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,
Petitioners,
v.

DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, and ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,
Respondents,
v.

THAD C. MCCANSE, Guardian ad litem,
Respondent.

On Writ of Certiorari to the Missouri Supreme Court

BRIEF OF THE AMERICAN COLLEGE OF PHYSICIANS AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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INTEREST OF THE *AMICUS CURIAE*

The American College of Physicians ("ACP") is a private, voluntary, nonprofit organization of physicians trained in internal medicine, the nonsurgical diagnosis and treatment of disease and illness in adults and young adults. ACP is the nation's largest medical specialty society, with a membership of more than 63,000 internists who include practitioners providing primary health care; medical specialists in such fields as cardiology, neurology,

and oncology; and medical researchers and educators. Founded in 1915 to uphold high standards in medical practice, education, and research, ACP continues to strive to meet those goals and has more recently added practice standards-setting; technology assessment; and health policy, ethical, and medico-legal issues analysis to its activities.

The framework for making decisions about who among the very seriously ill shall live, who shall die, and how, is not a matter within the exclusive purview of medicine. Medical professionals have a unique perspective to contribute, however, as society and the courts undertake consideration of these issues. The decision in this case will have an enormous impact on many of ACP's members, their patients, the families of patients, and the community at large. ACP therefore wishes to offer its views on the issues before the Court in this case.[1]

MEDICAL BACKGROUND

The following medical information regarding the nourishment of patients who cannot feed themselves, and the unique condition of the persistent vegetative state, is provided to assist the Court in its deliberations about this issue at the intersection of medicine, law, and ethics.

A. Nutritional Support

Two decades ago, not much could be done to prevent the inevitable malnutrition that would result when illness made the normal intake and digestion of food impossible. Then, an intravenous dextrose solution could provide only 600 calories per day; today, 3,000 to 6,000 calories daily can be provided to even the most seriously ill patients, through nasogastric and intravenous feeding techniques. Spencer & Palmisano, *Specialized Nutritional Support of*

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[1] Pursuant to Rule 36 of the Rules of this Court, the parties have consented to the filing of this brief. Letters of consent have been filed with the Clerk of the Court.

Patients—A Hospital's Legal Duty?, Qual. Rev. Bull. 160, 160-61 (May 1985). Means of providing nutrition and hydration to individuals who cannot do so for themselves and who cannot be spoon-fed so as to maintain adequate nutrition include use of a nasogastric tube, surgical implantation of a feeding tube into the stomach or intestine (such as the gastrostomy tube being used to nourish Nancy Cruzan), and intravenous feeding through a vein in the arm or hand or a major vein in the chest. American Society of Parenteral and Enteral Nutrition, *Standards for Nutrition Support: Hospitalized Patients* (1984). Thus, although Nancy Cruzan is not conscious of herself or her environment and there is no hope that she will be restored to awareness or cognitive functioning; although she is so stiff and contracted that her fingernails cut into her hands and she must be turned every few hours to prevent bedsores; and although she is completely dependent on others for care, including bathing, oral care, personal hygiene, and feeding (Pet. at 5), her normal weight of 115 pounds has actually risen to approximately 140 pounds during the years of her hospitalization. Pet. App. A94.

B. The Persistent Vegetative State

Patients who are in a persistent vegetative state are neither in a coma nor brain dead. As such, they can be maintained for many months or years without the prospect that they will regain consciousness. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment* 177 (1983) ("President's Commission Report"); Cranford, *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, 18 Hastings Center Report 27, 31 (Feb./Mar. 1988) ("Hastings Center Report"); Jennett & Plum, *Persistent Vegetative State After Brain Damage*, 1 Lancet 734, 734 (1972).

Brain death, coma, and the persistent vegetative state represent a continuum of conditions in which there is

loss of consciousness. The cerebral cortex of the cerebral hemispheres, which mediates consciousness or awareness, does not function in any of these conditions; the brainstem, which controls "vegetative" abilities such as breathing, functions to differing degrees based on whether the patient is in a coma or a persistent vegetative state. Brain death is a distinct legal standard for the determination of death, recognized in most States as an alternative to the cardiorespiratory standard (the irreversible cessation of circulatory and respiratory functions). Brain death is defined as the irreversible cessation of all functions of the entire brain, including the brainstem. Report of the Medical Consultants on the Diagnosis of Death to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Guidelines for the Determination of Death*, 246 J.A.M.A. 2184, 2184 (1981). The states of coma and persistent vegetative state, however, represent degrees of brain damage that fall short of brain death.

A comatose state is defined as a lack of consciousness or a lack of both wakefulness and awareness. Johnson, *Withholding Fluids and Nutrition: Identifying the Populations at Risk*, 2 Issues in Law & Med. 189, 191 (1986). The comatose patient's prognosis will vary depending on the cause of the coma. Patients in a coma appear to be in a state of unarousable sleep with their eyes closed. F. Plum & J. Posner, *Diagnosis of Stupor and Coma* 5 (3d ed. 1982). Within approximately 2-4 weeks of onset, comatose patients will generally either regain some level of consciousness, die, or enter a persistent vegetative state. *Diagnosis of Stupor and Coma* 3.

While the brainstem of patients in coma retains only very limited function, patients in a persistent vegetative state demonstrate a number of normal brainstem functions which include cycles of sleep and wakefulness (with eyes open), the ability to breathe and maintain blood pressure on their own, pupillary responses to light, and

gag and cough reflexes. They do not consistently follow people or moving objects with their eyes or focus on an object, though their eyes do wander and may cross the gaze of an observer. Hastings Center Report at 28. Although patients in a persistent vegetative state may appear awake, they are unaware of themselves or their environment because even though the brainstem continues to function, there is a total loss of cerebral cortical functioning. *Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient*, 39 Neurology 125, 125 (1989) (*"Position of the American Academy of Neurology"*).

