 and accompanying text.

136. See *supra* notes 106–11 and accompanying text. See also Byrn, *supra* note 68, at 16–36.

137. Countervailing state interests also can impact a patient's right to refuse treatment when that right is premised on a constitutional right of privacy. See *supra* notes 100–10 and accompanying text. See also *infra* notes 170–93 and accompanying text.

138. See generally Utter, *Freedom and Diversity in a Federal System: Perspectives on State Constitutions and the Washington Declaration of Rights*, 7 U. PUGET SOUND L. REV. 491 (1984).

139. See Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E. 2d 417, 424 (1977) ("Of even broader import [than the common law interest of the individual in being free from non-consensual invasion of his bodily integrity], but arising from the same regard for human dignity and self-determination, is the unwritten constitutional right of privacy. . ."); Cantor, *supra* note 4, at 559 ("Whether a patient's prerogative to spurn life-preserving treatment is grounded on constitutional privacy or on the common-law doctrine of informed consent, the object remains to promote individual dignity by honoring self-determination and choice.").

140. *In re Colyer*, 99 Wn. 2d 114, 120, 660 P.2d 738, 742 (1983). In three other jurisdictions courts have recognized that provisions in their state constitutions protected an individual's right to privacy which included the right to forego medical treatment. See *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220, 225 (1984) (holding that the explicit mention of privacy in California Const. art. 1, sec. 1 protected the right of a terminally ill adult to refuse medical treatment required to sustain that person's life); *In re Caulk*, 125 N.H. 226, 480 A.2d 93, 95 (1980) (recognizing that under New Hampshire's constitution, individuals have a right of privacy that may be asserted to prevent unwanted infringements of bodily integrity); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, 663 (1976) (while the court

disturbed in his private affairs, or his home invaded, without authority of law.”¹⁴¹

Unlike the Bill of Rights of the United States Constitution,¹⁴² article 1, section 7 of Washington’s Declaration of Rights of the state constitution explicitly addresses privacy. Although traditionally Washington courts have associated this constitutional provision with fourth amendment guarantees against unreasonable search and seizure,¹⁴³ constitutional history and textual analysis indicate that the framers of the Washington document sought protection different from that guaranteed by the Bill of Rights.¹⁴⁴ While convention delegates considered the text of the fourth amendment, they chose instead the language “private affairs.”¹⁴⁵ Despite the pre-*Colyer* absence of specific applications of article 1, section 7 to cases not involving search and seizure, state courts have spoken generally of privacy outside

ultimately relied on the U.S. Constitution as the basis for a right of privacy that encompassed an individual’s right to refuse life-sustaining treatment, the court did note that such right of privacy is found in the New Jersey Constitution at art. 1, ¶ 1).

141. WASH. CONST. art. 1, § 7.

142. The Bill of Rights by its terms and necessary implications has been viewed only to limit the freedom of government when dealing with individuals. Glennon & Nowak, *A Functional Analysis of the Fourteenth Amendment “State Action” Requirement*, 1976 SUP. CT. REV. 221.

143. *E.g.*, *State v. Myrick*, 102 Wn. 2d 506, 688 P.2d 151 (1984); *State v. White*, 97 Wn. 2d 92, 640 P. 2d 1061 (1982). *See also*, Comment, *The Origin and Development of Washington’s Independent Exclusionary Rule: Constitutional Right and Constitutionally Compelled Remedy*, 61 WASH. L. REV. 459 (1986).

144. Utter, *supra* note 138, at 496–99. U.S. CONST. amend. IV provides:

The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no Warrants shall issue, but upon probable cause, supported by Oath or affirmation, and particularly describing the place to be searched, and the person or thing to be seized.

The United States Supreme Court has also recognized that state constitutions may be more protective of individual rights than their federal counterparts. *See, e.g.*, *Pruneyard Shopping Center v. Robins*, 447 U.S. 74, 81 (1980); *Oregon v. Hass*, 420 U.S. 714, 719 n.4 (1975). *See also* Utter, *supra* note 138, at 493. With increasing frequency, Washington courts have accepted this challenge, often when applying art. 1, § 7. *See, e.g.*, *State v. Chrisman*, 100 Wn. 2d 814, 676 P.2d 419 (1984) (art. 1, § 7, unlike the fourth amendment, prohibited a police officer’s warrantless entry into the residence of a person he had just arrested for a misdemeanor unless the officer possessed certain facts); *State v. Ringer*, 100 Wn. 2d 686, 674 P. 2d 1240 (1983) (art. 1, § 7 limits warrantless searches incident to arrest to areas within the arrested person’s immediate control). *See generally* Utter, *supra* note 138, at n.4 and accompanying text.

Historically, state courts have not looked to individual rights’ guarantees in their state constitutions. *See* Comment, *supra* note 143. Yet this situation is changing. Recent writings by Justices Utter and Linde of the Washington and Oregon Supreme Courts, respectively, and Justice Brennan of the United States Supreme Court, note an emerging trend among state courts to construe as more protective state constitutional counterparts of Bill of Rights provisions. The justices urge greater reliance on state constitutional provisions in the future. Brennan, *State Constitutions and the Protection of Individual Rights*, 90 HARV. L. REV. 489 (1977); Linde, *First Things First: Rediscovering the State’s Bill of Rights*, 9 U. BALT. L. REV. 379 (1980); Utter, *supra* note 138.

145. *See supra* text accompanying note 141; JOURNAL OF THE WASHINGTON STATE CONSTITUTIONAL CONVENTION: 1889 at 497 (B. Rosenow ed. 1962), *noted in* *State v. White*, 97 Wn. 2d 92, 110, 640 P.2d 1061, 1071 (1982).

the search and seizure context.¹⁴⁶ In a recent holding, the Washington Supreme Court observed that the court should use the common law in force at the time of the constitution's enactment to aid it in construing specific constitutional provisions.¹⁴⁷ When the Washington state Constitutional Convention convened in 1889, the right of the individual "to be let alone" had long been recognized at common law.¹⁴⁸

The Washington Supreme Court, as the final arbiter of the state constitution, and fully aware of the state's common law history, has stated that terminally ill patients in hospitals and nursing homes have a reasonable expectation of privacy under article 1, section 7—privacy that protects their right to refuse treatment that only postpones their death. Further, because assertions of privacy under article 1, section 7 do not require a showing of state action as does an assertion of privacy under the federal constitution,¹⁴⁹ all patients in Washington, not just those in state-owned facilities, are guaranteed their rights to forego life-sustaining treatment. Focusing on the rights to privacy and bodily integrity rather than the fine distinctions between artificial nutrition and hydration and other medical treatments highlights the constitutional irrelevance of those distinctions.¹⁵⁰

