No. 88-1503

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

NANCY BETH CRUZAN, by her parents and co-guardians, LESTER L. and JOYCE CRUZAN, *Petitioner*,

v.

DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, ET AL. *Respondents*,

ON WRIT OF CERTIORARI TO THE SUPREME COURT OF MISSOURI

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING RESPONDENTS

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QUESTION PRESENTED

Whether a State may, consistently with the Due Process Clause, require clear and convincing evidence that an incompetent person would want life-sustaining medical procedures withdrawn before it approves the termination of such procedures.

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INTEREST OF THE UNITED STATES

This case presents the question whether a patient in a permanent vegetative state has a constitutional right to refuse medical treatment. The United States owns and operates many health-care facilities, including 172 medical centers and 104 nursing homes operated by the Department of Veterans Affairs (VA), and 167 medical centers operated by the military services. Because issues about termination of treatment arise at those facilities on a continuing basis, the United States has a direct interest in the manner in which this Court resolves the question presented.[1]

[1] The VA's current practice is to abide by state laws regarding whether life-sustaining procedures may be withdrawn. The VA, however, has written draft rules that would create a uniform policy

STATEMENT

1. On January 11, 1983, petitioner Nancy Cruzan was injured in an automobile accident. A state trooper arrived on the scene shortly after the accident and thought that she was dead. A few minutes later, medical personnel arrived and started CPR as well as other life-support procedures. Petitioner then began to breathe but did not regain consciousness. Her brain had been severely damaged by the lack of oxygen. Pet. App. A89-A92.

Three weeks after the accident, petitioner's parents and husband gave their consent to the surgical implantation of a feeding tube into petitioner's stomach. At that time, petitioner's prognosis was uncertain, and her family hoped for her recovery. Soon thereafter, however, petitioner lapsed into a permanent vegetative state. It is undisputed that there is no hope that she will ever improve, given the present state of medical science. Pet. App. A34. Petitioner's cerebral cortex—the portion of the brain that permits consciousness and cognitive thought—has been destroyed. Her brain stem, however, continues to function so she may breathe on her own.

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in VA facilities throughout the country. Under the draft rules, the representative of an incompetent patient, who has not previously executed an advance directive, generally may decide whether to continue life-sustaining treatment. The draft rules provide that life-sustaining treatment will not be withheld or withdrawn unless the attending physician is satisfied that the decision of the patient's representative is based on reliable indicators of the direction the patient would personally give were the patient able to do so. In the absence of such reliable indicators, life-sustaining treatment may be withheld only if the patient's physician and representative agree that such action would be in the patient's best interest.

The United States Army, which provides health services to soldiers and their families, also has a policy that allows an incompetent patient's family or guardian to direct that life-sustaining procedures be withdrawn. The patient's family or guardian is advised to consider three factors: (1) relief from suffering, (2) quality and duration of life, and (3) what the patient would have wanted if he were still competent. The United States Navy and Air Force currently follow state law in determining whether life-sustaining procedures may be withdrawn.

She now is a patient in the Missouri Rehabilitation Center, a state-owned hospital, and Missouri is bearing the cost of her care. *Id.* at A92-A96.

Petitioner's parents were appointed guardians on January 25, 1984.[2] They gradually gave up any hope that petitioner would recover. They also came to the conclusion that petitioner would not want to continue her existence in a permanent vegetative state. Tr. 444, 543-544. Accordingly, petitioner's parents asked the state hospital to halt life-support treatments, including the provision of nutrition and fluids through the tube inserted into petitioner's stomach. The hospital administrator told petitioner's parents that he could not honor their request without a court order. Pet. App. A5.

2. Petitioner's parents then filed this action in the probate division of the Circuit Court of Jasper County, Missouri. They claimed that petitioner had a common law and constitutional right to refuse unwanted medical treatment. They further contended that, although petitioner could not speak for herself, she would not want to be kept alive by means of the tube inserted into her stomach. Pet. App. A5.

The court heard three days of testimony concerning petitioner's lifestyle, her views on death, and her thoughts about life-support procedures. Witnesses testified that petitioner was a "very independent" person, and that she had a very close relationship with her family. Tr. 397, 415, 544. They also described several incidents in which petitioner had discussed the final illness or death of family members and acquaintances. See, *e.g.*, Tr. 536-541. In at least one of those conversations, petitioner had indicated to her housemate that she "didn't want to live" if she ever faced life "as a vegetable." Tr. 389-390, 395-396. Petitioner said that if she "couldn't do for herself things even halfway, let alone not at all, she wouldn't want to live that way and she hoped that her family would know that." Tr. 389.

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[2] Petitioner's husband did not participate in the guardianship proceeding, and he later obtained a divorce. Pet. App. A93.

The trial court entered judgment for petitioner. The court ruled that "[t]here is a fundamental right expressed in our Constitution as the 'right to liberty,' which permits an individual to refuse or direct the withholding or withdrawal of artificial death prolonging procedures." Pet. App. A98-A99. And the court found that petitioner's "lifestyle and * * * statements to family and friends suggest that she would not wish to continue her present existence without hope as it is." *Id.* at A94. The court accordingly entered an order directing respondents "to cause the request of [petitioner's parents] to withdraw nutrition or hydration to be carried out." *Id.* at A100.[3]

3. The Supreme Court of Missouri reversed. The majority first agreed that the common law recognizes a right to refuse treatment. Pet. App. A20-A21. The court ruled, however, that such a right was not implicated in this case because petitioner is unable to make a competent decision to refuse treatment. The court noted that she can weigh "neither the benefits nor the risks of treatment." *Id.* at A21.

The court next considered the constitutional claim asserted on petitioner's behalf. The majority observed that it had "grave doubts as to the applicability of privacy rights to decisions to terminate the provision of food and water to an incompetent patient." Pet. App. A25. The court then stated: "[E]ven if we recognize such a broadly sweeping right of privacy, a decision by Nancy's co-guardians to withdraw food and water under these circumstances cannot be sustained." *Ibid.*

The court reached that conclusion by weighing the State's interest in protecting life against petitioner's interest in refusing unwanted medical procedures. The court surveyed various sources of state law and concluded that the "state's interest is not in quality of life. The state's interest is an unqualified interest in life." Pet. App. A33. At the same time, the court found that peti-

[3] The trial court also held that the Equal Protection Clause required the State to respect the authority of petitioner's parents to act on her behalf. Pet. App. A99.

tioner had not sufficiently expressed a wish to be free from a feeding tube so that she could die. The court stated that a "decision to refuse treatment, when that decision will bring about death, should be as informed as a decision to accept treatment." *Id.* at A37. The court stated, however, "that the evidence offered at trial as to petitioner's wishes is inherently unreliable." *Id.* at A43. Accordingly, the court declared: "[W]e do not believe [petitioner's] right to refuse treatment, whether that right proceeds from a constitutional right of privacy or a common law right to refuse treatment, outweighs the immense, clear fact of life in which the state maintains a vital interest." *Id.* at A38.