Patients in a persistent vegetative state do not experience pain or suffering.

> There may be, and often are, facial movements and other signs indicating an apparent manifestation of conscious human suffering, but these actions result from subcortical (structures deep in the cerebral hemisphere that may be relatively undamaged) and brainstem actions of a primitive stereotyped, reflexive nature. In other words, PVS patients may "react" to painful and other noxious stimuli, but, they do not "feel" (experience) pain . . . .

Hastings Center Report at 31. "No conscious experience of pain and suffering is possible without the integrated functioning of the brainstem and the cerebral cortex . . . . Noxious stimuli may activate peripherally located nerves, but only a brain with the capacity for consciousness can translate that neural activity into an experience." Brief for the American Academy of Neurology as Amicus Curiae, *Brophy v. New England Sinai Hospital, Inc.*, No. 4152 (Mass. Sup. Jud. Ct.), at 21-22.

The persistent vegetative state can result from head injury, brain tumor, stroke, or, as in Nancy Cruzan's case, hypoxia-ischemia. Brain damage due to hypoxia-ischemia can occur when the brain does not receive adequate oxygen because of, for example, cardiac or res-

piratory arrest. While 15-20 minutes without blood flow will destroy the entire brain, including the brainstem, it generally requires only 4-6 minutes of oxygen deprivation to cause severe and irreversible damage to the cerebral cortex. Thus, damage to the cerebral hemispheres and cortex can be extensive while the brainstem remains intact. Cranford & Smith, *Some Critical Distinctions Between Brain Death and the Persistent Vegetative State*, 6 Ethics Sci. & Med. 199, 203 (1979).

The diagnosis of the persistent vegetative state is based primarily on clinical observation of the patient over an extended period of time, supported by laboratory tests, and can be made with a "high degree of medical certainty in cases of hypoxic-ischemic encephalopathy after a period of 1 to 3 months." *Position of the American Academy of Neurology*, at 125. In a recent report, the Council on Scientific Affairs and the Council on Ethical and Judicial Affairs of the American Medical Association stated that "a conservative criterion for the diagnosis of PVS would be observed unawareness for at least 12 months . . . ." Joint Report of the Council on Scientific Affairs and the Council on Ethical and Judicial Affairs of the American Medical Association, *Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support* 4 (1989).[2]

Unlike a diagnosis of brain death, for which particular laboratory studies are available to confirm the clinical diagnosis, there are currently no specific laboratory studies that unequivocally confirm the clinical diagnosis of the persistent vegetative state. Hastings Center Report at 29-30. MRI (magnetic resonance imaging) and

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[2] This statement was not specific to cases of hypoxic-ischemic encephalopathy, but was a conclusion based on the finding that "the data indicated that unawareness for six months predicts nonrecovery or overwhelming disability with a high degree of certainty regardless of the nature of the insult to the brain." Joint Report at 4.

CAT (computerized axial tomography) scanning show structural damage to the cerebral hemispheres but do not yield quantifiable data for distinguishing among patients with varying degrees of function. The degree of abnormality revealed by an EEG (electroencephalogram) varies significantly from case to case. A very recently developed diagnostic test that may allow confirmation of a clinical diagnosis is the PET (positron emission tomography) scan. Consciousness requires certain metabolic rates of glucose and oxygen consumption in the brain; these can be quantified through the use of PET scanning. However, data are not sufficient to demonstrate the diagnostic value of this test in this context, and the test is expensive and not yet widely available. *Id.* at 30.

Even in the absence of a confirmatory test, there have been only a few cases of recovery of cognitive function when a reliable clinical diagnosis of persistent vegetative state caused by hypoxia-ischemia was made. Two patients regained consciousness a year after a severe episode of hypoxia-ischemia, and were left with varying degrees of paralysis. President's Commission Report at 179. Three other cases of recovery after hypoxia-ischemia are reported in the brief in this case of the American Medical Association, the American Association of Neurological Surgeons and the Missouri State Medical Associations as *Amici Curiae* in Support of the Petition for Certiorari, at 9-10. The latest known recovery began 22 months after the hypoxia-ischemia (Snyder, et al., *Delayed Recovery From Postanoxic Persistent Vegetative State*, 14 Ann. Neurol. 152, 152 (1983)), not after more than six years, as in Nancy Cruzan's case. The extremely rare cases of recovery stand in stark contrast to the estimated 100,000 or more patients in this country over the last twenty years who have been in a persistent vegetative state due to hypoxia-ischemia. AMA Brief, *supra*, at 10.

SUMMARY OF ARGUMENT

I.

"[B]ody and mind, like man and wife, do not always agree to die together. It is bad when the mind survives the body; and worse still when the body survives the mind . . . ." C. Colton, *Lacon* 190 (Vol. I, 8th ed. 1824). More than 150 years after this was written by writer and poet Charles C. Colton, Nancy Cruzan's fate, born of advances in medicine, fits this insight more aptly than could ever before have been realized: her mind is as close to death as is possible while her body, sustained through artificial feeding, can survive for years and even decades. This Court should hold that Nancy Cruzan's right to bodily integrity under the Due Process Clause of the Fourteenth Amendment allows her, through her parents and guardians, to refuse the medical treatment that keeps her alive but not among the living.

A. Although not expressly enumerated in the Constitution, various fundamental rights have received constitutional protection, including freedom of association, the right to travel, rights regarding home, family, and education, and the right to privacy. The right to bodily integrity is another such right which deserves and has been accorded constitutional protection in a variety of contexts.

