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SURROGATE END OF LIFE DECISIONMAKING: THE IMPORTANCE OF PROVIDING PROCEDURAL DUE PROCESS, A CASE REVIEW

Kathryn L. Tucker*

I. INTRODUCTION

In a hospital in the State of Washington, at the direction of family-member surrogates, the feeding tube was withdrawn from a resident patient.[1] The patient had no advance directive or living will, nor had he expressed the desire (previously or contemporaneously) for withdrawal of life support. He had not been diagnosed as terminally ill or permanently unconscious. In fact, there was evidence that the patient had some cognitive function, desired to continue living, and desired continued life support. This evidence was presented to his caregivers immediately after the patient was advised of the withdrawal, yet life support was not resumed until five days later, and only after a court so ordered.

What happened to this patient raises fundamental questions about the procedures to be followed before life support is withdrawn from a patient who has not made an advance directive, the safeguards for ascertaining a patient's condition and wishes, and the situations in which a surrogate may direct life-support removal. May hospitals and doctors terminate life support at the direction of a surrogate without assurance that the patient (a) is terminally ill or permanently unconscious, and (b) cannot make and express his or her own decision whether to live or die? Are procedural safeguards defined solely by hospitals' and doctors' standards of care, or must they include standards articulated by the state's highest court?

* Ms. Tucker represented the patient through a guardian in the case discussed herein. Ms. Tucker was also counsel in both of the federal constitutional challenges which asserted that competent, terminally-ill patients have a constitutionally protected right to choose physician assistance in dying. *See* Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996) (en banc), *rev'd sub nom.* Washington v. Glucksberg, No. 96-110, 1997 WL 348094 (U.S. June 26, 1997); Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996), *rev'd*, No. 95-1858, 1997 WL 348037 (U.S. June 26, 1997). Ms. Tucker is Affiliate Professor of Law at the University of Washington School of Law and practices law with Seattle-based Perkins Coie.

The author wishes to recognize the great courage and tenacity of the patient's former spouse, who worked to ensure that the patient's wishes be known and respected, notwithstanding the patient's disability.

1. The identities of the patient, surrogates, hospital, and physicians, as they are irrelevant to a discussion of the issues presented herein, are not disclosed.

The case discussed here reveals that a wide chasm exists between the requirements of Washington state law[2] and medical practice. By operating without following the procedures established by the state's supreme court, medical practice has descended far down a slippery slope, permitting surrogates to direct life-support withdrawal from incompetent or questionably competent patients who are neither terminally ill nor permanently unconscious. This state of affairs should be of grave concern to all concerned with end of life decisionmaking.

II. BACKGROUND

The patient was a healthy, active man until he suffered a stroke that left him severely disabled at age thirty-seven. He regained some cognitive and communicative function following his stroke. He primarily communicated through eye movement, including the eye blink method and use of an eye gaze board.[3] Two years after the initial stroke, his care providers had conflicting views regarding whether his communicative ability or cognitive function had diminished or ended.

The patient's father and sister, who had been appointed his temporary guardians by a state court, requested, in their capacity as surrogate decisionmakers, that the patient's life support be withdrawn. The patient's life support consisted of food and liquid provided through a feeding tube implanted in his stomach.

Following receipt of the surrogates' request, one of the attending physicians ordered a neurological evaluation. The neurologist performed a single examination and concluded that the patient was "chronic vegetative." This term does not indicate, nor was it intended by this

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2. Withdrawal of life support at the request of a surrogate is governed by common law and the Constitutions of Washington and the United States. The Washington Legislature has not addressed the subject. The Natural Death Act, enacted in 1979 and amended in 1992, covers withdrawal of life support from incompetent patients who have executed written instructions on the subject prior to loss of competency. *See* Wash. Rev. Code §§ 70.122.010–.920 (1996). The Act does not apply absent a written directive. *See In re* Guardianship of Grant, 109 Wash. 2d 545, 747 P.2d 445 (1987), *amended by* 757 P.2d 534 (1988). In discussing such a situation, the *Grant* court stated:

> We note at the outset that this State's Natural Death Act is inapplicable. The act authorizes a competent adult to sign a directive requiring that lifesustaining treatment be withheld or withdrawn should he or she suffer from a terminal and incurable condition. As [the patient] was adjudicated incompetent at age 14, she was unable to avail herself of the act's provisions.