146. In *State v. Meacham*, 93 Wn. 2d 735, 612 P.2d 795 (1980), the court discussed a constitutional right to privacy in the context of a challenge to Washington's Uniform Parentage Act on the grounds that the Act's mandatory blood test violated an individual's right to personal privacy. Although the *Meacham* court held that the state's interest in protecting minors prevailed over the challenger's constitutional right to privacy, the court agreed that such a right existed. *Id.* at 737–38, 612 P.2d at 797–98. The court, however, did not indicate whether it was referring to the state or federal constitution. In *Fritz v. Gorton*, 83 Wn. 2d 275, 517 P.2d 911 (1974), the court addressed a political candidate's right to privacy regarding his financial affairs. The court concluded, however, that as long as there was no intrusion upon intimate personal matters, the public's right to know would prevail. *Id.* at 298, 517 P.2d at 923. Again, the court did not associate the right of privacy with any particular constitution.

147. *State v. Ringer*, 100 Wn. 2d 686, 674 P.2d 1240 (1983); Note, *New Limits on Police Vehicle Searches in Washington*, 60 WASH. L. REV. 177, 179 (1984). The *Ringer* court construed WASH. CONST. art. 27, § 2, which provides that "[a]ll laws now in force in the Territory of Washington, which are not repugnant to this Constitution, shall remain in force until they expire by their own limitation," as adopting the then current common law. *Ringer*, 100 Wn. 2d at 690–91, 694 P.2d at 1293.

148. See generally Comment, *The Right to Privacy in Nineteenth Century America*, 94 HARV. L. REV. 1892 (1981); Warren & Brandeis, *supra* note 123.

149. In *Alderwood Assoc. v. Washington Envtl. Council*, 96 Wn. 2d 230, 635 P.2d 108 (1981), the Washington Supreme Court held that in contrast to the first amendment of the U.S. Constitution, See *supra* note 95. Washington's art. 1, § 5 protected the exercise of free speech rights even in the absence of state action. The court in *Colyer* also implied that if privacy is founded on the state constitution, a showing of state action is not required. On its face, the language of art. 1, § 7 does not require state action.

150. See G. ANNAS & L. GLANZ, WITHHOLDING AND WITHDRAWING OF LIFE-SUSTAINING TREATMENTS FOR ELDERLY INCOMPETENT PATIENTS: A REVIEW OF COURT DECISIONS AND LEGISLATIVE APPROACHES, PREPARED FOR THE OFFICE OF TECHNOLOGY ASSESSMENT: CONGRESS OF THE UNITED STATES 5 (Dec. 24, 1985) which stated:

We think it is especially important to note that we do not distinguish between various forms of medical treatment on the basis of their utility, side effects, number of moving parts, novelty,

If the Washington Supreme Court were to review the constitutionality of a statute purporting to limit a patient's right to refuse artificial nutrition and hydration, the court, interpreting such a statute in light of article 1, section 7, would be compelled to strike down the statute. Similarly, were a court asked to enjoin a hospital or nursing home from force-feeding a patient, the court would grant the injunction because the right to forego artificial nutrition and hydration is protected by Washington's constitution. Both *Colyer* and *Hamlin* held that article 1, section 7 supports the privacy right of terminally ill adults to forego invasive medical care that merely prolongs their dying.

3. *The Federal Constitution*

Colyer relied heavily upon a federal constitutional right of privacy as one source for the right of terminally ill patients to forego life-sustaining treatment.¹⁵¹ Courts of New Jersey,¹⁵² Massachusetts,¹⁵³ Delaware,¹⁵⁴ Florida,¹⁵⁵ and Ohio¹⁵⁶ also have asserted that a right to privacy under the United States Constitution secures to the individual "independence in making certain kinds of important decisions"¹⁵⁷ free from government interference,¹⁵⁸ which includes medical decisions even though the outcome may be death.

Privacy, however, is not a right enumerated in the federal constitution.¹⁵⁹ While the Supreme Court has recognized a right of privacy in the context of marriage, procreation, contraception, abortion, and family relationships,¹⁶⁰ the Court has not considered whether this right protects a

expense or on other grounds. Such a distinctions [sic] tend to . . . detract from focusing on the individual patient, and his rights and welfare.

See also Seattle Times, Jan. 8, 1986, at 8, col. 1 (guidelines recently approved by Los Angeles medical and legal associations acknowledged that artificial nutrition and hydration are legally equivalent to other forms of life-sustaining treatments patients have a right to forego).

151. *See In re Colyer*, 99 Wn. 2d 114, 119-21, 660 P.2d 740, 741-42 (1983).

152. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976); *accord In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).

153. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *accord In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980); *In re Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978).

154. *Severns v. Wilmington Medical Center*, 421 A.2d 1334 (Del. Ch. 1980).

155. *Satz v. Permuter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd* 379 So. 2d 359 (Fla. 1980); *accord John F. Kennedy Hosp. v. Bludworth*, 452 So. 2d 921 (Fla. 1984).

156. *Leach v. Akron Medical Center*, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980).

157. *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977).

158. *Huff, Thinking Clearly About Privacy*, 55 WASH. L. REV. 777, 785-93 (1980).

159. *See, e.g., Griswold v. Connecticut*, 381 U.S. 479 (1965); *see also Utter, supra* note 138, at 495.

160. *E.g., Whalen v. Roe*, 429 U.S. 589 (1977) (restriction on government's ability to collect data

terminally ill patient's decision to forego life-sustaining treatment. The Supreme Court has refused to extend privacy to decisionmaking in some seemingly personal matters, such as homosexual conduct.¹⁶¹ Since terminal illness is a medical matter as is pregnancy, a greater similarity appears between a patient's right to refuse intrusive medical care and a woman's protected right to abortion than between unrecognized rights to sexual freedom and rights to nontreatment. Still, the Supreme Court has never addressed the issue of extending the privacy concept to a patient's decision about life-sustaining treatment.

Basing the right of foregoing life-sustaining treatment on a federal constitutional right of privacy, however, presents a limitation. The fourteenth amendment requires finding a basis for state action.¹⁶² While most courts applying a federally based privacy right to decisions involving foregoing medical treatment have not addressed the issue, Washington expressly confronted the problem in *Colyer*.¹⁶³ The *Colyer* court found state action in the combined presence of the state's ability to impose criminal sanctions on the hospital and its staff, the licensing of physicians, the required involvement of the judiciary in the process of guardianship appointment, and the state's *parens patriae*¹⁶⁴ responsibility to supervise the affairs of incompetents.