Thus, the Court has found a fundamental right to freedom from bodily invasion by the State in connection with both civil and criminal proceedings; in connection with drug testing; in interpreting the prohibition of cruel and unusual punishment and in reviewing the State's obligation to provide medical care to prisoners; in defining the rights of involuntarily-committed mental patients; and in recognizing individual rights of self-determination in the areas of contraception and childbearing. In short, the fundamental right to bodily integrity is not new to the Constitution or this Court.

B. Understanding the constitutional right to bodily integrity to include a right to refuse medical treatment, including life-sustaining treatment, is inevitable as a

matter of logic and common sense. It also is consistent with our long common-law history regarding the right to be free from undesired touchings, and the highly evolved doctrine requiring informed consent to medical treatment. Moreover, federal and state courts that have addressed the question have held, as a matter of federal constitutional law, that a patient has a fundamental right to refuse life-sustaining treatment, including nutrition and hydration. These decisions rely on the widely-accepted views of the medical and lay communities.

C. The law generally finds some way of affording rights to those who cannot speak for themselves. Thus, incompetent individuals retain rights, which can be meaningful only insofar as they are exercised by agents acting in the best interests of the incompetent individual. Because the refusal of medical treatment requires specific decisions, someone must be permitted to speak on the patient's behalf if her rights are not to be lost. ACP advances an approach to surrogate medical decisionmaking for patients in a persistent vegetative state, like Nancy Cruzan, in which the primary reference point is the widely held view throughout our society about the quality of life in a vegetative state.

II.

The State's interest in life, contrary to the holding of the Missouri Supreme Court, is not "unqualified." The actual circumstances of the life at issue cannot be ignored. The New Jersey Supreme Court's test, developed under similar circumstances, provides thoughtful guidance: The State's interest weakens and the rights of the individual grow "as the degree of bodily invasion increases and the prognosis dims." *In re Quinlan*, 70 N.J. at 41, 355 A.2d at 664 (1976). There is no State interest sufficiently compelling to outweigh Nancy Cruzan's fundamental right to refuse life-sustaining treatment, considering that she is in a persistent vegetative state and will never again possess any of the faculties of perception or cognition that define distinctively human life.

ARGUMENT

I. INDIVIDUALS HAVE A FUNDAMENTAL RIGHT TO BODILY INTEGRITY PROTECTED BY THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT.

The Supreme Court of Missouri has declared in this case that "the state's interest is in life; that interest is unqualified." 760 S.W.2d at 420 (Pet. App. A29). Such a broad pronouncement, however, eviscerates the rights of the patient, here a young woman in a persistent vegetative state and therefore having no hope of recovery. The Missouri Supreme Court has precluded any analysis of the nature and strength of the competing interests, contrary to this Court's consistent constitutional jurisprudence.

A. This Court Has Long Recognized That Certain Individual Rights Not Explicitly Enumerated In The Constitution, Including A Fundamental Right To Bodily Integrity, Are Protected Against State Interference.

In *Bowers v. Hardwick*, 478 U.S. 186, 194-95 (1986), this Court expressed the concern that it

> 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 . . . . There should be, therefore, great resistance to expand the substantive reach of [Due Process], particularly if it requires redefining the category of rights deemed to be fundamental.

The position advocated on behalf of Nancy Cruzan requires no redefinition of fundamental rights, however; it is derived from long-standing constitutional doctrines firmly rooted in the most basic premises of our Constitution about life and liberty. Reversing the Missouri Supreme Court's judgment against Nancy Cruzan, which

consigns her to a "fate worse than death," [3] would not entail this Court's taking "to itself further authority to govern the country without express constitutional [sanction], *Bowers*, 478 U.S. at 195, but rather, to quote Judge Bork, calls for "the judicial temperament to translate the framers' morality into a rule to govern unforeseen circumstances." [4]

Provisions of the Bill of Rights have repeatedly been interpreted to mean more than they say in so many words, to protect rights not explicitly enumerated in the text of the Amendments.[5] A further source of unenumerated rights is the Due Process Clause of the Fourteenth Amendment itself. To cite just a few but important examples, the Court has protected fundamental but unspecified rights in the realms of home, family, and education in *Meyer v. Nebraska*, 262 U.S. 390 (1923); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942); *Prince v. Massachusetts*, 321 U.S. 158 (1944); and *Lov-*

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[3] Feinberg & Ferry, *A Fate Worse Than Death: The Persistent Vegetative State in Childhood*, 138 Am. J. Diseases Child 128 (1984).

[4] Bork, "Tradition and Morality in Constitutional Law," *The Francis Bayer Lectures on Public Policy* (American Enterprise Institute for Public Policy Research 1984), at 11.

[5] For example, the fundamental right of freedom of association has been implied from the First Amendment's protection of freedom of speech, and is protected against state infringement by the liberty interest secured by the Fourteenth Amendment. *N.A.A.C.P. v. Alabama*, 357 U.S. 449 (1958). The right to travel has been inferred from the Privileges and Immunities Clauses of Article IV and the Fourteenth Amendment, the Commerce Clause, and the "federal structure of government adopted by our Constitution," and the Court has "not felt impelled to locate this right definitively in any particular constitutional provision." *Attorney General of New York v. Soto-Lopez*, 476 U.S. 898, 902 (1986) (citing cases). The Ninth Amendment, a deliberately non-specific provision of the Constitution, can be given content only through judicial interpretation. *Griswold v. Connecticut*, 381 U.S. 479, 488 (1965) (Goldberg, J., concurring).

ing v. Virginia, 388 U.S. 1 (1967). In giving content to the Due Process Clause, as Justice Goldberg explained in *Griswold v. Connecticut*, 381 U.S. 479 (1965),

> judges are not left at large to decide cases in light of their personal and private notions. Rather, they must look to the "traditions and [collective] conscience of our people" to determine whether a principle is "so rooted [there] . . . as to be ranked as fundamental." *Snyder v. Massachusetts*, 291 U.S. 97, 105. The inquiry is whether a right involved "is of such a character that it cannot be denied without violating those 'fundamental principles of liberty and justice which are at the base of all our civil and political institutions'. . . . *Powell v. Alabama*, 287 U.S. 45, 67.