Lastly, the court considered what it termed "Guardian Issues." Pet. App. A38. The court suggested that a third party—*i.e.*, a guardian— cannot exercise an incompetent person's right to be free from unwanted medical treatment. The court stated that "[i]t is logically inconsistent to claim that rights which are found lurking in the shadow of the Bill of Rights and which spring from concerns for personal autonomy can be exercised by another absent the most rigid of formalities." *Id.* at A40. Nevertheless, the court also indicated that it would recognize an incompetent patient's right to be free from medical treatment in cases where the proof of the patient's intent is clear. The court concluded by noting that a guardian may not elect to withdraw life-support treatments "in the absence of the formalities required under Missouri's Living Will statutes or the clear and convincing, inherently reliable evidence absent here." *Id.* at A41.[4]

Judge Blackmar dissented. He believed that the trial court's judgment was supported by the "common law and

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[4] A "Living Will" is a document that is executed while a person is competent but that takes effect when the person becomes incompetent; it directs physicians "to withhold or withdraw treatment that only prolongs the process of dying." Pet. App. A28 n. 15. Missouri has a statutory scheme that respects certain types of living wills. That statute did not take effect, however, until after petitioner's accident. *Id.* at A29.

equity." Pet. App. A45. He wrote that any "decision about Nancy's future should be made by those near and dear to her, and that no state policy requires the state to intervene in these decisions." *Id.* at A47.

Judge Higgins also filed a dissenting opinion. He wrote that the majority's position appeared to conflict with the approach adopted by other state courts, noting that "courts in at least 16 states have found a way to allow persons in the plight of Nancy Cruzan wishing to die to meet that end." Pet. App. A77. He also believed that the majority did not give proper deference to the trial court's finding regarding petitioner's wish to die.[5]

SUMMARY OF ARGUMENT

1. This Court has long looked to the understanding of the Framers and this Nation's traditions as sources for those liberty interests that are entitled to substantive protection under the Due Process Clause. We believe that such an approach—as opposed to an approach positing a generalized "right of privacy"—provides a more objective method for identifying those liberty interests entitled to heightened review.

2. Although this case concerns an adult who is currently incompetent, it is instructive to consider as an initial matter what, if any, rights a competent person would have to refuse life-sustaining medical procedures. There is considerable support for the claim that a competent adult would have a substantial liberty interest in refusing unwanted medical treatment. The Framers understood that the term "liberty" meant, at a minimum, freedom from state-imposed physical restraints. Under that view, a person's liberty interest is necessarily implicated by an attempt by the State to subject a competent adult to unwanted medical treatment, for the State could not impose unwanted medical treatment without

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[5] Judge Welliver joined both dissents. He also stated that the case should have been set for reargument because the regular judges of the court were evenly divided. Pet. App. A79-A82.

also restraining the person. This understanding of liberty is reinforced by our Nation's legal traditions. It was well established at common law that a competent person could decline medical treatment, even in life-threatening situations.

Nevertheless, other elements of our legal traditions cast doubt on whether a competent person's interest in refusing medical treatment should be regarded as largely unqualified. This case does not involve an attempt by the State to impose restrictions on liberty in order to punish or stigmatize petitioner; to the contrary, the State is motivated solely by benevolent concerns. And this Court's few decisions involving assertions of a right to refuse treatment do not suggest that the highest level of judicial scrutiny is required; instead, the Court has upheld government-imposed medical procedures where important governmental interests, such as the prevention of epidemics or the production of evidence in court, were at stake. Moreover, there is no longstanding tradition reflecting a societal consensus over whether the provision of essential nourishment is medical "treatment"; indeed, that question is a matter of substantial dispute. In light of all those factors, therefore, it cannot reasonably be maintained that a competent adult enjoys an unqualified interest in refusing a procedure that provides nourishment and hydration.

Even if a competent adult is deemed to have a fundamental liberty interest in refusing life-sustaining procedures, however, and even if the provision of nourishment and hydration is properly considered medical treatment, that right would not extend to a person who is currently incompetent. A State plainly has a strong interest in ensuring that any decision to refuse life-sustaining treatment is made after careful thought and full consideration of the consequences. That interest is deeply grounded in the State's profound interest in preserving human life. A currently incompetent adult, however, is by definition unable to give careful thought to the life-and-death questions regarding medical care.

3. This analysis does not mean that petitioner—when competent—could not have formed a constitutionally protected intent to refuse future medical treatment. Nevertheless, any constitutional right that a competent person may possess in having a decision to refuse treatment respected in the future, at a time when she might become incompetent, is plainly qualified by the State's compelling interests in overseeing such a decision to protect the incompetent person from abuse and mistakes in judgment.

In light of those vital governmental interests, the Due Process Clause should be construed to give the States considerable flexibility in adopting rules in this sensitive area. We believe that the proper standard of review should be whether the governmental rule is "reasonably designed" to serve legitimate state interests. This "reasonableness" test finds wide support in the Court's decisions regarding substantive due process liberties and, consistent with values of federalism and judicial restraint, allows States to move carefully in this field. That standard is deferential, but it is not toothless.

This analysis suggests that the liberty interest at issue (that of a competent adult to plan her future medical care) belongs to petitioner, not her parents. Petitioner was an adult at the time of her accident, and she was able to make her own decisions and exercise her own rights. There is no basis for concluding that petitioner's parents have a due process right to halt her treatment that is somehow independent of petitioner's own desires.

4. The Supreme Court of Missouri applied reasonable rules in this case. Reasonable minds can differ on whether courts are best suited to determine an incompetent patient's preferences, or whether more informal procedures are preferable. Thus, to the extent that the Supreme Court of Missouri held that petitioner's feeding tube could not be withdrawn without court approval, that decision should be affirmed.

The Missouri Supreme Court also reasonably adopted a "clear and convincing evidence" standard of proof. This case involves the most profound and fundamental ques-

tions of life or death. The state supreme court, in accordance with the decisions of several other state courts, reasonably concluded that any error should be made on the side of life. In so doing, however, the court did not take an unreasonably rigid approach to the evidence of petitioner's wishes. The court reviewed the evidence of petitioner's intent—primarily hypothetical statements made in response to another person's condition—and found the evidence to be insufficient under the clear-and-convincing standard. Accordingly, the Supreme Court of Missouri's analysis was consistent with the strictures of the Due Process Clause, even though reasonable judges might well disagree over the weight of the evidence in this tragic case.

ARGUMENT

I. THE SOURCE OF ANY SUBSTANTIVE DUE PROCESS RIGHT TO REFUSE UNWANTED MEDICAL TREATMENT OR PROCEDURES SHOULD BE DRAWN FROM OUR NATION'S HISTORY AND TRADITIONS, NOT FROM A GENERALIZED RIGHT TO PRIVACY

The Due Process Clause provides that no State may "deprive any person of life, liberty, or property, without due process of law." As the word "process" connotes, that Clause primarily imposes procedural safeguards against the arbitrary deprivation of life, liberty, or property. See, *e.g.*, *Daniels* v. *Williams*, 474 U.S. 327, 331 (1986). To be sure, the Due Process Clause has also "been interpreted to have substantive content, subsuming rights that to a great extent are immune from * * * state regulation or proscription." *Bowers* v. *Hardwick*, 478 U.S. 186, 191 (1986). See, *e.g.*, *Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925) (invalidating statute requiring all children to attend public schools); *Meyer* v. *Nebraska*, 262 U.S. 390 (1923) (invalidating statute prohibiting the teaching of German); *Poe* v. *Ullman*, 367 U.S. 497, 539-545 (1961) (Harlan, J., dissenting). But this Court has traditionally exercised restraint in identifying "liberty"

interests entitled to significant substantive protection. As this Court stated in *Bowers*, 478 U.S. at 194, the Court "is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution." See also *Graham* v. *Connor*, 109 S. Ct. 1865, 1871 (1989) (claims of constitutional protection against intrusive governmental conduct should, where possible, be based on an "explicit textual source" rather than "the more generalized notion of 'substantive due process' ").