The four grounds relied upon by the court, however, may not always be present together, and the court did not indicate whether any one or another combination of factors would be sufficient. First, *Colyer* itself eliminated the threat of criminal sanctions, since it held that good faith compliance

concerning individual citizens); *Roe v. Wade*, 410 U.S. 113 (1973) (woman's decision whether or not to have an abortion); *accord* *Doe v. Bolton*, 410 U.S. 179 (1973); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (unmarried persons' use of contraceptives); *Stanley v. Georgia*, 394 U.S. 557 (1969) (possession of obscene materials in the home); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (married persons' use of contraceptives). See generally J. NOWAK, R. ROTUNDA & J. YOUNG, CONSTITUTIONAL LAW 734-65 (2d ed. 1984). But see *Enslin v. Bean*, 436 U.S. 912 (1978) (Court refused to review sodomy conviction of an adult who had engaged in private, consensual homosexual act with another adult).

161. *Enslin*, 436 U.S. 912 (homosexual conduct between two consenting adults); *Whalen v. Roe*, 429 U.S. 589 (1977) (the Court recognized that privacy places some restriction on the government's ability to collect data about individual citizens, however, the Court upheld state law requiring physicians and pharmacies to forward to state authorities copies of narcotics prescriptions); *Lovisi v. Slaton*, 363 F. Supp. 620 (E.D. Va. 1973), *aff'd*, 539 F.2d 349 (4th Cir.), *cert. denied*, *Lovisi v. Zahradnick*, 429 U.S. 977 (1976) (heterosexual conduct when third persons are watching or participating).

162. See *supra* note 142.

163. *In re Colyer*, 99 Wn. 2d 114, 660 P.2d 738 (1983). "This privacy right [to forego life-sustaining treatment], if founded on the federal constitution and applied to the states through the Fourteenth Amendment, extends only to situations where state action exists." *Id.* at 120-21, 660 P.2d at 742 (emphasis added).

164. *Parens patriae* refers to the state's authority, exerciseable through its courts, to protect individuals who cannot adequately defend their own interests. PRESIDENT'S COMM'N, *supra* note 1, at 39.

with a proscribed decisionmaking procedure would not be criminal.¹⁶⁵ Second, the later opinion, *Hamlin*, removed routine participation of the Washington judiciary in foregoing treatment decisions, since competent patients may always exercise their own choices free of court involvement, and a guardian need not be appointed for an incompetent patient if a family member can intervene on the patient's behalf.¹⁶⁶ Third, since *Hamlin* indicated that the court need not be involved in routine decisions for incompetent patients in the absence of disagreement among family members and health care personnel,¹⁶⁷ the state's *parens patriae* authority would not be invoked. Finally, though the state's regulation and licensing of health care facilities and personnel remain candidates for finding state action, it is unclear whether these factors alone are sufficient.¹⁶⁸ Thus a patient's opportunity to exercise a federal constitutional privacy right may be limited to situations where state action could otherwise be found, such as residence in a state-owned health care facility.¹⁶⁹

4. State Interests

Colyer held that a patient's right to forego life-sustaining treatment is not absolute, but must be balanced against four countervailing state interests: (1) the preservation of life; (2) the prevention of suicide; (3) maintaining the integrity of the medical profession, and (4) the protection of third party interests.¹⁷⁰ While language in *Colyer* implies that these interests must be weighed against the patient's decision to forego treatment on a case by case basis,¹⁷¹ the court's evaluation of these interests, as applied to Bertha

165. *Colyer*, 99 Wn. 2d at 138, 660 P.2d at 751.

166. *In re Hamlin*, 102 Wn. 2d 810, 818-19, 689 P.2d 1372, 1337 (1984).

167. *Id.* at 820-21, 689 P.2d at 1378.

168. For example, see *Blum v. Yaretsky*, 457 U.S. 991 (1982). In *Blum*, nursing home patients attempted unsuccessfully to argue that private operation of a nursing home involved a symbiotic relationship between the state and the home, based on heavy state subsidies, licensing of the facilities, and government-paid medical expenses. The Court, however, held that despite the extensive state regulation to which the nursing home was subject, that alone was not enough to constitute state action. See also *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345 (1974) (holding that the extensive licensing and regulation of a public utility did not involve sufficient state action to subject the utility to constitutional restraint). See generally J. NOWAK, R. ROTUNDA & J. YOUNG, *supra* note 160, at 514-16.

169. Actions of any governmental entity give rise to state action for the purposes of constitutional limitations. J. NOWAK, R. ROTUNDA & J. YOUNG, *supra* note 160, at 498. Compare *Cantor*, *supra* note 4, at 547. *Cantor* notes that there are advantages to viewing a patient's right to forego treatment as grounded on the common law as opposed to the federal constitution: the patients do not have to worry about establishing state action because their claims are as enforceable against a private hospital or practitioner as they are against a government-sponsored institution subject to the fourteenth amendment.

170. See *supra* notes 100-10 and accompanying text.

171. See *supra* note 104 and accompanying text.

Colyer, suggests that state interests will rarely prevail when the patient is incurably, terminally ill and the treatment in question serves only to postpone death.¹⁷² Although artificial nutrition and hydration treatments were not before the *Colyer* court, a review of state interests with regard to artificial sustenance does not support a contrary result.

Most courts, including *Colyer*, have determined that the preservation of life is the most significant state interest.¹⁷³ The sanctity of life is a fundamental value in our society, and the state's responsibility to its citizens includes protecting their health and welfare. The Washington Supreme Court in *Colyer* recognized, however, that the state's interest in preserving life and protecting individual welfare does not require that all lives be sustained in all circumstances.¹⁷⁴ The state cannot insist on preserving patients' health against their wishes. Society values, to a greater extent, the right of individual choice.¹⁷⁵

The *Colyer* court asserted that where the treatment merely prolongs the dying process, the balancing of the state's interest in preserving life against the patient's right to refuse treatment should include an evaluation of treatment invasiveness.¹⁷⁶ Artificial nutrition and hydration present such a context: the treatments cannot treat or cure a terminal condition; artificial sustenance can only prolong the dying process. Each method of artificial nutrition and hydration is physically and emotionally invasive.¹⁷⁷ A patient bound by physical restraints to prevent dislodging the tube or needle would lose any remaining personal freedom and dignity. In cases of terminal illness, the state's interest is merely in preserving life for a limited time, not in preserving a productive, satisfying life that would otherwise be lost.