Griswold, 381 U.S. at 493 (Goldberg, J., concurring). Finally, in the line of cases anchored by *Griswold* and including *Roe v. Wade*, 410 U.S. 113 (1973), the Court has provided protection for unenumerated rights of privacy.

From each of these constitutional sources, the Court has specifically inferred, in varied contexts, a constitutional right to bodily integrity.

1. *The Bill of Rights and the right to bodily integrity.* Invasions of the body compelled by the State have often been decried by this Court, in recognition of the individual's fundamental right, guaranteed by the Bill of Rights, to be free from State interference with physical autonomy. In a decision construing the Seventh Amendment as well as the authority of the "national" courts, the Court held that a tort plaintiff cannot be ordered to submit to a surgical examination. *Union Pacific Ry. Co. v. Botsford*, 141 U.S. 250 (1891). The Court stated that

> [n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.

Id. at 251. When the Court concluded, in *Schmerber v. California*, 384 U.S. 757 (1966), that the taking and analysis of a blood sample from a person accused of driving while intoxicated did not violate the Fourth, Fifth, or Fourteenth Amendments, it nevertheless reaffirmed that "[t]he integrity of an individual's person is a cherished value of our society." *Id.* at 772. Setting guidelines under which suspects can be compelled to submit to the intrusion of a blood test, the Court said that

> [t]he interests in human dignity and privacy which the Fourth Amendment protects forbid any such intrusions on the mere chance that desired evidence might be obtained. In the absence of a *clear indication* that in fact such evidence will be found, these *fundamental human interests* require law officers to suffer the risk that such evidence may disappear . . . .

Id. at 769-70 (emphasis added). The Court emphasized that the fact that the Constitution does not prevent "minor intrusions" by the State "into an individual's body under stringently limited conditions in no way indicates that it permits more substantial intrusions, or intrusions under other conditions." *Id.* at 772.

Two decades later, the more substantial intrusion of surgery to remove a bullet from a criminal defendant, to be used in evidence against him, was held to be an unreasonable search under the Fourth Amendment. "A compelled surgical intrusion into an individual's body for evidence . . . implicates expectations of privacy and security of such magnitude that the intrusion may be 'unreasonable' even if likely to produce evidence of a crime." *Winston v. Lee*, 470 U.S. 753, 759 (1985).

In the area of government drug-testing and the Fourth Amendment, this Court recently observed that it cannot "be disputed that the process of collecting the [urine] sample to be tested, which may in some cases involve visual or aural monitoring of the act of urination, itself implicates privacy interests." *Skinner v. Railway Labor*

Executives Ass'n, 109 S. Ct. 1402, 1413 (1989). See also *National Treasury Employees Union v. Von Raab*, 109 S. Ct. 1384, 1393 (1989). In these cases, as in the earlier cases, the Court sought to protect individuals' bodily integrity and physical self-determination, even when information valuable to the State was at stake.

The Court's rulings prohibiting certain forms of criminal punishment as "cruel and unusual" also reflect the value society places on the integrity of the body and human dignity. See *In re Kemmler*, 136 U.S. 436, 447 (1890) ("punishments are cruel when they involve torture or a lingering death . . ."); *Louisiana ex rel. Francis v. Resweber*, 329 U.S. 459, 464 (1947) ("cruelty against which the Constitution protects a convicted man is cruelty inherent in the method of punishment . . ."); *Gregg v. Georgia*, 428 U.S. 153, 173 (1976) (Eighth Amendment forbids punishments that "involve the unnecessary and wanton infliction of pain").[6]

The Court also has held that deliberate indifference to the serious medical needs of a prisoner violates the Eighth Amendment. *Estelle v. Gamble*, 429 U.S. 97 (1976). Because the Eighth Amendment reflects "broad and idealistic concepts of dignity, civilized standards, humanity, and decency," *id.* at 102 (quoting *Jackson v. Bishop*, 404 F.2d 571, 579 (8th Cir. 1968)), and forbids punishments that do not meet " 'the evolving standards of decency that mark the progress of a maturing society,' " *id.* (quoting *Trop v. Dulles*, 356 U.S. 86, 101 (1958)), the government must provide medical care to prisoners. Nancy Cruzan is not a prisoner of the State. But considering her condition—oblivious to her environment, with cerebral cortical atrophy that is irreversible and progressive, and with extremities contracted by irreversible damage (Pet. App. A8), it is reasonable to ask that "evolving standards of decency that mark the

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[6] *Gregg v. Georgia*, 428 U.S. at 169-73, provides a chronicle of the constitutional prohibition of cruel and unusual punishment.

progress of a maturing society" be allowed to operate to permit her to forego the medical technology that unremittingly holds her prisoner.