Reflecting this restraint, this Court's general standard for reviewing substantive due process claims is highly deferential to legislative judgments. As a rule, a state (or federal) statute that trenches upon a liberty interest will be upheld so long as it is rationally related to a legitimate state interest. See, *e.g.*, *Califano* v. *Aznavorian*, 439 U.S. 170, 176-178 (1978); *Williamson* v. *Lee Optical Co.*, 348 U.S. 483, 488 (1955). In certain narrow areas, however, the Court has held that particular liberty interests are subject to a more exacting standard of judicial review. The critical determination in finding that a liberty interest will be afforded heightened protection is that it constitutes a "fundamental right." *Michael H.* v. *Gerald D.*, 109 S. Ct. 2333, 2341 (1989) (plurality opinion).

The state courts that have considered whether a person in petitioner's situation has a fundamental right to refuse life-sustaining medical procedures have identified two possible sources for such a right. Some courts, extrapolating from *Griswold* v. *Connecticut*, 381 U.S. 479 (1965), and *Roe* v. *Wade*, 410 U.S. 113 (1973), have discovered a fundamental right to refuse treatment in a general "right of privacy." See, *e.g.*, *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, 663 (1976); *Superintendent of Belchertown State School* v. *Saikewicz*, 370 N.E.2d 417, 422 (Mass. 1977). In our view, the Missouri Supreme Court was entirely correct in questioning that approach. See Pet. App. A22-A24. Although the Court has discerned certain substan-

tive due process rights grounded in concerns for privacy, the Court has declined to extend those rights beyond limited aspects in the areas of "family, marriage, [and] procreation." *Bowers* v. *Hardwick*, 478 U.S. at 191 (rejecting claim that there is a due process right to engage in homosexual sodomy). Accordingly, the Court should decline petitioner's invitation to extend the "right of privacy" to cover all types of decisions about medical treatment and procedures. Such an approach invites judicial intervention based on little more than "the predilections of those who happen at the time to be Members of th[e] Court." *Moore* v. *East Cleveland*, 431 U.S. 494, 502 (1977) (plurality opinion); see also *Bowers* v. *Hardwick*, 478 U.S. at 194; L. Hand, *The Bill of Rights* 38 (1958).

Other courts, however, have identified a fundamental right to refuse medical treatment based on the historical understanding of "liberty" held by the Framers and reflected in the common law. See, *e.g.*, *Tune* v. *Walter Reed Army Medical Center*, 602 F. Supp. 1452 (D.D.C. 1985); *McConnell* v. *Beverly Enterprises-Connecticut, Inc.*, 209 Conn. 692, 553 A.2d 596, 601 (1989); *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 72 (1981). That approach, we submit, is more in keeping with the Court's teachings. In contrast to abstract motions of a generalized "right to privacy," historical sources—including the Framers' understanding and our Nation's longstanding traditions—provide a more objective basis for identifying liberty interests entitled to heightened judicial protection. By limiting the scope of substantive due process to those interests that have received the sanction of history, tradition and law, the Due Process Clause serves "to prevent future generations from lightly casting aside important traditional values" without at the same time becoming a judicial license "to invent new ones." *Michael H.* v. *Gerald D.*, 109 S. Ct. at 2341 n.2 (plurality opinion). Thus, in considering whether petitioner has a significant liberty interest in refusing medical treatment, this Court should look to historical sources, including the understand-

ing of the Framers and our Nation's deeply rooted traditions, especially as reflected in law.

II. EVEN IF A CURRENTLY COMPETENT ADULT HAS A QUALIFIED FUNDAMENTAL RIGHT TO REFUSE LIFE-SUSTAINING MEDICAL TREATMENT, THAT RIGHT DOES NOT EXTEND TO AN INCOMPETENT PATIENT IN THE CIRCUMSTANCES OF THIS CASE

In order to determine whether petitioner, a previously competent adult who is now incompetent, has any fundamental right to refuse life-sustaining medical procedures, it is appropriate to consider what, if any, due process rights a currently competent adult would have in similar circumstances. The Court need not, of course, definitively resolve any questions regarding the rights of competent adults in this case. Nevertheless, there are at least three reasons why this preliminary inquiry is instructive. First, if a currently competent adult has no significant liberty interest in refusing life-sustaining treatment, then it could scarcely be argued that an incompetent adult has such a right. Second, it would be difficult if not impossible to determine what weight should be given to any decision petitioner made when she was competent without having some notion of the rights of competent persons to refuse treatment generally. And third, any limitations that may exist upon the rights of competent persons may suggest important factors in determining the appropriate standard of review for resolving controversies involving currently incompetent persons.

1. The exact content of the original understanding of the concept of "liberty" protected by the Due Process Clause remains a matter of considerable dispute. But it is universally agreed that, at a minimum, the Framers understood "liberty" to mean freedom from state-imposed physical restraints.[6] As this Court has observed, freedom

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[6] See Shattuck, *The True Meaning of the Term "Liberty" in Those Clauses in the Federal and State Constitutions Which Protect "Life, Liberty and Property,"* 4 Harv. L. Rev. 365, 382 (1890);

from physical restraints "always has been recognized as the core of the liberty protected by the Due Process Clause." *Youngberg* v. *Romeo*, 457 U.S. 307, 316 (1982); see *Michael H.* v. *Gerald D.*, 109 S. Ct. at 2341 (plurality opinion); *Meyer* v. *Nebraska*, 262 U.S. at 399. Although we are unaware of any direct evidence of the Framers' views regarding freedom from unwanted medical procedures, it is difficult to imagine how a State could impose a physically intrusive medical procedure on a competent adult without subjecting her to some form of bodily restraint. Thus, even if the concept of "liberty" is given its most narrow definition, the "liberty" protected by the Due Process Clause would likely be construed to include the interest of a competent adult in refusing unwanted medical treatments. See *Rochin* v. *California*, 342 U.S. 165, 172 (1952) (agents violated due process when they seized suspect and forcibly extracted the contents of his stomach).

This understanding of the traditional meaning of "liberty" finds support in the Court's decisions interpreting the related guarantee, set forth in the Fourth Amendment, of "[t]he right of the people to be secure in their persons * * * against unreasonable searches and seizures." The Court has consistently held that state-mandated intrusions into the human body designed to uncover evidence of wrongdoing are "searches" for purposes of the Fourth Amendment. See, *e.g.*, *Skinner* v. *Railway Labor Executives' Ass'n*, 109 S. Ct. 1402, 1412 (1989) (drug testing by urinalysis and drawing of blood); *Winston* v. *Lee*, 470 U.S. 753, 760 (1985) (surgical procedure to remove bullet from chest); *Schmerber* v. *California*, 384 U.S. 757, 767-768 (1966) (alcohol testing by drawing of blood). To be sure, none of those decisions is directly

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Warren, *The New "Liberty" Under the Fourteenth Amendment*, 39 Harv. L. Rev. 431 (1926). Blackstone defined "liberty" as "the power of locomotion, of changing situation, or removing one's person to whatsoever place one's own inclination may direct, without imprisonment or restraint, unless by due course of law." 1 W. Blackstone, *Commentaries on the Law of England* *130.

concerned with unwanted medical intrusions undertaken for therapeutic rather than investigatory purposes. Nevertheless, they demarcate a zone of interests closely associated with the historical understanding of "liberty" shared by the Framers.