The state's interest in preventing suicide has also led occasionally to court-ordered medical treatment, including, in some jurisdictions, court-

172. See *supra* note 104.

173. *Colyer*, 99 Wn. 2d at 122, 660 P.2d at 743. See also *In re* President & Directors of Georgetown College, 331 F.2d 1000 (D.C. Cir.) (treatment compelled on basis of state's interest in preserving life where patient had good chance of recovery), *cert. denied*, 377 U.S. 978 (1964); Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417, 425 (1977).

174. *Colyer*, 99 Wn. 2d at 122, 660 P.2d at 743 (1983).

175. See Cantor, *supra* note 4, at 556. For example, the state cannot stop people from smoking, mandate low cholesterol diets, or require everyone to get 20 minutes of exercise a day in order to preserve health.

176. *Colyer*, 99 Wn. 2d at 122, 660 P.2d at 743 (1983).

177. *In re* Conroy, 98 N.J. 321, 486 A.2d 1209, 1247-50 (1985) (Handler, J., concurring in part and dissenting in part). Cantor, *supra* note 4, states:

[P]atients care about and may suffer embarrassment and frustration from diminished intellectual functioning, frustration and helplessness from being dependent on others for every aspect of bodily functioning, humiliation from being viewed in a grossly debilitated state, rage at being physically restrained from removing life-sustaining equipment, or emotional pain from sensing a burden upon surrounding loved ones.

Id. at 565-66.

ordered artificial nutrition and hydration. Generally, these cases of forced feeding involved nonterminal persons who were healthy except for their self-imposed starvation.¹⁷⁸ Where a patient is terminally ill, Washington's legislature and its judiciary have stated that death following the withholding or withdrawing of life-sustaining treatment is not attributable to the act or omission of foregoing medical care.¹⁷⁹ Death is said to result from the patient's underlying terminal condition.¹⁸⁰ Preventing suicide, therefore, would not be a consideration weighing against a terminally ill patient's decision to forego artificial sustenance.

Next, the *Colyer* court concluded that the state's interest in maintaining the integrity of the medical profession is not compromised when terminally ill patients choose to forego life-sustaining treatment.¹⁸¹ This result should not be affected when the treatment is artificial nutrition and hydration. Current medical ethics and practice do not obligate health care practitioners to provide futile care,¹⁸² and there is widespread consensus that where the burdens of a particular treatment, including artificial nutrition and hydration, outweigh the benefits, the patient may be better served by not being provided such care.¹⁸³ Where the court, the legislature, the patient, or the family support the determination to withhold or withdraw treatment, the medical profession's integrity should remain intact.¹⁸⁴

178. See, e.g., *Elizabeth Bouvia v. Riverside Hosp.*, No. 159780 (Super. Ct. Riverside filed Dec. 16, 1983), cited in L.A. Daily J., Dec. 23, 1983, at 14, col. 5. Ms. Bouvia suffered from cerebral palsy, a nonprogressive, nonterminal muscular disorder which left her quadriplegic. Note, *Suicide, Euthanasia, Murder: The Line Blurs*, *supra* note 30, at 413 n.4. She had checked herself into the hospital where she requested the court to enjoin the hospital from force-feeding her. Cox, *Disabled Woman's Request to Die Raises Legal Furor*, L.A. Daily J., Dec. 8, 1983, at 1, col. 6. The court refused to grant Ms. Bouvia's request.

See also *In re Caulk*, 125 N.H. 226, 480 A.2d 93 (1984), where the New Hampshire Supreme Court refused to permit a prison inmate to intentionally starve himself to death. The court held that since the prisoner was not facing death from illness, but rather was setting in motion the death-producing agent, the state's interest in preserving its criminal justice system and in preserving life would prevail to compel artificial nutrition and hydration. *Id.* at 96-97.

179. *Colyer*, 99 Wn. 2d at 123, 660 P.2d at 743; WASH. REV. CODE § 70.122.050.

180. See *supra* note 109 and accompanying text; *infra* note 200 and accompanying text; see also Cantor, *supra* note 4, at 549. Society's anti-suicide policy is directed principally at preventing disturbed individuals from rashly destroying themselves, a policy having little relevance to patients faced with an inevitable dying process. *Id.*

181. *Supra* note 110 and accompanying text.

182. Lynn & Childress, *supra* note 33, at 18-21.

183. See *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484, 491 (1983); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209, 1236 (1985); PRESIDENT'S COMM'N, *supra* note 1, at 90; Lynn & Childress, *supra* note 33, at 18-19; Wanzer, *supra* note 34, at 958-59. Compare Callahan, *supra* note 10 (despite the moral licitness of discontinuing feeding under some circumstances, there are worthy emotions that may be repelled by the idea of starving someone to death, even in those cases where it might be for the patient's own good).

184. Amundsen, *The Physicians' Obligation to Prolong Life: A Medical Duty without Classical Roots*, 8 HASTINGS CENTER REP. 23, 27 (1978) (contrary to popular belief, the Hippocratic Oath

Some authorities argue, however, that administering artificial nutrition and hydration fulfills the need of health practitioners to actively intervene in patient care and to postpone death.¹⁸⁵ But health practitioners can positively promote a terminally ill patient's welfare in other ways than by managing artificial nutrition and hydration.¹⁸⁶ The personal values of health professionals who are morally offended by decisions to forego artificial sustenance should not interfere with the right of patients or their surrogates to make these decisions when prevailing medical ethics do not demand that life be prolonged in all circumstances.¹⁸⁷

In some instances, the state's interest in protecting third parties, particularly other family members, has prevailed to require medical intervention. When treatment has been compelled on this basis, typically the patient was not terminally ill,¹⁸⁸ the patient had dependent children,¹⁸⁹ the treatment was expected to restore the patient's health,¹⁹⁰ or the treatment was not

contains no duty to prolong a life inflicted with a terminal condition); Byrn, *supra* note 68, at 29–33 (while neither the doctor nor the hospital is required to undertake a course of treatment contrary to good medical judgment, “[t]he rule of the supremacy of the ‘doctor’s conscience’ finds no real support in law”); Wanzer, *supra* note 34, at 958 (equating a patient’s appropriate level of medical care should vary with the patient’s condition and prognosis).

185. See Micetich, Steinecker & Thomasma, *supra* note 67, at 975, 977; Wanzer, *supra* note 34, at 956. *But see* the recently announced opinion of the American Medical Association’s Council on Ethical and Judicial Affairs which states, “[t]he social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the choice of the patient, or his family or legal representative if the patient is incompetent to act in his own behalf, should prevail.” Memorandum from the American Medical Ass’n to FEDNET (Mar. 17, 1986) (discussing life-prolonging treatment) (copy on file with the *Washington Law Review*).