2. *Liberty guaranteed by the Due Process Clause and the right to bodily integrity.* In considering the substantive rights of involuntarily-committed mentally retarded persons under the Fourteenth Amendment, the Court has found that the right to personal security which constitutes an "historic liberty interest" protected by the Due Process Clause, *Ingraham v. Wright*, 430 U.S. 651, 673 (1977), requires that the involuntarily committed, as well as the criminally incarcerated, not be confined in unsafe conditions. *Youngberg v. Romeo*, 457 U.S. 307, 316 (1982). Likewise, the "[l]iberty from bodily restraint [which] always has been recognized as the core of the liberty protected by the Due Process Clause from arbitrary governmental action" survives not only incarceration but also involuntary commitment. *Id.* at 316 (quoting *Greenholtz v. Nebraska Penal Inmates*, 442 U.S. 1, 18 (1979) (Powell, J., concurring)). The use of drugs to control and punish prisoners also has been held to violate the Eighth and Fourteenth Amendments. *Nelson v. Heyne*, 355 F. Supp. 451, 455 (N.D. Ill. 1972), *aff'd*, 491 F. 2d 352 (7th Cir. 1974).

This Court recognized the individual's interest in "human dignity" when it held that forced stomach-pumping, in order to obtain evidence of narcotics that had been swallowed, violates the Due Process Clause of the Fourteenth Amendment. *Rochin v. California*, 342 U.S. 165 (1952). Finding that stomach-pumping "shocks the conscience" and "offend[s] a sense of justice," the Court explained that it "would be a stultification of the responsibility which the course of constitutional history has cast upon this Court to hold that in order to convict a man the police cannot extract by force what is in his mind but can extract what is in his stomach." *Id.* at 172-73.

Although equal protection was the constitutional basis upon which the Court struck down a statute that provided for the involuntary sterilization of "habitual criminals," the Court stated that the statute violated "one of the basic civil rights of man." *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. at 541.[7]

3. *The right to privacy and the right to bodily integrity.* In the context of a right to privacy, an alternate constitutional source for a right of bodily integrity, the decisions in *Griswold* and *Roe* can be seen to reflect the value historically placed on bodily self-determination. In carving out a private sphere with respect to contraception and childbearing, this Court has implicitly recognized limits on state power when such power touches physical autonomy. In *Griswold*, Justice Douglas wrote for the Court that prior decisions, involving rights implied from the specific guarantees of the Bill of Rights and/or inherent in the Due Process Clause, suggest that the Constitution's enumerated safeguards for personal freedom "have penumbras formed by emanations from those guarantees that help give them life and substance. . . . [V]arious guarantees create zones of privacy." 381 U.S. at 484 (citation omitted).

While this Court's decisions in *Bowers* and in *Webster v. Reproductive Health Services*, 109 S. Ct. 3040 (1989), suggest an unwillingness to extend the protection of the right to privacy to forms of behavior implicating substantially different values and historical contexts than those of prior cases, as well as a willingness to weigh more heavily the asserted state regulatory interests, noth-

[7] Prior to that decision, sterilization by the State had been upheld as furthering the public welfare in *Buck v. Bell*, 274 U.S. 200 (1927). There the Court held that "[t]he principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. . . . Three generations of imbeciles are enough." *Id.* at 207 (citation omitted). Though never formally overruled, *Buck* appears to be an aberration in this Court's fundamental rights jurisprudence.

ing in these decisions undermines the basic framework of the constitutional right to privacy.

In summary, the fundamental right to the integrity of the body already is established by this Court's decisions, and is protected against various types of governmental compulsion by the Due Process Clause of the Fourteenth Amendment, the freedoms guaranteed in the Bill of Rights, and the constitutional right to privacy.

B. The Fundamental Right To The Integrity Of The Body Must Include A Right To Refuse Medical Treatment, Including Life-Sustaining Treatment.

The fundamental right to bodily integrity necessarily includes a right to refuse medical treatment. Intrusions upon the body in the form of medical treatment are usually permitted only with the adult patient's informed consent. "The root premise is the concept, fundamental in American jurisprudence, that '[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body . . . .' " *Canterbury v. Spence*, 464 F. 2d 772, 780 (D.C. Cir. 1972) (quoting *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914)).[8] This right to be free of undesired physical touching has its origins in thirteenth century English common law. See *United States v. Charters*, 829 F.2d 479, 490 (4th Cir. 1987). As a matter of medical ethics, the "primary responsibility of physicians is to apply medical knowledge to help *patients* identify and achieve *their* medical goals." American College of Physicians, *American College of Physicians Ethics Manual*, 111 Ann. Int. Med. 327, 334 (1989) (*"ACP Ethics Manual"*) (emphasis added).[9]

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[8] *See also Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093 (1960), *clarified*, 187 Kan. 186, 354 P.2d 670 (1960).

[9] "Medical goals frequently sought jointly by patients and physicians may include prevention of disease, cure of disease, prolonga-

Moreover, "[t]he right to refuse medical treatment has been specifically recognized as a subject of constitutional protection." *United States v. Charters*, 829 F.2d at 491 (footnotes omitted). In particular,

> [t]he right to be free of unwanted physical invasions has been recognized as an integral part of the individual's constitutional freedoms, whether termed a liberty interest protected by the Due Process Clause, or an aspect of the right to privacy contained in the notions of personal freedom which underwrote the Bill of Rights. *Id.*[10]

A number of state courts have also found a federal constitutional right to refuse life-sustaining or life-saving medical treatment. In the landmark case of *In re Quinlan*, 70 N.J. 10, 39, 355 A.2d 647, 663, *cert. denied*, 429 U.S. 922 (1976), the New Jersey Supreme Court held that the federal constitutional right of privacy first announced in *Griswold* "[p]resumably . . . is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances . . . ."[11] Accord, *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re Quackenbush*,

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tion of life, relief of symptoms, restoration or maintenance of function, and, at times, the withholding or withdrawing of life-sustaining treatment." *ACP Ethics Manual* 334.