Id. at 553, 747 P.2d at 449 (citations omitted).

3. Communication by eye movement is a method commonly used with stroke survivors who have lost the ability to move and speak. For a moving memoir of a woman who suffered a stroke and required this method of communication, see Julia Tavalaro & Richard Tayson, *Look Up for Yes* (1997).

doctor to indicate, a permanent loss of consciousness.[4] No other neurologist or nonattending physician examined the patient to determine his medical condition. Neither of his two attending physicians had diagnosed the patient as vegetative. The patient was not terminally ill.

The hospital's Ethics Committee considered the surrogates' request and the neurologist's findings and voted to approve the withdrawal. Life support was then withdrawn. At the time life support was withdrawn, the patient had not been determined to be either terminally ill or permanently unconscious by any physician. No prognosis committee confirmed that he was either permanently unconscious or terminally ill prior to the withdrawal.[5]

The patient had been married and divorced prior to his stroke and had remained good friends with his former spouse.[6] His former spouse visited him regularly and communicated with him, and he communicated with her, as with others, through eye blinks or movements.

The former spouse was not involved in the decision to terminate life support; she received an express mail letter from the guardians advising her that the feeding tube had been withdrawn the day before. She visited the patient immediately to discuss the withdrawal. She perceived that the patient communicated a desire for continued life support. She sought to effectuate his wishes, first by alerting hospital staff and his guardians, and then, this proving futile, by invoking judicial assistance. One of the patient's nurses also believed that she had observed the patient communicate his desire for continued life support. The nurse documented this in the patient's medical chart. However, life support was not resumed until five days later, and only after a court order was obtained by the former spouse.

The patient survived this withdrawal of life support. In a later guardianship proceeding, the former spouse obtained court authorization to maintain a tort action on the patient's behalf against the medical providers who had terminated his life support. The plaintiff sought a pretrial ruling that state law required minimum procedural protections to be afforded the patient prior to removal of life support at the direction of

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4. This neurologist explained at deposition and trial that her use of the term "chronic vegetative" meant that the patient appeared vegetative on the occasion of the exam, but that she had not formed an opinion as to whether the patient's condition was transient, reversible, or permanent.

5. A "prognosis committee" consists of two nonattending physicians with relevant qualifications. *See In re* Welfare of Colyer, 99 Wash. 2d 114, 134–35, 660 P.2d 738, 749–50 (1983), *modified by In re* Guardianship of Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

6. The former spouse was the only friend or family member who lived in Washington State. She had far more contact with the patient than did his out-of-state friends and relatives.

surrogates,[7] and that these minimum procedural protections defined defendants' minimum standard of care. The motion was denied. The court refused to find that case law imposed such requirements on medical care providers. The case was then tried to a jury. The judge refused to instruct the jury that the law imposed *any* such requirements on the medical providers. The jury returned a defense verdict. The patient died before his appeal could be reviewed; the appeal was therefore dismissed as moot.

III. DID THE PATIENT'S DOCTORS OWE HIM A DUTY TO PROVIDE CERTAIN MINIMUM PROCEDURAL PROTECTIONS PRIOR TO REMOVAL OF LIFE SUPPORT?

On three occasions prior to the events in this case, the Washington Supreme Court considered the matter of withdrawal of life support from patients at the request of surrogates.[8] In each instance the Court held that certain minimum procedural protections must be afforded patients for whom medical decisions on this life-or-death matter are made by surrogates. This makes sense. Citizens may not take each other's lives, except in rare circumstances authorized by the State. Absent authorization, such actions are criminal. The State may not authorize the taking of life (or liberty or property) without due process, and the process that is due depends on the stakes involved and the chances of error. No stakes are higher than when a human life is at issue, and the chances of error are high when the issue is knowing what is going on inside the mind of a person disabled from speaking, writing, or making almost any

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7. *See infra* Part III.