186. Withholding life-sustaining treatment does not mean withholding care. “Supportive care should be appropriately ‘aggressive,’ with adequate pain control, attention to bladder and bowel function, discontinuance of ‘routine’ tests, unlimited visiting hours, opportunities to talk or be silent, and assistance in arranging personal affairs.” Lo & Jonsen, *Clinical Decisions to Limit Treatment*, 93 ANNALS INTERNAL MED. 764, 767 (1980). *See also* PRESIDENT’S COMM’N, *supra* note 1, at 89–90; Wanzer, *supra* note 34, at 958–59.

187. Byrn, *supra* note 68, at 29–33. *See also* Lynn & Childress, *supra* note 33, at 20 (withholding or withdrawing artificial sustenance may even be morally obligatory when a patient has made it clear such intervention is unwanted).

188. *E.g.*, *Commissioner of Correction v. Myers*, 379 Mass. 255, 399 N.E.2d 452 (1979) (court ordered hemodialysis of prison inmate, who, though he depended on the treatment to cleanse his blood, was not terminally ill; court was concerned with the state’s interest in upholding orderly prison administration).

189. *E.g.*, *In re President & Directors of Georgetown College*, 331 F.2d 1000 (D.C. Cir.) (court ordered a life-saving blood transfusion for mother of seven month old child after mother refused, on religious grounds, in face of life-threatening ruptured ulcer), *cert. denied*, 377 U.S. 978 (1964). *Compare In re Osborne*, 294 A.2d 372 (D.C. 1972) (court refused to order transfusion for father of two children); *In re Brooks’ Estate*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965) (court refused to order transfusion for mother of adult children when mother refused blood transfusion necessary to treat peptic ulcer).

190. *E.g.*, *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965) (blood transfusion ordered for patient with bleeding ulcer from which he was expected to recover); *Georgetown College*, 331 F.2d 1000. *But see In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 644, 38 N.Y.S.2d 266 (1981) (court ordered blood transfusion for terminally ill, profoundly retarded cancer patient).

especially invasive.¹⁹¹ Conversely, in decisions involving artificial nutrition and hydration and the terminally ill, the restoration of health is not a factor. Though the state's interest in protecting the spiritual and material well-being of dependent children might have significance if the parent could recover, little benefit accrues to children whose terminally ill parent is artificially maintained by feeding tubes and hydration lines in a health care institution. Indeed, the emotional and financial burdens imposed by court-ordered medical treatment may harm a child's interest.¹⁹²

Countervailing state interests do not mandate the provision of artificial nutrition and hydration to all terminally ill patients. Good medical practice and humanitarian concerns, as well as the principles of *Colyer*, require a case by case consideration of the best interests and rights of the individual.¹⁹³ While a court must weigh state interests against a terminally ill patient's fundamental right to refuse treatment, in practice, these interests will rarely generate an outcome contrary to a patient's or surrogate's choice. Society's notions of human dignity and respect for the individual are too fundamental. The question that should be weighed on a case by case basis is the value of the treatment to the patients themselves.¹⁹⁴

III. STATUTORY BASIS FOR FOREGOING ARTIFICIAL NUTRITION AND HYDRATION: WASHINGTON'S NATURAL DEATH ACT

A. *The Act*

In 1979, finding that modern medical technology had made possible the artificial prolongation of life beyond natural limits, and understanding that many people are incompetent at the time of terminal illness and cannot make decisions about their medical care,¹⁹⁵ Washington's legislature enacted the Natural Death Act (NDA).¹⁹⁶ This Act specifically addresses the right of terminally ill patients to refuse life-sustaining treatment.¹⁹⁷ It

191. *E.g.*, *State v. Meacham*, 93 Wn. 2d 735, 738, 612 P.2d 795, 797 (1980) (on grounds of promoting minor child's interest, court upheld statutorily required blood test for purpose of determining child's paternity since pain inflicted by blood withdrawal is inconsequential and "any hazard to health is virtually nonexistent").

192. *See Cantor, A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity vs. the Preservation of Life*, 26 RUTGERS L. REV. 228, 251-54 (1973).

193. *See In re Hamlin*, 102 Wn. 2d 810, 815, 689 P.2d 1372, 1375 (1984); *Cantor, supra* note 4, at 570-76.

194. *See infra* notes 220-34 and accompanying text.

195. WASH. REV. CODE § 70.122.010 (1985).

196. *Id.* §§ 70.122.010-.905.

197. *Id.* §§ 70.122.030, -.060. The term "procedures" rather than "treatment" is used in the NDA. The difference in meaning is not significant and the terms are frequently used interchangeably. *See supra* note 133. Senate Bill 3228 would amend Washington's NDA to change "procedures" to

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authorizes health care practitioners to withhold and withdraw life-sustaining procedures from an incompetent, terminally ill patient,¹⁹⁸ if that patient had, when competent, executed a written directive to that effect.¹⁹⁹ The NDA defines a "life-sustaining procedure" as "any medical or surgical

"treatment." See *supra* note 17.

198. The NDA only applies to patients in a "terminal condition." WASH. REV. CODE §§ 70.122.020-.905 (1985). "Terminal condition" is defined as an "incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serve only to postpone the moment of death of the patient." *Id.* § 70.122.020(7) (emphasis added). The emphasized language is problematic. See, e.g., Uniform Commissioners' Comments to § 1 of the Uniform Rights of the Terminally Ill Act ("Strictly speaking, if death is 'imminent' even with the full application of life-sustaining treatment, there is little point in having a statute permitting withdrawal of such procedures.").

199. WASH. REV. CODE § 70.122.030 (1985) provides that a patient's written directive, commonly called a living will, shall be signed by the declarer in the presence of two disinterested witnesses who know the declarer and who believe the declarer to be "of sound mind." Living wills have not been tested in Washington courts, and some health care institutions refuse to honor them. (Telephone conversation with Yong O. Hall, State Long Term Care Ombudsman, Department of Social & Health Services, Jan. 24, 1986.) Still, language in *Colyer* suggests their enforceability. See *In re Colyer*, 99 Wn. 2d 114, 118, 660 P.2d 738, 741 (1983) ("When [an NDA] directive has been signed, the course is set: the directive is to be effectuated in good faith . . . and no civil or criminal liability attaches."). However, Washington's NDA contains no provisions concerning a health care provider's liability for refusing to effectuate a patient's directive. Some other states' living will statutes do mandate penalties for a health practitioner's failure to comply. See, e.g., COLO. REV. STAT. §§ 12-36-107(3)(b) and 12-36-117(1)(s) (providing that a physician's refusal to comply with a patient's declaration constitutes "unprofessional conduct" for which his or her license to practice medicine may be revoked).