[10] See also *Bee v. Greaves*, 744 F.2d 1387, 1393 (10th Cir. 1984) ("the decision whether to accept treatment with antipsychotic drugs is of sufficient importance to fall within this category of privacy interests protected by the Constitution"); *Davis v. Hubbard*, 506 F. Supp. 915 (N.D. Oh. 1980) (Due Process right to refuse treatment, under some circumstances, when in state custody); *Gorman v. University of Rhode Island*, 646 F. Supp. 799, 814 (D.R.I. 1986), *aff'd and rev'd in part*, 837 F.2d 7 (1st Cir. 1988) (constitutional privacy right includes decisions about accepting psychiatric treatment).

[11] The *Quinlan* court also found that such a privacy right is contained in the New Jersey Constitution. 70 N.J. at 39, 355 A.2d at 663.

156 N.J. Super. 282, 383 A.2d 785 (1978); *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 426 N.E. 2d 809 (1980); *In re Guardianship of Grant*, 109 Wash. 2d 545, 747 P.2d 445 (Wash. 1987) (en banc), *modified*, 757 P.2d 534 (Wash. 1988).

In the one federal case specifically raising this question regarding a patient in a persistent vegetative state, the court ruled that the patient had a constitutional right to refuse life-sustaining treatment, including life-sustaining hydration and nutrition. *Gray v. Romeo*, 697 F. Supp. 580 (D.R.I. 1988). In so holding, the court found that controlling decisions about one's medical care "is an aspect of the right of self-determination and personal autonomy that is 'deeply rooted in the Nation's history and tradition.'" *Id.* at 586 (quoting *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977)).

The *Gray* court held that the right to control fundamental medical decisions is "properly grounded in the liberties protected by the Fourteenth Amendment's due process clause. This right is also grounded in the notion of an individual's dignity and interest in bodily integrity." 697 F. Supp. at 585. Further, this right to control fundamental medical decisions applies "even if the decision results in that person's death." *Id.* at 586 (citing *Tune v. Walter Reed Army Medical Hospital*, 602 F. Supp. 1452, 1454 (D.D.C. 1985)).

State courts addressing the issue also have specifically recognized a federal constitutional right to refuse life-sustaining nutrition and hydration. See *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986) (federal and state constitutional right); *Brophy v. New England Sinai Hospital, Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986) (federal constitutional right and common law right); *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987) (federal and state constitutional right as well as common law right). These and other courts, unlike the Missouri Supreme Court, have

recognized that the provision of food and water through nasogastric tubes, gastrostomies, and intravenous infusions require consent and "are significantly different from bottle-feeding or spoon-feeding—they are medical procedures . . . instituted by skilled health-care providers to compensate for impaired physical functioning." *In re Conroy*, 98 N.J. 321, 373-74, 486 A.2d 1209, 1236 (1985). While "it is hard to shed the 'emotional symbolism' of food[,] . . . analytically, artificial feeding . . . can be seen as equivalent to artificial breathing by means of a respirator. Both prolong life through mechanical means when the body is no longer able to perform a vital bodily function on its own." *Id.* See also *Gray*, 697 F. Supp. at 586-87; *Rasmussen*, 741 P.2d at 689 n.24; *Brophy*, 398 Mass. at 437 n.32, 497 N.E.2d at 637 n.32.

These judicial pronouncements fully comport with the current views of the medical community. The President's Commission Report concluded that life-sustaining treatment not only includes respirators and kidney dialysis machines, but also special feeding procedures, provided that one of the effects of treatment is to prolong life.[12] The American Medical Association concurs, see *Current Opinions of the Council on Ethical and Judicial Affairs*, Op. No. 2.18 (1986) ("[l]ife-prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition, or hydration"), as does ACP. See *ACP Ethics Manual* 333 ("[a]n emerging clinical and judicial opinion is that enteral and parenteral nutrition and hydration should be likened to other medical interventions and may be withheld or withdrawn . . .").

Thus, the fundamental right to bodily integrity must include much more than protection against physical pun-

[12] The President's Commission specifically found, and many state courts agree, that once-recognized distinctions between "ordinary" treatment (always required) and "extraordinary" treatment (optional) are not a useful basis for analyzing treatment decisions. President's Commission Report at 88.

ishment and invasions of the person in order to obtain evidence for criminal prosecution. It must also allow an individual to refuse life-sustaining medical treatment. Fundamental rights "are protected not only against heavy-handed frontal attack, but also from being stifled by more subtle governmental interference." *Bates v. City of Little Rock*, 361 U.S. 516, 523 (1960) (citations omitted). As Justice Brandeis admonished: "Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent . . . . The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well meaning but without understanding." *Olmstead v. United States*, 277 U.S. 438, 479 (1928) (Brandies, J., dissenting).

C. Patients In A Persistent Vegetative State Have Not Lost Their Fundamental Right To Bodily Integrity Merely On Account Of Their Inability To Exercise That Right For Themselves.

> The law must often adjust the manner in which it affords rights to those whose status renders them unable to exercise choice freely and rationally. Children, the insane, and those who are *irreversibly ill with loss of brain function*, for instance, all retain "rights," to be sure, but often *such rights are only meaningful as they are exercised by agents* acting with the best interest of their principals in mind.

Thompson v. Oklahoma, 108 S. Ct. 2687, 2693 n.23 (1988) (plurality opinion) (emphasis added). The alternative—as the Missouri Supreme Court has held, that the patient loses her rights because no one is permitted to speak on her behalf—is unsatisfactory, for in effect it destroys the right.

Other state courts correctly have rejected Missouri's approach, and have sought in varying but thoughtful ways to permit the meaningful implementation of an incompetent patient's right to refuse medical treatment. These

courts have followed two approaches: (1) "'substituted judgment,' a decisional process whereby an attempt is made to ascertain what an incompetent patient would have done if he were competent," *United States v. Charters*, 829 F.2d at 497, and (2) a "best interests" or objective test under which

> it is appropriate to presume that an incompetent individual would choose in a manner similar to others in the same circumstance and opt for what is in his best interests . . . . Furthermore, the government's *parens patriae* interest in the well being of its citizens converges with the best interests choice and there is no need to view the two as competing.