The available evidence regarding the Framers' understanding of "liberty" is reinforced by consideration of our Nation's history and traditions, particularly as reflected in the common law. It is well established that history and tradition provide an appropriate source for defining the contours of constitutionally protected "liberty." In the classic formulation, Justice Cardozo wrote in *Snyder* v. *Massachusetts*, 291 U.S. 97, 105 (1934), that the Due Process Clause protects those rights "so rooted in the traditions and conscience of our people as to be ranked as fundamental." The relevant traditions, in Justice Cardozo's view, were those that enjoyed the long-standing sanction of law, including the common law—"the authentic forms through which the sense of justice of the People" expresses itself. *Id.* at 122. Subsequent decisions have confirmed that this approach delimits a narrow range of due process rights entitled to substantive protection. See, *e.g.*, *Griswold* v. *Connecticut*, 381 U.S. at 501 (Harlan, J., concurring); *Moore* v. *East Cleveland*, 431 U.S. at 503 (plurality opinion); *Bowers* v. *Hardwick*, *supra*; *Michael H.* v. *Gerald D.*, *supra*.

It was well settled at common law that a competent person could decline medical treatment. See *Mills* v. *Rogers*, 457 U.S. 291, 294 n.4 (1982); W. Keeton, *Prosser and Keeton on the Law of Torts* § 18, at 116-119 (5th ed. Supp. 1984). Indeed, a physician committed a common-law tort when he touched a patient if he did not first obtain the patient's informed consent. Then-Judge Cardozo succinctly stated the common-law rule in *Schloendorff* v. *Society of New York Hosp.*, 211 N.Y. 125, 129-130, 105 N.E. 92, 93 (1914): "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an

operation without his patient's consent commits an assault, for which he is liable in damages." Accord *Natansen* v. *Kline*, 186 Kan. 393, 350 P.2d 1093, 1104 (1960); *Mohr* v. *Williams*, 95 Minn. 261, 104 N.W.2d 12 (1905).

2. Other elements in our Nation's history and traditions, however, suggest that any constitutionally based due process right to refuse medical procedures must be regarded as significantly qualified. First, some kinds of state-imposed physical restraints are clearly less intrusive deprivations of "liberty" than others. This Court has previously recognized a distinction, for due process purposes, between incarceration by the State to secure an alleged criminal offender or inflict punishment, and restraints imposed by the State for the purpose of enhancing a person's welfare. Thus, in *Addington* v. *Texas*, 441 U.S. 418, 425 (1979), the Court acknowledged that "civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection." But the Court declined to extend the "beyond a reasonable doubt" standard of proof used in criminal trials to civil commitment proceedings, noting, among other things, "[i]n a civil commitment state power is not exercised in a punitive sense." *Id.* at 428. For the same reason, state-imposed medical procedures, although no doubt implicating a significant liberty interest, should not be regarded as presenting the same degree of intrusion as arrest or imprisonment.

Nor do the few decisions of this Court dealing directly with an asserted constitutional right to refuse medical treatment suggest that such a right would be so fundamental that only the most compelling government interests could overcome it. For example, in the leading case of *Jacobson* v. *Massachusetts*, 197 U.S. 11 (1905), the Court upheld a state law requiring smallpox vaccinations over the objections of a competent adult. The Court acknowledged that a person has a substantial liberty interest in being free from unwanted medical treatments, but

held that "his liberty may at times, under the pressure of great dangers, be subjected to such restraint * * * as the safety of the general public may demand." *Id.* at 29.

Similarly, although the common-law privilege against unwanted medical intrusions was once thought to preclude a court from ordering a party to litigation to submit to a medical examination, *Union Pacific Ry.* v. *Botsford*, 141 U.S. 250 (1891), later decisions have settled that there is no significant constitutional impediment standing in the way of such an order. Specifically, in *Sibbach* v. *Wilson & Co.*, 312 U.S. 1 (1941) and *Schlagenhauf* v. *Holder*, 379 U.S. 104, 112-114 (1964), this Court upheld, in the face of constitutionally based objections, the provision of Fed. R. Civ. P. 35(a) that permits a federal district court to direct a party to litigation, "on motion for good cause shown and upon notice to the persons," to submit to a medical examination. In so ruling, the Court did not suggest that the right to refuse medical intrusions was "fundamental." To the contrary, the Court in *Sibbach* rejected the contention that Rule 35(a) "offends the important right to freedom from invasion of the person," in part because no such invasion "attaches to refusal to comply with its provisions," and in part because "[i]f we were to adopt the suggested criterion of the importance of the alleged right we should invite endless litigation and confusion." 312 U.S. at 14.

Moreover, although the common-law privilege to refuse medical treatment has generally been recognized to extend to life-saving as well as other procedures,[7] history

[7] Virtually all courts that have considered the matter have concluded that the common-law privilege to refuse unwanted medical treatment extends to life-threatening situations. See, *e.g.*, *In re Gardner*, 534 A.2d 947, 951 (Me. 1987); *Tune* v. *Walter Reed Army Medical Hospital*, 602 F. Supp. at 1455; *Natanson* v. *Kline*, *supra*. The few decisions that have directed the imposition of medical procedures to competent adults in life-threatening situations have rested on the conclusion that this is in fact what the person would want, and that their consent had been withheld only because of

and tradition speak much less clearly with respect to the termination of nourishment.[8] There obviously can be no serious claim that a competent adult has a due process right to starve himself to death by refusing food and water ingested in an ordinary manner. To the contrary, the States historically prohibited attempted suicide, and some States make it a crime to assist a suicide, see *President's Commission for the Study of Medicine and Biomedical and Behavioral Research: Deciding to Forego Life-Sustaining Treatment* 37 & n.73 (1983) (*President's Commission*). This Court has consistently assumed that those laws are constitutional. See *Paris Adult Theatre I* v. *Slaton*, 413 U.S. 49, 68 n.15 (1973); *Mormon Church* v. *United States*, 136 U.S. 1, 49-50 (1890); *Reynolds* v. *United States*, 98 U.S. 145, 166 (1878). Thus, there can be no claim grounded in our Nation's history and traditions that the Due Process Clause protects attempted suicide, whether by starvation or otherwise.[9]

We do not suggest that the refusal of any form of medical treatment in a life-threatening situation is tantamount to attempted suicide. There is a common-sense distinction between resisting physical intrusions by third parties (in this case the State) and taking affirmative measures to end one's own life. See, *e.g.*, *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, 670, cert. denied, 429 U.S. 922 (1976). The court in *In re Conroy*, 486 A.2d 1209

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religious objections to the act of giving written consent itself. See *Application of President & Directors of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir. 1964) (Wright J., in chambers); *Powell* v. *Presbyterian Medical Center*, 49 Misc. 2d 215, 267 N.Y.S. 2d 450 (Sup. Ct. 1965).

[8] Members of the Court in *Michael H.* disagreed on the level of specificity required in deciding whether a certain right has been historically protected. Compare 109 S. Ct. at 2344 n.6 (Scalia, J.); with *id.* at 2346-2347 (O'Connor, J., concurring); and *id.* at 2350-2351 (Brennan, J., dissenting).

[9] For example, courts have held that a State may require the force feeding of a prisoner on a hunger strike. See, *e.g.*, *Von Holden* v. *Chapman*, 87 A.D.2d 66, 450 N.Y.S.2d 623, 627 (1982).