WASH. REV. CODE § 70.122.030(1) (1985) provides in relevant part:

The directive shall be essentially in the following form, but in addition may include other specific directions:

DIRECTIVE TO PHYSICIANS

Directive made this _____ day of _____ (month, year).

I _____, being of sound mind, wilfully, and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

(a) If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

(b) In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences from such refusal.

(c) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

(d) I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

Signed _____

City, County, and State of Residence

The declarer has been personally known to me and I believe him or her to be of sound mind.

Witness _____

Witness _____

procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which . . . prolong[s] the moment of death."²⁰⁰ The Act explicitly excludes medication and procedures to alleviate pain, but it prohibits no other specific medical intervention.²⁰¹ The NDA also provides that health care practitioners' good faith compliance with a properly executed directive will preclude civil and criminal liability for the resulting death.²⁰² Additionally, the patient's cause of death is to be attributed to his or her underlying terminal condition.²⁰³

B. Analysis: The Applicability of the NDA to Artificial Nutrition and Hydration

Washington's NDA protects the right of a terminally ill patient, who has properly executed a written directive, to forego artificial nutrition and hydration. By the plain language of the statutory definition of life-sustaining procedures, the Act does not exclude methods of artificial nutrition and hydration when these measures serve only to postpone the moment of death.²⁰⁴ Hydration lines and feeding tubes supplant the vital function of voluntary ingestion absent in some terminally ill patients,²⁰⁵ and they do not treat or cure the patient's underlying terminal condition. Artificial nutrition and hydration are also not among the procedures the NDA explicitly excludes.²⁰⁶ Thus the text of the NDA on its face and by its own definitions permits the withholding and withdrawing of artificial nutrition and hydration from a terminally ill patient who has directed the foregoing of life-sustaining procedures, at least if such intervention is not needed to mitigate pain.²⁰⁷

200. WASH. REV. CODE § 70.122.020(4) (1985).

201. *Id.* § 70.122.020(4).

202. *Id.* § 70.122.050.

203. *Id.* § 70.122.080.

204. Under Washington law, words are to be given their plain, ordinary meaning; if the language used in a statute is unambiguous, departure from its plain meaning is not justified by policy considerations. *State ex rel. Edwards v. Heimann*, 633 F.2d 886 (9th Cir. 1980).

205. *See Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484, 490 (1983); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209, 1236 (1985).

206. The maxim *expressio inius est exclusio alterius* provides that the enumeration of exclusions from the operation of a statute indicates that the statute should apply to all cases not explicitly excluded. 2A J. SUTHERLAND, STATUTES AND STATUTORY CONSTRUCTION § 47.23 (Sands 4th ed. 1984). Thus, the NDA's specific mention of one exception to what constitutes a life-sustaining procedure creates the inference that all other forms of medical intervention can be included.

207. Because the NDA states that procedures necessary for the alleviation of pain are not life-sustaining procedures, one could argue that if artificial nutrition and hydration are needed for patient comfort, they cannot be withheld or withdrawn. Some states' natural death acts specifically address this contingency. *See supra* note 83 and accompanying text. The Uniform Rights of the Terminally Ill Act § 5(c) provides that "[t]his [Act] does not affect the responsibility of the attending physician or other

Though the legislature originally may not have considered the particular application of the statute to artificial nutrition and hydration, this does not preclude coverage of those procedures.²⁰⁸ Since the legislature cannot specifically address every circumstance under an act such as the NDA, the statute's stated purpose serves as an important guide to new questions.²⁰⁹ The NDA's purpose was to recognize the common law right of adult persons to make decisions regarding the use of modern medical technology that prolongs life beyond its natural limits,²¹⁰ and the right of individuals to maintain personal dignity and avoid unnecessary pain and suffering.²¹¹ Construing the Act's coverage to include artificial nutrition and hydration is consistent with this recognition.²¹²

Additionally, the legislature stated that patients have a right to privacy,²¹³ which is consistent with the state constitution's privacy provision.²¹⁴ To the extent that a terminally ill patient's right to forego artificial nutrition and hydration is encompassed by these rights, it will be covered by the statute.²¹⁵ Considering the fundamental rights to forego medical treatment identified by the supreme court in *Colyer* and *Hamlin*, the legislature should not amend the NDA to foreclose its use as a means to refuse artificial nutrition and hydration.

C. Problems and Solutions

Some patients executing the standard NDA directive may not have thought of the artificial provision of fluids and nutrients as life-sustaining procedures. Uncertainty about a patient's intent regarding artificial nutrition and hydration can be alleviated by encouraging individuals to specifically address this in their directives.²¹⁶ Patient variability mandates that decisions to forego life-sustaining procedures, even when authorized by a

health-care provider to provide treatment, including nutrition and hydration, for comfort care or the alleviation of pain."

208. J. SUTHERLAND, *supra* note 206, at § 45.09.

209. *Id.*

210. WASH. REV. CODE § 70.122.010 (1985).

211. *Id.*

212. *Id.* But see PRESIDENT'S COMM'N, *supra* note 1, at 145 ("[I]t is hard to place great reliance on preexisting common law rights, since had the common law established such rights there would have been no real need for the statutes.").

213. WASH. REV. CODE § 70.122.010 (1985).

214. See *supra* note 141 and accompanying text.

215. Statutes will be presumed constitutional. J. SUTHERLAND, *supra* note 206, at § 45.11. Even when a statute is subject to various interpretations, courts will adopt the construction consistent with legislative purpose. *Id.*

216. The NDA contains only *suggested* language for a patient's directive. See *supra* note 199. A person's ability to modify the NDA's suggested language was affirmed by the Washington Supreme Court in *DiNino v. State*, 102 Wn. 2d 327, 684 P.2d 1297 (1984).

standard NDA directive, be made in consideration of a patient's individual circumstances.²¹⁷ In the absence of special direction, health care providers charged with effectuating a patient's general directive first should determine whether specific evidence indicating a patient's decision to accept artificial sustenance exists elsewhere.²¹⁸ Where specific reference to feeding tubes and hydration lines cannot be found, the patient's general attitude regarding life-sustaining treatment, demonstrable from standard NDA language,²¹⁹ is evidence that the patient intended that artificial nutrition and hydration should be withheld or withdrawn.