Id. at 498. The Missouri Supreme Court found the subjective test to be problematic, but it simply ignored the best interests approach.[13] This reflects the Missouri court's steadfast refusal to allow "quality of life" determinations to be considered, as we discuss below in Part II. Consistency does not, however, hallow a weak argument.

Regarding the implementation of the rights of an incompetent patient, the *Quinlan* court stated:

> The only practical way to prevent the destruction of the right is to permit the guardian and family of Karen to render their best judgment, subject to the qualifications hereinafter stated, as to whether she would exercise it in these circumstances. If their conclusion is in the affirmative this decision should be accepted by a society the overwhelming majority of whose members would, we think, in similar circumstances, exercise such a choice in the same way for themselves or for those closest to them.

Quinlan, 70 N.J. at 41, 355 A.2d at 664. The "qualification" that the court imported into what otherwise might

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[13] Given the limitations of space, the issues raised by the subjective approach to surrogate decisionmaking will not be discussed here. Instead, ACP will focus on an objective approach to effectuating Nancy Cruzan's rights.

appear to be a purely subjective test is, as the Missouri Supreme Court itself noted, the interest in "preserving a 'cognitive, sapient life.' . . . In other words, the reduced prospects of what the [*Quinlan*] court called a 'cognitive' and 'sapient' life would be taken as prima facie grounds for the inference that the patient would not wish to preserve her life." 760 S.W.2d at 425 n.21 (Pet. App. A40) (quoting Arkes, *"Autonomy" and the "Quality of Life": The Dismantling of Moral Terms*, 2 Issues in Law & Med. 421, 428 (1987)). In sum, the *Quinlan* court took judicial notice of widely held views throughout our society about the quality of life in a vegetative state, that is, "the common moral judgment of the community at large," *Quinlan*, 70 N.J. at 44, 355 A.2d at 665, as the primary reference point for decisionmaking on behalf of patients in this condition.[14] Within this zone of general moral agreement, the *Quinlan* court would permit those closest to the patient to make the decision on her behalf.

It might be argued that any form of surrogate decisionmaking that begins from an "objective" quality of life assessment would produce the same conclusion for all similarly situated patients, and thus in fact would impose on patients in a persistent vegetative state a "duty" to die. This argument misapprehends the nature of the approach to surrogate decisionmaking that originated in *Quinlan* and that ACP endorses. Properly characterized, this approach to surrogate decisionmaking for patients in a persistent vegetative state—which is based on the elemental principle that their rights should not be lost on account of their condition—yields only prima facie grounds for an inference that treatment should be withdrawn. The inference is rebuttable based on evidence

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[14] See, *e.g.*, American Medical Association, *Public Opinion on Health Care Issues: 1986* (Chicago 1986) (73% of respondents said they favored withdrawing treatment when asked, "Would you favor or oppose withdrawing life-support systems, including food and water, from hopelessly ill or irreversibly comatose patients if they or their families request it?").

that an individual patient would have wished otherwise. Likewise, in exploring the facts of a given case in an effort to confirm the inference, a court is aided by the existence of any evidence, as in Nancy Cruzan's case, that the patient did not wish to be maintained, in the popular parlance, "as a vegetable."

II. IN THE CONTEXT OF MEDICAL DECISIONMAKING CONCERNING PATIENTS IN A PERSISTENT VEGETATIVE STATE, NO STATE INTEREST IS SUFFICIENTLY COMPELLING TO OVERRIDE THE PATIENT'S FUNDAMENTAL RIGHT TO BODILY INTEGRITY.

The foundation of the Missouri Supreme Court's decision in this case is that "the state's interest is in life; that interest is unqualified." 760 S.W.2d at 420 (Pet. App. A29). But the State's mere assertion of an "unqualified" interest does not end the discussion, any more than the mere assertion of a protected right would automatically win the day. State regulation that abridges the exercise of a fundamental right, "unless shown to be necessary to promote a *compelling* governmental interest, is unconstitutional." *Shapiro v. Thompson*, 394 U.S. 618, 634 (1969) (emphasis in original). Upon examination, it is apparent that Missouri's interest in preserving life is not, in fact, unqualified,[15] and, more significantly, that the State's broad, abstract pronouncement of an interest in "life" is not compelling, or even rational, in the case of a patient in a persistent vegetative state.

Missouri has not advanced and cannot advance an interest of sufficient gravity, actually implicated on the facts of Nancy Cruzan's tragic condition, to override her

[15] The Missouri Supreme Court's conclusion is manifestly contradicted by the very existence of Missouri's Life Support Declarations Act. Mo. Rev. Stat. §§ 459.010 *et seq.* In adopting this statute, the legislature of Missouri has expressly authorized certain patients to forego "death-prolonging procedures" and thus, in the vernacular applied in this area since the *Quinlan* case, has recognized in certain circumstances a "right to die."

right to refuse medical treatment and to compel the continued unwanted violation of her person.[16]

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[16] Justification for the compelled continuation of Nancy Cruzan's continued treatment is not provided by state interests that sometimes have been noted in this context, though not by the Missouri Supreme Court. Those are the prevention of suicide and homicide and the protection of the ethics of the medical profession.

Deaths that follow the withdrawal of life-sustaining treatment cannot accurately be considered suicide or homicide. When a competent adult refuses heart bypass surgery and dies as a result, his death certificates properly lists, for example, cardiac arrest subsequent to myocardial infarction, not suicide, as the "cause of death." When a physician does not suggest heart bypass surgery as a reasonable alternative to a 90-year-old patient in the late stages of coronary artery disease and the patient's death ensues, this is not homicide. In both circumstances and in those presented to the Court in this case, the cause of death is the patient's underlying physical condition.