(N.J. 1985), summarized this position: "Refusing medical intervention merely allows the disease [or condition] to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease [or condition], and not the result of a self-inflicted injury." *Id.* at 1224. Accord *Rasmussen* v. *Fleming*, 154 Ariz. 200, 204, 741 P.2d 674, 685 (1986). Nor do we suggest that either the States or the federal government *must*, as a constitutional matter, regard a surgically implanted feeding tube as different in kind from other types of medical procedures.

We do submit, however, that our Nation's history and traditions cannot be said to establish any unequivocal consensus with respect to whether a competent adult should be able to refuse or remove a surgically implanted feeding tube, when the consequences of that action will lead to death.[10] And the question is plainly a matter of significant controversy as to which reasonable minds can and will differ. On the one hand, courts have held that the provision of food and fluids through a tube to a patient who is physically unable to eat is a medical procedure. See *Gray* v. *Romeo*, 697 F. Supp. 580, 587 (D.R.I. 1988); *In re Guardianship of Grant*, 747 P.2d 445, 453 (Wash. 1987); *In re Conroy*, 486 A.2d at 1236. The American Medical Association agrees with that position. See *Withholding Or Withdrawing Life-Prolonging Medical Treatment*, Current Opinions of the Ethical and Judicial Affairs of the American Medical Association (1986). Congress, however, has drawn a different conclusion, at least in the context of severely disabled infants. As part of the Child Abuse Amendments of 1988, Congress specifically required that federal grantees must treat with-

[10] It should not be surprising that there is a paucity of historical material dealing with the precise problem of feeding tubes, since medical science has only recently advanced to the point where it is not uncommon that persons may be kept alive indefinitely in a permanent vegetative state. See *Standards and Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC)*, 255 J.A.M.A. 2905 (1986).

drawal of an infant's nutrition and hydration, as opposed to other types of medical care, as a form of medical neglect. See Pub. L. No. 100-24, § 101, 102 Stat. 111-112, 117, to be codified at 42 U.S.C. 5106a(b)(10), 5106g(10).

3. But even assuming *arguendo* that a competent adult would have a fundamental right to demand the removal of a surgically implanted feeding tube, it does not follow that any such right would extend to an adult who is currently *incompetent*. Whatever else may be said about the outer limits of such a right, it cannot plausibly be maintained that it would extend to a decision made without adequate consideration of the consequences.[11] Courts have recognized as a matter of common law that a physician must ensure that a patient makes an informed decision

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[11] We do not suggest that this qualification exhausts the limitations on any liberty interest in refusing medical treatment. For example, the traditional right to refuse treatment would also be highly qualified where, for example, a mentally ill person has been found incompetent to stand trial, has been convicted of a crime and imprisoned, or has been involuntarily committed to a mental institution. It is clear that such confinement carries with it the circumscription or loss of many rights, see *Hudson* v. *Palmer*, 468 U.S. 517, 524 (1984), including the extinction of many of the liberty interests enjoyed by other citizens. See also *Youngberg* v. *Romeo*, 457 U.S. at 318-323. The Court has recognized that this curtailment of rights is necessary, as a practical matter, to accommodate competing "institutional needs and objectives," *Hudson*, 468 U.S. at 524, which include the need to protect the safety and well-being of inmates and others at the institution. Thus, for example, we think that the question whether a potentially violent or gravely disabled inmate may refuse antipsychotic medication presents far different considerations from those at issue in this case. (That question is currently before the Court in *Washington* v. *Harper*, No. 88-599 (argued Oct. 11, 1989). We have provided the parties with copies of our brief as amicus curiae filed in that case.) Moreover, questions involving the medical treatment of other institutionalized persons, such as those committed to a mental hospital, also present distinct issues because of the State's legitimate concern with the rights of other patients, and because mentally incompetent persons cannot, and may never have been able to, form independent judgments about their appropriate treatment. See note 14, *infra*.

before declining medical treatment in a potentially life-threatening situation. *Truman* v. *Thomas*, 611 P.2d 902 (Cal. 1980). By the same reasoning, any due process right to refuse treatment should be limited to decisions made with the patient's informed consent. Indeed, this Court has concluded that a requirement of "prior written consent for any surgery" would be constitutional. *Planned Parenthood* v. *Danforth*, 428 U.S. 52, 67 (1976). The same should be true of a requirement of prior consent to refuse surgery or other forms of medically indicated treatment where the decision to decline treatment may directly lead to death or disability.

This qualification is ultimately grounded in the State's profound interest in preserving human life. See Pet. App. A38 ("The state's relevant interest is in life, both its preservation and its sanctity."). A rash or ill-considered decision to refuse treatment that leads to death may be regarded as an unwanted loss of life, a tragedy that the State surely has a compelling interest in seeking to prevent. Thus, the States should be free to take reasonable measures to ensure that competent patients are fully informed of the consequences of any decision to refuse life-sustaining medical procedures, as well as to take reasonable steps to ensure that the patient has given adequate, careful consideration to the alternatives.

This qualification establishes that, if there is a fundamental right to refuse medical treatment, that right cannot be exercised by a person who is currently incompetent. The notion that a currently incompetent adult may make an informed decision to refuse life-sustaining treatment is a contradiction in terms. This is not to say that a *competent* adult may not make a fully informed and considered decision to refuse treatment in the future; nor does it mean that such a decision for the future is not entitled to be respected through some form of substitute decisionmaking (a possibility we address in Part III). But unless petitioner can demonstrate that she formed an intent to refuse treatment sometime *before* she became in-

competent, she cannot, notwithstanding the tragic circumstances that have befallen her, now claim a fundamental liberty interest in refusing unwanted treatment.[12]

III. THE LIBERTY INTEREST IN REFUSING LIFE-SUSTAINING MEDICAL TREATMENT IS NOT "FUNDAMENTAL" WHEN AN ATTEMPT IS MADE TO EXERCISE THAT INTEREST ON BEHALF OF AN INCOMPETENT

Although petitioner cannot be said to have any fundamental right to refuse treatment based on her present

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[12] Although the Supreme Court of Missouri did not rely in this case on any Missouri policy prohibiting the termination of life-sustaining procedures when patients are in public, as opposed to private care, we also think that any due process right to refuse treatment should not entail the right to have *state* employees at a *state*-owned hospital assist in the removal of life-sustaining devices. The historical interest potentially protected by the Due Process Clause is the interest in being free from unwanted medical treatment, not a right to the aid of state officials to carry out a wish to die. Indeed, as the Court noted last Term in *DeShaney* v. *Winnebago County Dep't of Social Services*, 109 S. Ct. 998, 1003 (1989), this Court's "cases have recognized that the Due Process Clauses generally confer no affirmative right to government aid." The Due Process Clause limits the power of the States to force medical procedures on unconsenting patients within its borders; however, it emphatically does not forbid a State from adopting a policy of not terminating life-support systems in its own hospitals. That is clear from the Court's decision in *Webster* v. *Reproductive Health Services*, 109 S. Ct. 3040 (1989), in which the Court upheld a Missouri law prohibiting the use of public employees and facilities to perform abortions. The plurality stated that "the State's decision * * * to use public facilities and staff to encourage childbirth over abortion 'places no governmental obstacle in the path of a woman who chooses to terminate her pregnancy.'" *Id.* at 3052 (quoting *Harris* v. *McRae*, 448 U.S. 297, 313 (1980)). Likewise, as long as a patient is free to leave a state hospital, the State erects no unconstitutional barrier to a patient's exercise of due process liberty interests by having a rule requiring the use of life-sustaining procedures in its hospitals. See generally *Brophy* v. *New England Sinai Hospital*, 398 Mass. 417, 497 N.E.2d 626, 639 (1986) (modifying judgment so that the hospital did not have to remove feeding tube but requiring it "to assist the guardian in transferring the ward to a suitable facility, or to his home").

condition as an incompetent, that does not exhaust the constitutional issues presented by this difficult case. It is also necessary to consider: (1) whether petitioner made a decision about life-sustaining medical treatment when she was competent; and (2) whether petitioner's parents have a constitutional right to make treatment decisions on petitioner's behalf.