Despite the uncertainty caused by the NDA's omission of artificial nutrition and hydration from the statutory definition of "life-sustaining procedures," the legislature should not amend the definition to specifically deal with artificial sustenance. Express inclusion of these procedures might raise questions about other treatments.²²⁰ Additionally, a complete statutory enumeration of life-sustaining procedures could not keep pace with changes in medical technology.

Washington's NDA permits competent patients to consent to future nontreatment by allowing such persons to execute a legally effective written directive that authorizes the foregoing of life-sustaining treatment in the event of terminal illness or injury. The majority of terminally ill patients, however, either never execute a directive,²²¹ or have always been incompetent.²²² The NDA cannot be invoked to authorize decisions to forego life-sustaining treatment for these people. But, as the court held in *Colyer and Hamlin*, the right to forego life-sustaining treatment extends to all patients, whether or not a directive has been signed. A written directive

217. See *supra* text accompanying note 193. However, despite the fact that in executing an NDA directive a patient may not have considered a wide variety of potential illnesses and treatments, respect for patient autonomy requires that every effort be made to discern and fulfill the patient's preferences as previously communicated. See Cantor, *supra* note 4, at 559-60.

218. For example, health care personnel would determine whether the patient had ever specifically discussed artificial nutrition and hydration with other health care providers or with family. See PRESIDENT'S COMM'N, *supra* note 1, at 132-34; Cantor, *supra* note 4, at 555. In the case of implementing a patient's directive, the patient's physician also becomes a surrogate decisionmaker insofar as he or she is charged with determining that the patient is terminally ill. The *Colyer* court recommended that when specific direction is absent, surrogate decisionmakers should consider an incompetent patient's character and personality, statements made prior to becoming ill, and the patient's general attitude toward medical care. *In re Colyer*, 99 Wn. 2d 114, 131, 660 P.2d 738, 747 (1983). See also Cantor, *supra* note 4, at 555, 559.

219. See WASH. REV. CODE § 70.122.030(1) (1985), *supra* note 196 and accompanying text.

220. J. SUTHERLAND, *supra* note 206, at § 47.17-.26.

221. See PRESIDENT'S COMM'N, *supra* note 1, at 136-45. People may fail to execute a directive for many reasons: ignorance of its existence, inattention to its significance, uncertainty about how to execute one, or failure to foresee the kind of medical circumstances that in fact develop. *Id.* at 144.

222. See *supra* note 8 and accompanying text.

complying with Washington's NDA is but one means for persons to express a future choice.

IV. RECOMMENDATIONS FOR FUTURE ACTION: GUIDELINES FOR SURROGATE DECISIONMAKING

In *Hamlin*, the court outlined procedural guidelines for surrogate decisionmaking. Initially, a prognosis board must unanimously approve the attending physician's finding that the patient is incurably ill.²²³ Then the surrogate must use his or her own best judgment to assert the rights and best interests of the incompetent person.²²⁴ But beyond stating in *Colyer* that the surrogate's decision be one the patient would have made if competent, the court offered little substantive guidance for the decisionmaking process. To fill this gap, Washington should adopt a modified version of the approach recently taken by the New Jersey Supreme Court in the case of *In re Conroy*.²²⁵

First, the New Jersey court described a "subjective test" whereby life-sustaining treatment could be foregone "when it is clear that the particular patient would have refused the treatment under the circumstances involved."²²⁶ The surrogate must have both convincing evidence of the patient's desire not to have life-sustaining intervention²²⁷ and medical information equivalent to that which a competent patient would have had before consenting to or rejecting treatment.²²⁸ This approach promotes a patient's common law and constitutional right of personal choice. It also appropriately incorporates the traditional reliance of health care decisionmaking on the doctrine of informed consent.²²⁹

The New Jersey court then outlined two "best interests" tests to promote the welfare of terminally ill patients who never clearly expressed their desires, and thus for whom the subjective test cannot be used.²³⁰ Under the first "best interest" test, if there is some evidence that the patient would have refused treatment, and it is clear to the surrogate decisionmaker that

223. *Hamlin*, 102 Wn. 2d at 819, 689 P.2d at 1378. According to *Colyer*, a prognosis board should consist of no fewer than two physicians with qualifications relevant to the patient's condition, plus the attending physician. *Colyer*, 99 Wn. 2d at 135, 660 P.2d at 749-50.

224. *Hamlin*, 102 Wn. 2d at 818, 689 P.2d at 1377.

225. 98 N.J. 321, 486 A.2d 1209 (1985).

226. 486 A.2d at 1229.

227. *Id.* at 1229-31. Such intent may be embodied in a living will or in oral directives to family or health care providers. *Id.* at 1229. The probative value of the evidence would depend on the remoteness, consistency, and thoughtfulness of the prior statements or actions and on the person's maturity at the time of the statements or acts. *Id.* at 1230.

228. *Id.* at 1231.

229. *See id.* at 1229, 1231. *See also supra* notes 125-26 and accompanying text.

230. *Conroy*, 486 A.2d at 1231-32.

the treatment in question will merely prolong the patient's suffering, then that treatment can be foregone. The surrogate must evaluate the same types of medical evidence as in the subjective test,²³¹ but he or she also must find that the burdens of treatment in terms of pain and suffering outweigh whatever benefits the patient might experience.²³² When there is no evidence of the patient's wishes regarding terminal care, the second "best interest" test must be met. This purely objective approach centers entirely on evaluating the burdens to the patient. The surrogate must find that the net burdens of the patient's life with treatment "clearly and markedly outweigh the benefits that the patient derives from life,"²³³ and further, that the presence of recurring, unavoidable, and severe pain of life with treatment makes administering that treatment inhumane.

New Jersey's approach to surrogate decisionmaking reflected a realistic awareness that terminally ill patients may or may not have previously and conclusively expressed wishes regarding life-sustaining treatment. The court also correctly recognized that the principle of individual choice requires that, to the extent a patient's wishes are known, they should guide surrogate decisionmaking, but the absence of such sentiment does not preclude the withholding or withdrawal of treatment if necessary to promote patient welfare. Finally, the court evinced an understanding that all terminal care decisionmaking should involve consideration of treatment alternatives, and that whoever makes the decision must assess the impact of the treatment's burdens and benefits.

The New Jersey court, however, wrongly confined its two "best interest" methods of surrogate decisionmaking to situations involving a patient's disproportionate experience of pain. Pain may not be a consideration for many terminally ill patients because modern drugs and medical techniques

231. *Id.* at 1232.