8. *See In re* Guardianship of Grant, 109 Wash. 2d 545, 747 P.2d 445 (1987), *amended by* 757 P.2d 534 (1988); *Hamlin*, 102 Wash. 2d at 810, 689 P.2d at 1372; *Colyer*, 99 Wash. 2d at 134–35, 660 P.2d at 749–50.

In its only decision addressing withdrawal of life support from a patient at the request of a surrogate, the U.S. Supreme Court indicated that it will defer to the states on the question of what procedural requirements must be met. Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990). The Court recognized that although there is a constitutional liberty interest in being free of unwanted life-sustaining treatment, a state's requirement that a patient's wishes favoring withdrawal be established by clear and convincing evidence was permissible. *Id.* at 279. This is so because the Supreme Court deemed the decision regarding this end-of-life issue to be so personal to the individual patient that efforts to prevent error and the usurpation of the *patient's* wishes must be upheld. *Id.* at 281.

Washington has opted for a less restrictive standard than that which was at issue in *Cruzan*. It is permissible to remove life support in Washington without meeting the rigorous evidentiary standard required by Missouri. However, a lesser standard should not be randomly or carelessly applied. Careful and rigorous implementation is necessary, lest this enormously personal matter be wrongly decided. To do less would be inconsistent with the principles recognized in *Cruzan*.

movement. The Washington Supreme Court has thus repeatedly honored the common-sense and constitutional proposition that a patient's life may be terminated only if he or she is surely terminal or permanently vegetative and either has made such a choice known in advance or is unable to make a choice.

In the first of the Washington cases addressing this issue, *In re Welfare of Colyer*,[9] the court considered whether Bertha Colyer's husband could direct the removal of her life support after she was determined to be in a vegetative state following a heart attack and deprivation of oxygen to her brain for an extended period of time. After reviewing case law of other states, which evidenced a trend in favor of patient autonomy, the Washington Supreme Court stated: "[W]e now hold that an adult who is incurably and terminally ill has a constitutional right of privacy that encompasses the right to refuse treatment that serves only to prolong the dying process."[10]

The court considered at length the condition in which the patient must be prior to the withdrawal of life support and stated that there must be a "medical determination that the patient is incurable and will not return to a sapient state."[11] This determination was found to be a medical one that "must also incorporate safeguards."[12] The court specifically considered whether an ethics committee would be an appropriate and sufficient safeguard and determined that it would *not* be.[13] "In actuality, what is needed is a prognosis board to confirm the attending physician's diagnosis. Concurrence by professional colleagues who are not attending physicians but who nonetheless have an understanding of the patient's condition would protect against erroneous diagnoses as well as questionable motives."[14] Accordingly, the court directed that the following procedure be employed: "[W]e recommend that in future decisions of this nature, there should be unanimous concurrence from a prognosis board or committee. Such a committee should consist of no fewer than two physicians with qualifications relevant to the patient's condition, plus the attending physician."[15] The *Colyer* court permitted the withdrawal of treatment because such procedural protections had in fact

9. *In re* Welfare of Colyer, 99 Wash. 2d 114, 134–35, 660 P.2d 738, 749–50 (1983), *modified by In re* Guardianship of Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

10. *Id.* at 120, 660 P.2d at 742.

11. *Id.* at 133–34, 660 P.2d at 749.

12. *Id.* at 134, 660 P.2d at 749.

13. *Id.*

14. *Id.* (citation omitted).

15. *Id.* at 134–35, 660 P.2d at 749.

been met: that is, two nontreating, qualified physicians had agreed that Bertha Colyer was incurable and would never recover to a sapient state.[16]

In the second case, *In re Guardianship of Hamlin*,[17] the Washington Supreme Court considered withdrawal of life support from Joseph Hamlin, who had suffered cardio-respiratory arrest and lack of oxygen to his brain for an extended period of time, causing him to become irreversibly vegetative. In Mr. Hamlin's case, the attending physician diagnosed him as vegetative, and this diagnosis was confirmed by "*at least twenty physicians*."[18] The court applied *Colyer*, stating, "*In* Colyer, *we established a set of procedural guidelines to follow in future cases involving the withholding or withdrawal of life sustaining treatment from an incompetent patient*."[19] *Hamlin* eliminated the *Colyer* requirement that there be a guardianship hearing prior to the withdrawal.[20] The *Hamlin* court stated that the additional procedural protection of a guardianship proceeding was unnecessary:

> We are convinced that the *remaining procedural safeguards* surrounding this decision will adequately protect against abuse.
>
> *First*, this decision can be reached *only after* there is a medical diagnosis by the attending physicians that (1) the incompetent patient is in a persistent vegetative state with no reasonable chance of recovery and (2) the patient's life is being maintained by life support systems.... *Second*, this initial diagnosis *must* be unanimously approved by the prognosis committee.[21]

The third in this trilogy of Washington decisions addressing at length the matter of withdrawal of a patient's life support at the direction of a

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16. *Id.* at 131–35, 660 P.2d at 748–50.

17. 102 Wash. 2d 810, 689 P.2d 1372 (1984).

18. *Id.* at 814, 689 P.2d at 1375 (emphasis added).

19. *Id.* at 816, 689 P.2d at 1376 (emphasis added). The court noted that in Mr. Hamlin's case, no prognosis committee per se was convened because the situation arose prior to the *Colyer* decision. *Id.* at 817, 689 P.2d at 1376. However, the court took pains to note that there was consensus among all of the more than twenty physicians that Hamlin was irreversibly vegetative. It is noteworthy that, notwithstanding unanimous confirmation of Hamlin's irreversibly vegetative condition by so many doctors, the hospital sought judicial authorization prior to withdrawing treatment. In contrast, in the case discussed herein, with only a single disinterested physician's diagnosis of a "chronic" vegetative state, the care providers withdrew the patient's life support.

20. *Id.* at 818–20, 689 P.2d at 1377–78.

21. *Id.* at 819, 689 P.2d at 1378 (emphasis added). *See also In re* Guardianship of Ingram, 102 Wash. 2d 827, 835, 689 P.2d 1363, 1367 (1984) (recognizing that *Hamlin* established that if treating physicians, *prognosis committee*, and appointed guardian all agreed, life support could be withdrawn without judicial involvement).

surrogate is *In re Guardianship of Grant.*[22] In *Grant*, the patient was not vegetative but, rather, was terminally ill. Thus, the Washington Supreme Court considered for the first time whether it was permissible to permit a surrogate to direct the withholding of life-sustaining treatment to a terminally ill, nonvegetative, but incompetent person. The *Grant* court held that it was permissible, provided that certain minimum procedural requirements were followed:

> We hold that prior court authorization to withhold life sustaining treatment shall not be required where *all* the following circumstances are present:
>
> 1. The incompetent patient's attending physician, together with two other physicians qualified to assess the patient's condition, determine with reasonable medical judgment that the patient is in an advanced stage of a terminal and incurable illness and is suffering severe and permanent mental and physical deterioration.[23]

The procedural requirements articulated in *Grant* were consistent with those established in *Colyer*, recognized and reaffirmed in *Hamlin*: at a minimum, the patient whose life support is to be withdrawn at the request of a surrogate must be diagnosed by the attending physician(s) as either terminally ill or irreversibly vegetative, and such diagnosis must then be confirmed by no fewer than two disinterested physicians with relevant qualifications. Thus, although the *Grant* court did not specifically employ the term "prognosis board," it in no way suggested that previously enunciated requirements were in any way lessened or eliminated, particularly as regards apparently vegetative patients.[24] Had the court intended to overrule, or lessen in any way, such important minimum procedural protections as were recently established in its two earlier cases, it would have done so explicitly and with explanation.[25]

That Washington requires both a prerequisite condition (either irreversible unconsciousness or terminal illness) and confirmation of that

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22. 109 Wash. 2d 545, 747 P.2d 445 (1987), *amended by* 757 P.2d 534 (1988).

23. *Id.* at 566, 747 P.2d at 456 (emphasis added). The additional procedural requirements of *Grant* were not at issue in the case discussed herein.

24. In fact, in *Grant*, the Court noted that not only had Barbara Grant's attending physician determined that she was terminally ill, but four other physicians had agreed with that determination, exceeding the minimum requirement of two disinterested physicians to confirm the prerequisite attending physicians' diagnosis. *Id.* at 568, 747 P.2d at 457.