1. This Court has consistently held that all persons—not only competent adults—enjoy the liberty interests protected by the Due Process Clause. For example, in *Youngberg* v. *Romeo*, 457 U.S. 307 (1982), the Court ruled that a severely retarded man with the mental age of an infant retained substantive liberty interests in medical care, freedom of movement, and appropriate training. *Id.* at 315-316. Similarly, in *Parham* v. *J.R.*, 442 U.S. 584 (1979), the Court recognized the liberty interests of children to be free from civil commitment. See also *Jackson* v. *Indiana*, 406 U.S. 715, 717 (1972) ("mentally defective deaf mute" has due process right to fair confinement). Thus, "the trend in the law" has been to give incompetent persons rights similar to other individuals. *Saikewicz*, 370 N.E.2d at 428.

It follows that a person in petitioner's situation—once competent but now in a permanent vegetative state by virtue of a grievous injury—should not have her liberty interest in refusing medical treatment extinguished *solely because* she is incompetent. The law, of course, has long allowed persons to direct the disposition of their property after death. See *Taylor* v. *Mason*, 22 U.S. 325 (1824); see also *Hodel* v. *Irving*, 481 U.S. 704, 716 (1987). And there is no reason why the law should not also recognize the well-considered choice of a competent person that, were the situation to arise, she would not want to be kept alive in a permanent vegetative state by means of physically intrusive life-sustaining procedures. To require the impossible—*i.e.*, a rule that the vegetative person must currently speak for herself—"would result in the nullification of the [person's due process] right at the very

moment of its assertion." *NAACP* v. *Alabama*, 357 U.S. 449, 459 (1958). See *John F. Kennedy Memorial Hosp.* v. *Bludworth*, 452 So. 2d 921, 924 (Fla. 1984). It would condemn the incompetent person to a world where the only course of action would be the governmentally forced continuation of intrusive medical procedures, no matter how painful or futile.

In this regard, it is relevant that the common law, which as we described above recognized a privilege to refuse medical treatment, also speaks to situations in which patients cannot decide for themselves at the moment a medical choice must be made. For example, the common law has addressed situations where a surgeon discovers conditions that warrant an extension of surgery while a previously competent patient is under anesthesia. In general, the surgeon can extend the operation in such circumstances only if a "reasonable [person] would consent." Restatement (Second) of Torts § 62, illus. 4 (1964). The surgeon, however, cannot go beyond the scope of the originally planned operation if he knows that the patient "would not consent to the new or extended operation." *Id.*, illus. 5. Hence, the common law, this Court's decisions, and common sense all agree: if petitioner had exercised any liberty interest in refusing life-sustaining medical procedures when she was still competent, that decision should not go unprotected *solely* because she is now unable to decide for herself.

Even if we assume that any right to refuse treatment extends to decisions made to govern future events, however, there are powerful governmental interests in overseeing the implementation of such decisions that significantly qualify that right. One, of course, is the State's profound interest in preserving and protecting the lives of those who cannot protect themselves. See Mo. Rev. Stat. § 475.120.3 (1989) (providing that a guardian must promote the safety and health of the ward); *Jones* v. *Helms*, 452 U.S. 412 (1981) (upholding law making it a felony to abandon a dependent child). Where currently

competent adults are concerned, the instinct for self-preservation will ordinarily provide adequate protection against abuse of the right to refuse treatment. But where a once-competent adult is no longer able to speak for herself, this natural check is gone. As a consequence, the State has a correspondingly greater interest in ensuring that life-and-death decisions made on behalf of an incompetent patient are made with great care to prevent possible abuses.

In addition, the State's interest in ensuring that any decision to refuse life-sustaining medical treatment is fully informed and considered also faces special obstacles in situations involving incompetent patients. No matter how well we plan, the future will likely bring with it surprises, or simply new perspectives on old problems. And there is always a danger in giving effect to decisions made under hypothetical circumstances, when the full enormity and gravity of the consequences cannot fully be comprehended. In view of those considerations, the State is surely justified in imposing and demanding the most careful standards and procedures in attempting to ascertain whether a previously competent person truly did form an intent to refuse future medical treatment.

In light of the compelling governmental interests in protecting incompetent persons and in assuring accurate determinations of an incompetent patient's wishes, decisions by the States and the federal government about appropriate evidentiary standards and procedures for giving effect to decisions by previously competent adults should not be subject to any heightened standard of judicial review. Instead, the Due Process Clause should be construed to afford considerable flexibility to governmental decisionmakers in this sensitive and difficult area. The appropriate standard of review is, we believe, one that asks whether the governmental regulation is "reasonably designed" to serve a legitimate state interest. See *Webster*, 109 S. Ct. at 3058. This "reasonableness" test finds support in the Court's decisions regarding other

substantive liberties protected by the Due Process Clause that are qualified by significant countervailing interests. For example, in cases involving the rights of prisoners, where an individual's constitutionally protected rights are not extinguished, but nevertheless are qualified by the substantial governmental interests in maintaining the proper administration of a prison environment, this Court has held that the appropriate standard of review is whether a prison regulation is " 'reasonably related' to legitimate penological objectices." *Turner* v. *Safley*, 482 U.S. 78, 87 (1987). Similarly, in *Youngberg* v. *Romeo*, *supra*, the Court considered the liberty interests of an involuntarily committed retarded person and held that his "liberty interests require the State to provide * * * *reasonable training* to ensure safety and freedom from undue restraint." 457 U.S. at 319 (emphasis added).

The use of a such a standard in this context is not only rooted firmly in law but serves instrumentalist and federalism values as well, inasmuch as it allows the States "to move slowly and to gain experience in this highly sensitive field." *In re Conroy*, 486 A.2d at 1244. Moreover, although this standard of review is deferential, it is not toothless. Under this approach, the States may *not* adopt rules that completely foreclose any possibility that a competent person may direct her future medical treatment. But as we discuss in Part IV, it permits a wide range of evidentiary standards and procedural rules designed to protect incompetent persons against abuse and to ensure that any decision they may have made when competent was well considered.

2. Although a decision by a competent person to refuse medical treatment may be projected forward in time, and thus may be asserted in the future by a surrogate (subject to reasonable regulation by the State), it does not follow that the surrogates themselves have any constitutional right to insist that medical treatment be withheld for an incompetent person. Any right to decline medical treatment belongs to petitioner, not her parents. Accord-

ingly, the inquiry must be focused on what *petitioner* would want. The task is "to determine and to effectuate, insofar as possible, the decision that the patient would have made if competent." *In re Conroy*, 486 A.2d at 1229.