232. *Id.*

233. *Id.* In comparison, *Barber v. Superior Court*, 174 Cal. App. 3d 1006, 195 Cal. Rptr. 484, 491 (1983), proposes a "proportionate treatment approach":

[P]roportionate treatment is that which, in the view of the patient, has at least a reasonable chance of providing benefits to the patient, which benefits outweigh the burdens attendant to the treatment. . . . [A] treatment course which is only minimally painful or intrusive may nonetheless be considered disproportionate to the potential benefit if the prognosis is virtually hopeless for any significant improvement in condition.

Id., 195 Cal. Rptr. at 491.

Other courts have used a "substitute judgment/best interest" approach to surrogate decisionmaking. *E.g.*, *Superintendent of Belchertown State Town v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976). For a broad discussion of this approach, see PRESIDENT'S COMM'N, *supra* note 1, at 931-47; Rubin, *supra* note 8, at 22-28. But courts' use of this two-pronged approach has been criticized. *See, e.g.*, Chapman, *supra* note 8, at 920-947 (courts have applied subjective decision-making standards in cases where there is no reliable evidence of any previously expressed wishes regarding life-sustaining treatment by the patient; in such cases an objective approach should have been used). *See also* Cantor, *supra* note 4, at 557.

often can minimize pain.²³⁴ Pain is a subjective experience and difficult to assess.²³⁵ To require the presence of prolonged, constant, severe pain before a surrogate can determine that life-sustaining treatment should be foregone would preclude for many a dignified death. More than pain, many patients fear becoming physically dependent for basic hygiene, depleting wealth they desire to bequeath, or being remembered for how they died rather than how they lived.²³⁶

A second, though less significant, shortcoming of *Conroy* is its preoccupation with identifying three specific “test” points along what is in fact a continuum of evidence regarding previously expressed patient intent. At one end of this continuum are patients who have executed a detailed living will. For them the surrogate’s role will be largely administrative.²³⁷ Other patients, like Joseph Hamlin, will never express any opinion about terminal care. Their surrogate decisionmakers should engage in a fully objective assessment of *all* treatment burdens and benefits.²³⁸ The majority of patients will fall between the two extremes. For them, a surrogate must make an objective evaluation of medical criteria, treatment burdens and benefits, and an assessment of subjective evidence regarding the patient’s preference. If the objective and subjective considerations suggest different results, evidence of patient preference should be ascribed weight according to its strength and degree of reliability.

Decisions to withhold or withdraw artificial nutrition and hydration can be made according to this approach. Besides pain, a surrogate should consider such objective factors as the extent of bodily invasion and loss of independence imposed by the artificial sustenance, the potential for complications, and the likelihood of emotional suffering. The surrogate will consider first the patient’s previously expressed wishes, and then, to the extent necessary, make an objective evaluation of the burdens and benefits of artificial sustenance to the patient. When a patient’s prior expressions indicate a choice to forego artificial nutrition and hydration, or when a surrogate determines that the burdens of artificial sustenance outweigh its benefits absent evidence of a contrary patient choice, artificial nutrition and hydration should be foregone.

Washington should adopt *Conroy’s* approach to surrogate decisionmaking, with the understanding that evidence of patient preferences exists

234. PRESIDENT’S COMM’N, *supra* note 1, at 277–86.

235. Cantor, *supra* note 4, at 569.

236. *Id.* at 565–67. *See also* Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220, 222 (1984) (where the patient himself described his “unbearable, degrading, and dehumanizing” existence, as well as “the humiliating indignity of having to have every bodily need and function tended to by others”).

237. *See* Annas, *When Procedures Limit Rights*, 15 HASTINGS CENTER REP. 24, 25 (1985).

238. Cantor, *supra* note 4, at 557–59, 563–71.

along a continuum, and provided that a surrogate is required to consider all aspects of continuing and terminating life-sustaining treatment. Pain should not be a prerequisite to a surrogate's decision to refuse treatment on a patient's behalf.

V. CONCLUSION

Recent medical advancements that offer dying patients extended survival have generated complex policy issues. Patients' desires for legislative and judicial protection of their right to forego the advancements of medical science have conflicted with health care providers' fears of legal liability and society's fundamental respect for the sanctity of life.

In two comprehensive decisions, the Washington Supreme Court recognized the right of all terminally ill adults to forego medical intervention that serves only to prolong the dying process. This right, according to the court, is founded upon the common law's longstanding protection of bodily integrity and self-determination, and state and federal constitutional protections of personal privacy. Washington's legislature asserted the same principles of self-determination and privacy when it enacted the Natural Death Act. Both the state's highest court and its legislature have realized that modern social values and good medical practice do not demand that a life afflicted with a terminal condition be sustained at all costs.

Decisions to forego artificial nutrition and hydration are indistinguishable from decisions to forego other forms of life-sustaining treatment. As courts confronting the issue have often noted, artificial means of providing sustenance are unlike typical human ways of satisfying fluid and nutritional needs. Intravenous lines and feeding tubes are analogous to mechanical respirators, about which there is widespread consensus that patients have a right to forego—each treatment replaces an essential biological function, and neither addresses the patient's underlying, incurable condition. For patients unable to make their own choice, surrogate decisionmakers can act on the patient's behalf.

Though the emotional symbolism of food is difficult to shed even in the realm of complex medical care, the attempt to do so must be made by courts and legislators as this symbolism can sometimes interfere with a dying patient's interest in a humane, dignified, and comfortable death. Since some patients are better served by not providing artificial nutrition and hydration,²³⁹ the emotional appeal of providing artificial sustenance to all

239. Not eating is natural to the terminally ill; anorexia is common among the dying. Zerwekh, *supra* note 40, at 47–49. Dehydration can bring relief from distressing symptoms such as vomiting, respiratory congestion, pressure from tumor swelling, and pain. *Id.* Reduced fluids serve almost as natural anesthesia. *Id.* The need to restrain and sedate patients in order to maintain a feeding route can

those unable to feed themselves is not persuasive. Accordingly, Washington's lawmakers and its courts must not retreat from their mutual, broad recognition of the beneficial limits of modern medical science and the importance of human dignity and personal choice in our society. Our society is a compassionate one. Legal foreclosing of a patient's right to refuse artificial nutrition and hydration would violate this treasured social value.

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lead to increased anxiety and fear. Lynn & Childress, *supra* note 33, at 18–19. *See also In re Conroy*, 98 N.J. 321, 486 A. 2d 1209, 1236 (1985).