25. This is well illustrated by *Hamlin*, which did modify *Colyer* with regard to the need for judicial involvement in the decisionmaking process. The court was explicit in making this modification and provided elaborate reasoning for doing so. *See Hamlin*, 102 Wash. 2d at 817–21, 689 P.2d at 1376–78.

condition by a minimum of two disinterested, qualified physicians is recognized in guidelines prepared by a panel of nationally prominent judges and professors of law, medicine, and ethics to assist state courts in handling cases involving termination of treatment.[26] The Guidelines note that "[s]ome states have also mandated that the medical condition/prognosis of the patient be taken into account" prior to withdrawal of life support, and recognize that Washington is among those states.[27] Further, the Guidelines recognize that some states, including Washington, require confirmation of the diagnosis of the prerequisite medical condition: "[A] series of state court opinions have been issued requiring certification of the medical conclusions of the treating physician by independent medical experts."[28]

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26. Coordinating Council on Life-Sustaining Med. Treatment Decision Making by Courts, Nat'l Center for State Courts, *Guidelines for State Court Decision Making in Life-Sustaining Medical Treatment Cases* 89–94 (2d ed. 1992) [hereinafter *Guidelines*]. The Guidelines are funded by the State Justice Institute.

27. *Id.* at 62 n.90 (citing *Grant*, *Ingram*, and *Colyer*). The Guidelines note: "Various courts have ruled that certain medical requirements must be met prior to a determination to forgo [life support]." *Id.* at 89 n.153.

28. *Id.* at 89–91 n.154 (citing *Colyer*, *Hamlin*, and *Grant*). It is clear that *Colyer* and *Hamlin* require the patient to be *irreversibly* vegetative to permit withdrawal. When these cases were decided, in 1983 and 1984 respectively, the term used to describe an irreversibly vegetative patient was "persistent vegetative state." Recently, the term "persistent" has been refined by the medical community to mean an extended, but not "permanent," vegetative state. The term "permanent vegetative state" is now used to describe irreversible or permanent unconsciousness. *Compare* Council on Scientific Affairs & Council on Ethical and Judicial Affairs, American Med. Assoc., *Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support*, 263 JAMA 426 (1990) [hereinafter *AMA Council Report*] *with* Multi-Society Task Force on PVS, *Medical Aspects of the Persistent Vegetative State* (pts. 1 & 2), 330 New Eng. J. Med. 1499, 1572 (1994).

Regardless of the label employed, the Washington Supreme Court in both *Colyer* and *Hamlin* emphasized that the patient's vegetative condition must be *irreversible* prior to withdrawal of life support. It is hard to imagine how anyone could justify taking the life of someone who has not personally requested such action and who will or might regain consciousness. Indeed, the Natural Death Act, Wash. Rev. Code §§ 70.122.010–.920 (1996), specifies that life support can be withdrawn from a vegetative patient only where the patient's state is one of "permanent unconsciousness." *See* Wash. Rev. Code §§ 70.122.010–.030. Since the late 1980s, medical societies have been in agreement that establishment of irreversibility requires a minimum period of observation of the vegetative patient. That period is three to six months. This medical consensus was reached after *Colyer* and *Hamlin* were decided. The American Medical Association set forth its policy regarding withdrawal of life support from vegetative patients in 1990, and established a three- to six-month minimum period of observation of uninterrupted vegetative state behavior prior to withdrawal. *See AMA Council Report*, *supra*. Both *Colyer* and *Hamlin* emphasize that irreversibility must be established; thus, the principles established in those cases, when applied with modern medical consensus, plainly require that this minimum waiting period be observed and that permanency or irreversibility be established prior to withdrawing life support.