In this case, the co-guardians are petitioner's parents. This Court has, of course, held that the Due Process Clause guarantees parents certain freedoms in rearing their children. See *Pierce* v. *Society of Sisters*, *supra*; *Meyer* v. *Nebraska*, *supra*; cf. *Wisconsin* v. *Yoder*, 406 U.S. 205 (1972). But this Court's decisions with respect to parental rights apply only in the case of minor children. Our legal traditions do not recognize that the parents of adult children may exercise their children's liberty interests for them. See *Smith* v. *Seibly*, 72 Wash. 2d 16, 431 P.2d 719 (1967) (emancipated child must consent to operation); *Cohen* v. *Delaware, L. & W.R.R.*, 150 Misc. 450, 269 N.Y.S. 667, 672 (1934) (when emancipated, "the child is thrown upon [his] own resources and is free to act upon [his] own responsibilities and in accordance with [his] own desire").

Petitioner was a competent adult at the time of her tragic accident in January 1983; prior to that time, petitioner was fully able to make her own choices and to exercise her own rights. Thus, there is no basis for concluding that petitioner's parents have a due process right to halt her treatment and that their "right" is independent from petitioner's own desires. See *In re Quinlan*, 355 A.2d at 664 ("there is no parental constitutional right" to choose the proper treatment for an adult child). The Due Process Clause is concerned only with petitioner's preferences.

The subjective nature of this inquiry powerfully vindicates Missouri's concern—as expressed by the Missouri Supreme Court (Pet. App. A29)—about having to draw official distinctions concerning the "quality" of different lives. Under the substituted—judgment test, the fact-finder is interested only in the *patient*'s judgments about

medical procedures, and the *patient's* assessment of whether a certain type of life is worth living. See also *In re Westchester County Medical Center (O'Connor)*, 72 N.Y.2d 517, 531 N.E.2d 607, 613 (1988) ("no person or court should substitute its judgment as to what would be an acceptable quality of life for another"). The right is based on the premise that each patient's decision regarding her own medical treatment must be respected "whether that decision is wise or unwise." *Brophy*, 497 N.E.2d at 633. Accordingly, under the analysis required by the Due Process Clause, the "substitute" decisionmaker asks what the incompetent patient would want, not what she should want.[13]

This analysis applies in this case because petitioner was a competent adult before her accident. It is thus appropriate to look into petitioner's past to see if it can be reliably determined that she formed a considered view about whether she would want to be kept alive in her current condition. By the same token, the analysis would not apply in the case of persons who were never competent to express an intent. In such a case, there is no reliable evidence of what the patient would have done under the circumstances. *Rassmussen* v. *Fleming*, 741 P.2d at 688-691. In that type of case—where the traditional, qualified right to refuse medical treatment is not implicated—a different analysis would be required.[14] In

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[13] This is not to say that an inquiry into the patient's best interests is not relevant in ascertaining what she would want. Most people are presumed to want what is in their best interests. For that reason, state law typically imposes a "best interests" test in cases where a third party must make decisions for someone who is not able to speak competently for herself. See, *e.g.*, *Palmore* v. *Sidoti*, 466 U.S. 429, 433 (1984).

[14] The "substituted judgment" analysis would therefore be inapplicable in cases involving long-term mentally incompetent patients. Moreover, if such persons have been institutionalized, the substantial state interest in protecting the welfare of other patients may be implicated by individual treatment decisions, for example those involving antipsychotic drugs. See U.S. Brief at 21, in *Washington* v. *Harper*, No. 88-599. In cases involving infants, not only

this case, however, petitioner "was once capable of developing views relevant to the matter at hand." *President's Commission* at 13.

IV. THE SUPREME COURT OF MISSOURI APPLIED REASONABLE RULES IN THIS CASE

The foregoing discussion suggests that it is important to distinguish between the due process rights of currently competent adults, currently incompetent adults, and previously competent adults who are now incompetent. Whatever may be said about the rights of a currently competent adult, an adult who is now incompetent cannot make an informed decision to refuse treatment, and thus cannot be said to have a qualified fundamental right. An adult who was previously competent may not have any rights she may have enjoyed extinguished solely because she is now incompetent. Nevertheless, in view of the State's powerful interests in protecting incompetent persons against abuse and in ensuring that any decision made in the past was well considered, state rules of evidence and procedure designed to give effect to previous decisions to refuse treatment should be upheld as long as they are "reasonably designed" to serve an important state interest. *Webster*, 109 S. Ct. at 3058. We turn, then, to the question whether Missouri's rules, as articulated by its Supreme Court, satisfy this reasonableness test.

1. There are several different but reasonable procedures that the state and federal governments may choose to follow in this sensitive area. For example, we believe it entirely permissible for a State (or the federal govern-

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is the substituted judgment analysis inapplicable, but the rights of parents to make decisions regarding the care and treatment of their children would also have to be taken into account. In light of the many valid state interests in this context—*e.g.*, in fostering the sanctity of life, in protecting life, and in respecting considered family choices—the States surely have wide latitude in adopting reasonable policies to protect the very young. Cf. *Bowen* v. *American Hospital Ass'n*, 476 U.S. 610 (1986).

ment) to establish a procedure that does not entail judicial participation in the process of ascertaining the wishes of an incompetent person. See *Application of President & Directors of Georgetown College, Inc.*, 331 F.2d at 1017-1018 (Burger, J., on denial of rehearing en banc). The highest courts in Arizona, Georgia and Minnesota, for example, have endorsed procedures that contemplate that a court will generally *not* be involved in the decision whether to end life-sustaining treatments. *See Rasmussen* v. *Fleming*, 741 P.2d at 691; *In re L.H.R.*, 253 Ga. 439, 321 S.E.2d 716, 723 (1984); *Conservatorship of Torres*, 57 N.W.2d 332, 341 n.4 (Minn. 1984). We believe that such an approach—one that assumes the active involvement of the patient's family and physician is adequate to guard against abuse or mistakes in ascertaining the patient's wishes—is reasonable and fully consistent with the Constitution.

The Supreme Judicial Court of Massachusetts has embraced a different approach. In *Superintendent of Belchertown State School* v. *Saikewicz*, that court held that life-sustaining procedures could be discontinued only on the order of a probate judge. 370 N.E.2d at 434. The Massachusetts court ruled: "[S]uch questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created." *Id.* at 435. The Massachusetts approach for discovering the patient's intent is also reasonable. It does not erect such an impregnable barrier to ascertaining the wishes of an incompetent person that it deprives her of any opportunity to exercise any right to refuse treatment, yet it also reflects the longstanding judgment that courts may appropriately play an important role in ensuring that incompetent persons are protected from abuse or mistakes.

In short, there is no consensus in the law as to whether a court should be involved in the decision to end (or not to begin) life-sustaining medical procedures. Reasonable

minds can and will differ on whether courts are best suited to make the inquiry into the incompetent patient's preference, or whether more informal, nonjudicial procedures are preferable. Both approaches, however, are fully permissible under the Due Process Clause. Accordingly, to the extent that the Supreme Court of Missouri held that petitioner's feeding tube could not be withdrawn without court approval, the decision should be affirmed.

2. The Supreme Court of Missouri also embraced a strict standard of proof to support a finding that an incompetent patient would not want to be kept alive. Certain statements in the opinion suggest a standard so strict that it could have the effect of depriving most persons of the opportunity to exercise any right to refuse treatment by expressing their wishes in advance. See pp. 31-32, *infra*. But the actual holding of the court is that "no person can assume that choice for an incompetent in the absence of * * * clear and convincing, inherently reliable evidence." Pet. App. A41; see also Pet. App. A43 (record evidence of "Nancy's wishes is inherently unreliable and thus insufficient"). We believe that such a standard of proof—one that requires clear and convincing evidence to support a finding that the incompetent patient would wish to die—is entirely permissible under the Due Process Clause.