The defendants in the case discussed argued that because life support was withdrawn in *Colyer* and *Hamlin* with less than three months of observed uninterrupted vegetative status, it was

In this case, the plaintiff's pretrial motion for partial summary judgment asked the trial court to rule that these minimum procedural protections were indeed required and defined a minimum standard of care. It was undisputed that they had not been provided. The trial court denied this request.[29]

The trial judge subsequently refused to instruct the jury that state law required certain minimum procedural protections be afforded patients prior to withdrawal of their life support. The judge's actions left the jury with no way of understanding that the doctors and hospital had failed to afford the patient the minimum process held necessary by the state's highest court. The jury had no way of knowing that life support had been removed from a patient in a manner contrary to the law. A defense verdict was returned and, as indicated above, the patient died before his appeal could be considered.

The defense argued that it was *constitutionally required* to permit life-support withdrawal from a patient who is neither terminally ill nor permanently unconscious *and is incompetent.* This was plainly wrong as a legal matter. In federal constitutional analysis, the patient's interest is balanced against the state's.[30] Where a patient is terminally ill or permanently unconscious, the state's interest in preservation of life, as considered against the patient's wishes, is substantially diminished.[31] Such a patient's interest in self-determination outweighs the state's

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permissible to do so in this case. This reasoning ignores the emphasis in *Colyer* and *Hamlin* on irreversibility, and the fact that medical consensus has since established a minimum three- to six-month observation period.

Washington is not alone in requiring confirmation by a specified number of nontreating, disinterested, qualified physicians. For example, the states of Connecticut, Florida, Georgia, Illinois, and New Jersey also impose such a requirement. *See Guidelines, supra* note 26, at 89–91 n.153.

29. This was one of the trial court errors that could have been resolved on appeal had the appeal not become moot due to the patient's death.

30. *See, e.g.*, Planned Parenthood v. Casey, 505 U.S. 833 (1992); Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996) (en banc), *rev'd sub nom.* Washington v. Glucksberg, No. 96-110, 1997 WL 348094 (U.S. June 26, 1997); *see generally* Thomas Wm. Mayo, *Constitutionalizing the "Right to Die,"* 49 Md. L. Rev. 103, 104 n.7 (1990).

31. Preservation of life is one of the state interests asserted in cases involving end-of-life decisionmaking. *See, e.g.*, Mayo, *supra* note 30, at 110 n.39; *In re* Guardianship of Grant, 109 Wash. 2d 545, 556, 747 P.2d 445, 451 (1987), *amended by* 757 P.2d 534 (1988); Yale Kamisar, *When Is There a Constitutional "Right to Die"? When Is There No Constitutional "Right to Live"?*, 25 Ga. L. Rev. 1203, 1211 (1991) ("If death is unpreventable—if the best medical treatment available can only postpone death for a short time—the interest in preserving life seems much weaker."). That the state's interest in protecting and preserving life grows as the potential for life increases is a basic tenet of reproductive rights jurisprudence, which permits greater state regulation of abortion as the potential for life increases with advancing gestation. *See, e.g.*, *Casey*, 505 U.S. at 833; Roe v. Wade, 410 U.S. 113 (1973).

interest. However, *absent* diminished life expectancy, the balance tips in favor of the state. Where the patient is incompetent, an additional substantial state interest comes into play: the protection of vulnerable citizens from abuse.[32]

It is nonsense to suggest, as did the defense in this case, that the Constitution requires withdrawal of life support from an incompetent but non-terminal patient who has not been diagnosed as permanently unconscious when a surrogate requests it. Indeed, in the federal constitutional litigation asserting that *competent terminal* patients have the right to choose death with physician assistance, the opponents argued vociferously that to allow patient choice at all will lead inexorably down a "slippery slope," at the bottom of which it would become permissible to euthanize disabled persons, and that this must never be permitted. Disturbingly, that is precisely what occurred here. In *Compassion in Dying v. Washington*,[33] the amicus curiae brief opposing assisted suicide submitted by the National Legal Center for the Medically Dependent and Disabled in the Ninth Circuit stated:

> A constitutional right to assisted suicide cannot be confined to the narrow category which the district court describes: i.e., competent adults with terminal conditions who seek lethal help from physicians. It will expand beyond these boundaries to include all who are deemed to lack sufficient "quality of life," especially people with disabilities, whether or not they have "terminal conditions," and whether or not they are competent adults.[34]

Similarly, the amicus curiae brief of the United States Catholic Conference, another opponent of assisted suicide, stated:

> Moreover, there is no reason to believe in this litigious society that such a claimed right to assisted suicide can or will stop with the terminally ill. As Justice Cardozo observed, any principle tends "to

32. *See, e.g.*, Note, *Physician-Assisted Suicide and the Right to Die With Assistance*, 105 Harv. L. Rev. 2021, 2034 (1992). The author states:

> [W]hen considering the state's interest in preserving an individual's life in a suicide assistance case, a court should find that, absent evidence of coercion *or the patient's incompetence*, the state's interest is negligible compared with the patient's interest. *However, if the patient is incompetent* or if other evidence calls into question the voluntariness of the patient's decision, the state's interest in preserving life should be accorded substantial weight.

Id. (emphasis added).

33. 79 F.3d 790 (9th Cir. 1996) (en banc), *rev'd sub nom.* Washington v. Glucksberg, No. 96-110, 1997 WL 348094 (U.S. June 26, 1997).

34. Brief *Amicus Curiae* of Julie L. Aardappel et al., in Support of Defendants-Appellants at 2, *Compassion in Dying* (No. 94-35534).

> expand itself to the limit of its logic." Once *any* right to assisted suicide is conceded for any class of persons, it will be difficult or impossible to confine the right to that class. Since all medical conditions can be placed on a continuum, any distinction will simply be challenged as arbitrary. What criteria, for example, will be used to distinguish the 80-year-old dying of cancer from the 70-year-old with Alzheimer's disease, the 60-year-old with severe depression and advanced leukemia, the 50-year-old depressed over an unsuccessful business venture or the loss of a spouse, or the incompetent of any age whose quality of life fails to meet someone else's expectations? Anyone who doubts the reality of the slippery slope should consider the Netherlands, where over a thousand people a year are *involuntarily* euthanized.[35]

Another opponent of assisted suicide, the International Anti-Euthanasia Task Force, argued in its brief:

> If assisted suicide becomes just another "medical treatment" option, no different under the law than withdrawing life-sustaining medical treatment, then there is no logical manner, in light of the substituted judgment cases, that assisted suicide, or more likely, euthanasia, can ever be kept from being inflicted on incompetent persons who cannot specifically request it.[36]

The constitutional rebuttal to the slippery slope argument is that competency and terminal illness are (relatively) bright lines that can be drawn, and *when the patient is both competent and terminal*, the patient's interests outweigh the state's.[37] Correspondingly, when the patient is

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35. Brief of the United States Catholic Conference et al., as *Amici Curiae* in Support of Appellants State of Wash. et al. at 30–31, *Compassion in Dying* (No. 94-35534) (citations omitted).

36. Brief of the International Anti-Euthanasia Task Force as Amicus Curiae in Support of Defendants/Appellants' Brief at 30, *Compassion in Dying* (No. 94-35534); *see also* Note, *supra* note 32, at 2034 ("[S]ome opponents of physician-assisted suicide argue that permitting some assisted suicides may lead to the killing of patients who want to live. This 'slippery slope' argument expresses a utilitarian rationale for prohibiting suicide assistance."); Maria T. CeloCruz, *Aid-in-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?*, 18 Am. J.L. & Med. 369, 384 (1992) (reviewing slippery slope argument against legalizing voluntary active euthanasia and danger that it would lead to "involuntary euthanizing of the handicapped, incompetent, and others whose lives society considers not worth living").

37. This is the position taken by appellees in the *Compassion* litigation responding to this notion: "The State's interest in preserving life is much greater in the case of a nonterminal individual. That interest might well outweigh the nonterminal individual's interest in self-determination." Brief of Appellees at 18 n.20, *Compassion in Dying* (No. 94-35534). As for extension of the constitutional right claimed in the *Compassion* case to terminally ill, depressed patients who wish to hasten death because of their depression, appellees therein do not advocate such extension, recognizing the

incompetent and/or nonterminal, the state's interests prevail. Thus, in no instance could the Constitution, even if it is read to permit expansion of the rights of competent dying patients, require or permit the euthanizing of incompetent, disabled persons, as the defendants in the case discussed herein suggested is the current practice in Washington State.[38]

What the defense claimed was acceptable current practice is in fact the *bottom* of the slippery slope that *both* proponents *and* opponents of expanding patient choice at the end of life agree should never be countenanced.[39]

The defense sought to buttress their case by asserting that Washington's surrogate prioritization statute[40] altered the law established in *Colyer*, *Hamlin*, and *Grant*. This legislation, however, is an extremely specific and narrowly limited enactment that only identifies the order of priority of familial relation for consent purposes, such as whether the patient's spouse must be consulted versus the patient's parent.[41]

Moreover, *Grant* was decided in December 1987, *after* the enactment of the prioritization statute, which became effective on July 26, 1987.[42] *Grant* makes no mention of section 7.70.065 and, indeed, as pointed out above, *Grant* required both a terminal diagnosis and confirmation by a prognosis committee.

Indeed, this argument is entirely inconsistent with the *Grant* framework, which permits withdrawal of life support at the request of a surrogate *only* if *all* enumerated circumstances are present. The list of circumstances requires, first, that the prerequisite medical condition be diagnosed by the attending and two other qualified physicians. Next, the

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greater state interests at stake: "[depressed patients] can be screened out and are not within the category of mentally competent patients that this lawsuit addresses." *Id.* at 15 n.13.

38. This is true under either liberty or equal protection analysis. In the liberty analysis, as stated above, the state's interests outweigh the patient's when the patient is nonterminal and incompetent. For equal protection purposes, such patients are differently situated from terminal, competent patients, and it is permissible to treat them differently. *See generally* Mayo, *supra* note 30, at 126–55 (analyzing whether Fourteenth Amendment protects right of patient in persistent vegetative state to refuse life support and concluding it does not); Ira Mark Ellman, Cruzan v. Harmon *and the Dangerous Claim That Others Can Exercise An Incapacitated Patient's Right To Die*, 29 Jurimetrics J. 389, 394–99 (1989).

39. As noted by Professor Yale Kamisar, in the case of a nonterminal patient: "[T]o say that a person who can be kept alive for many years should have her life support disconnected because she is 'better off dead' or 'might as well be dead' . . . is to grapple with 'the hopelessly elusive question of a life not worth living.'" Kamisar, *supra* note 31, at 1212.

40. Wash. Rev. Code § 7.70.065 (1996).

41. The legislative history of the surrogate prioritization statute reveals no reference to this legislation's alleged intent to eliminate or alter the common law's important patient protections.

42. Act of July 26, 1987, ch. 162, § 1, 1987 Wash. Laws 544–45.

surrogate is to apply substituted judgment, that is, determine whether the patient would, if able, choose to direct the withdrawal of treatment. If such a determination cannot be made, the surrogate then determines whether withdrawal would be in the patient's best interest.[43] If, as defendants contended, the surrogate prioritization statute eliminated the need for the first step in the process (the diagnosis and confirmation of a prerequisite medical condition), the *Grant* court would not have set out the elaborate framework that it did. The fact that it did, notwithstanding that section 7.70.065 was then in effect, clearly indicates that the surrogate prioritization legislation did not implicitly supersede the common law requirements of *Colyer*, *Hamlin*, and *Grant*.

IV. CONCLUSION

Of interest to all physicians, attorneys, and others grappling with the issue of withdrawal of life support at the direction of a surrogate is the chasm, revealed by the case discussed herein, between what the law requires and what mainstream medical providers are in fact doing. In the trial of this case, the defense introduced testimony of expert physicians, including prominent faculty members of a leading university medical school, who testified that it was accepted practice to accommodate surrogate requests for withdrawal of life support regardless of whether the patient was either terminally ill or permanently unconscious as determined by a minimum number of qualified physicians. This disturbing divergence between practice and law no doubt exists in other states, not just Washington.

Where a state court of last resort has established certain minimum procedural protections that must be afforded patients prior to the withdrawal of life support at the direction of a surrogate, those procedures should be followed by medical providers. The medical community may do more, but it should never do less.

43. *See In re* Guardianship of Grant, 109 Wash. 2d 545, 566–67, 747 P.2d 445, 456–57 (1987), *amended by* 757 P.2d 534 (1988).