Several state courts have adopted the "clear and convincing evidence" standard of proof. See, *e.g.*, *Rassmussen* v. *Fleming*, 741 P.2d at 691; *In re Storar*, 420 N.E.2d at 72. And this Court noted last Term that the "clear and convincing evidence" standard may be proper in cases where the court is asked to take an "action more dramatic than entering an award of money damages or other conventional relief." *Price Waterhouse* v. *Hopkins*, 109 S. Ct. 1775, 1792 (1989) (plurality opinion). See also *Addington* v. *Texas*, 441 U.S. 418 (1979) (clear and convincing evidence required in order to commit person as mentally ill). In this case, of course, "[t]here is more involved than a typical dispute between private litigants

over a sum of money." *In re Storar*, 420 N.E.2d at 72. To the contrary, this tragic case involves a question of life or death. As a result, a State may reasonably conclude that "if an error occurs it should be made on the side of life." *In re Westchester County Medical Center (O'Connor)*, 72 N.Y.2d 517, 531 N.E.2d 607, 613 (1988).

This is not to say, however, that a State *must* require "clear and convincing evidence" of the incompetent patient's intent to be free from life-sustaining procedures. Indeed, as we indicated above, a State need not involve its courts at all in the decision. See p. 29, *supra*. If a State does decide to bring the courts into the process, a State may permissibly assume that the finder of fact will be sufficiently aware of the consequences of her decision so that it is unnecessary to mandate the use of any special evidentiary standard. See, *e.g.*, *Brophy* v. *New England Sinai Hospital, Inc.*, *supra*. The point is that the Supreme Court of Missouri's requirement of clear and convincing evidence (that petitioner would wish to die under these tragic circumstances) reflects a reasonable judgment consistent with the Due Process Clause—one that takes into account both petitioner's liberty interest and the State's profound interest in protecting life.

3. The States also have a wide range of discretion in assessing the weight of different kinds of evidence with respect to whether the incompetent patient reliably expressed her intent when she was competent. The New York Court of Appeals in *In re Westchester County Medical Center* noted that "[t]he ideal situation is one in which the patient's wishes were expressed in some form of a writing, perhaps a 'living will.'" 531 N.E.2d at 613. The Missouri Supreme Court in this case agreed with that view. The state supreme court apparently would have upheld the trial court's judgment (permitting removal of the feeding tube) if petitioner had complied with the "formalities required under Missouri's Living Will statutes." Pet. App. A41. Accord *In re Conroy*, 486 A.2d

at 1229 (patient's "intent might be embodied in a written document"). The Missouri court reasonably believed that a written document embodying petitioner's intent would have provided the most reliable evidence.

Although we agree that an expression of intent memorialized in a written document provides the best evidence of intent, a rule insisting on such evidence to the exclusion of other types of proof would be difficult to sustain in this case because Missouri's Living Will statute had not even taken effect at the time of petitioner's accident. See Pet. App. A29. But, although there are suggestions in the Missouri Supreme Court's opinion that petitioner's due process rights cannot be exercised "absent the most rigid of formalities," Pet App. A40, we do not understand the holding of the court to rest on that observation. Its holding, rather, is that clear and convincing evidence of intent is rqeuired. Thus, we do not believe that the Court need address the question whether a State may, as a prospective matter, adopt a rule that would respect expressions of future wishes regarding medical treatment only if such statements are found in formal legal documents.[15]

Nor do we read the Missouri Supreme Court opinion as adopting a rule that had the effect of rigidly excluding all testimony of the incompetent patient's family. "Almost invariably the patient's family has an intimate

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[15] Given the universality of state laws requiring that the disposition of property upon death be made by a written will, it would be difficult to argue that there is anything inherently unreasonable with a prospective rule requiring a formal written document to exercise any right to refuse life-sustaining treatment after one becomes incompetent. Of course, in the absence of a written will disposing of property, the rules of intestate succession apply, and those rules are generally designed to reflect what the legislature determines to be the intent of most persons about the proper distribution of their property upon death. Thus, one consideration in assessing the reasonableness of any rule requiring a "living will" would be the manner in which the State proceeds in the absence of such a writing.

understanding of the patient's medical attitudes and general world view." *In re Jobes*, 529 A.2d 434, 445 (N.J. 1987). Thus, family members are often "best qualified to make substituted judgments for incompetent patients." *Ibid.*; *President's Commission* at 43-45, 127-128. Cf. *Parham* v. *J.R.*, 442 U.S. at 602 ("historically it has been recognized that natural bonds of affection lead parents to act in the best interest of their children").

On the other hand, we disagree with petitioner's contention (Br. 25-29) that the testimony of the patient's family must be given conclusive weight. Even the most closely-knit and caring family may find it difficult to focus exclusively on what the patient would want because "the patient's disabilities may be more painful to relatives than to the patient herself." Rhoden, *Litigating Life and Death*, 102 Harv. L. Rev. 375, 440 (1988). Indeed, human experience unfortunately teaches that, unlike petitioner's family, not every family will have the best interests of the patient at heart. Thus, although it would be odd for a State rigidly to disregard all evidence from the patient's family members, it also need not give such evidence conclusive weight.

In sum, we do not read the decision under review as embracing unreasonably rigid approaches to the evidence of petitioner's wishes. Both the trial court and the Supreme Court of Missouri looked to the "oral expressions of the patient" in an attempt to discern petitioner's views. *In re Westchester County Medical Center*, 531 N.E.2d at 614. The trial court found that petitioner's "lifestyle and * * * statements to family and friends suggest that she would not wish to continue her present existence." Pet. App. A94. The Supreme Court of Missouri then examined petitioner's statements and found them insufficient to meet the "clear and convincing evidence" standard.[16] See Pet. App. A37, A43. Other courts have like-

[16] Petitioner argues (Br. 34-35) that evidence of petitioner's independent nature is persuasive evidence that she would not want to be kept alive. We believe, however, that a court need not view

wise accorded diminished weight to such hypothetical statements made by a healthy young person in response to another person's condition. See *In re Jobes*, 529 A.2d at 443; *In re Westchester County Medical Center*, 531 N.E.2d at 614. The Supreme Court of Missouri's analysis, therefore, was consistent with the Due Process Clause, even though reasonable judges might well disagree on whether the evidence in this particular case was clear and convincing. Compare Pet. App. A37, A43 (majority opinion) with *id.* at A66 (Higgins, J., dissenting).

CONCLUSION

The judgment of the Supreme Court of Missouri should be affirmed.

Respectfully submitted.

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such evidence as particularly probative evidence of a wish to die. Moreover, we agree with the Supreme Court of Missouri that a decision to remove a feeding tube—which supplies essential nourishment that all human beings need to sustain life—is one as to which there is far less societal consensus than there is with respect to the removal of other medical support systems or a refusal to accept medical procedures that are provided only to persons who are gravely ill. In terms of ascertaining the intentions of an incompetent patient, therefore, it is surely permissible for a State, intensely interested in preserving life, to require a stronger showing of an intention to refuse food and water than to refuse other medical procedures necessary to forestall disease processes.