As to medical ethics, the State need not protect (and certainly has no compelling interest in protecting) what is not threatened. It is the unambiguous consensus of the medical profession that it is not unethical to withdraw life-sustaining treatment from a patient in a persistent vegeative state. American Medical Association, *Current Opinions of the Council on Ethical and Judicial Affairs*, Op. No. 2.18 (not unethical under certain circumstances to discontinue all means of life-prolonging medical treatment, including nutrition and hydration) *Position of the American Academy of Neurology*, at 125 ("artificial provision of nutrition and hydration is a form of medical treatment and may be discontinued in accordance with the principles and practices governing the withholding and withdrawal of other forms of medical treatment"); *ACP Ethics Manual* 333 ("It is not unethical to discontinue or withhold fluids and nutritional support under certain circumstances.").

Moreover, while a physician's primary duty is to the patient, *ACP Ethics Manual* 331, in fulfilling the moral duty to promote the patient's interest, physicians share certain goals with the family. M. Waymack & G. Taler, *Medical Ethics and the Elderly: A Case Book* 55 (1988). In addition to being the patient's advocate and ensuring the preservation of the patient's dignity, the physician also has an ethical obligation to comfort and support the patient's family. *ACP Ethics Manual* 332. Families such as Nancy Cruzan's "have suffered terribly these many years" of "their now interminable bedside vigil." They "have seen only defeat through

ACP respectfully submits that the State's interest in "life" is barely implicated, as against the judgment of the patient's family, guardians, and physicians, when the life in question is being "lived" in a persistent vegetative state. This was the view expressed in *In re Quinlan*, where the New Jersey Supreme Court became the first court in the nation to struggle with the legal implications of modern life-sustaining medical technology. That court took the position that "the State's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest." *In re Quinlan*, 70 N.J. at 41, 355 A.2d at 664. For patients like Nancy Cruzan, trapped in a persistent vegetative state with no hope of ever again perceiving or experiencing any aspect of life, that point has come.[17]

As if foreseeing the quite recent technological advances that permit Nancy Cruzan's tragic plight, Justice Field said in dissent in *Munn v. Illinois*, 94 U.S. 113, 142 (1877):

> By the term "life," as [used in the Fourteenth Amendment], something more is meant than mere

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the memories they hold of a vibrant woman for whom the future held but promise." 760 S.W.2d at 412 (Pet. App. A10).

[17] The issue is not the abstract morality of discontinuing Nancy Cruzan's treatment, but rather whether the State of Missouri has the power to mandate the continuation of such treatment against the exercise of Nancy Cruzan's right, by those who know and love her, to refuse it. If in *all* circumstances it would be wrong to withdraw life-sustaining treatment, of course, the distinction between this issue as a matter of abstract morality and as a matter of State power would be slight; behavior widely agreed to be morally wrong is properly removed from the protected sphere of personal choice by state proscription. Acknowledging that the decision to forego treatment on behalf of a patient in a persistent vegetative state remains within the sphere of constitutionality protected personal liberty is, however, neither wrong as a matter of law nor as a matter of the common values of our society, which the law cannot help but, and indeed should, reflect.

> animal existence . . . . [It] extends to all those limbs and faculties by which life is enjoyed . . . . The deprivation not only of life, but of whatever God has given to every one with life, for its growth and enjoyment, is prohibited by the provision in question . . . .

Justice Field's concept of "life" embodies an insight of both common law and common sense, that state concern for life means concern for those qualities of cognition and awareness that are distinctively human. Patients in a persistent vegetative state do not possess, nor do they have any potential ever again to possess, any of those qualities of distinctively human life which the State has a legitimate interest in preserving.

In *Clinical Ethics*, a leading manual for physicians-in-training and more senior practitioners, Drs. Jonsen, Siegler, and Winslade summarize a widely-shared view in the medical community concerning quality-of-life judgments in decisions to withhold treatment:

> (a) Quality of life may be considered as decisive in a clinical decision to withhold or withdraw interventions necessary for life when the following conditions are all present: (i) The indications for medical treatment are such that the goal of preservation of organic life without attainment of the other goals of medicine is likely to be the only accomplishment; (ii) The preferences of the patient are not and cannot be known; (iii) The quality of life of the patient falls below the threshold that can, on the basis of wide and objective criteria, be considered minimal.

A. Jonsen, M. Siegler & W. Winslade, *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine* 115-16 (2d ed. 1986). Some might argue that the position advocated here by ACP could give rise to a "slippery slope." Indeed, the Missouri Supreme Court expressed the concern that "[w]ere quality of life at issue, persons with all manner of handicaps might find the state seeking to terminate their lives." 760 S.W.2d at 420 (Pet. App. A29).

But apart from the fact that no one has suggested that the *State* should have the power to terminate life-support or any other form of treatment, the line drawn in this case is quite bright, and the rule proposed by ACP is narrow. This case concerns a unique condition—the persistent vegetative state. Patients in that condition are not handicapped or disabled; they are in a unique category of artificially maintained existence that does not even rise to the level of "mere animal existence." *Munn*, 94 U.S. at 142. They have "no realistic possibility of returning to any semblance of cognitive or sapient life." *Quinlan*, 70 N.J. at 39, 355 A.2d at 663. The question before the Court today is whether Nancy Cruzan's right to bodily integrity, which includes her right to refuse life-sustaining medical treatment, is outweighed by some compelling state interest. The answer is no.

CONCLUSION

For the foregoing reasons, the judgment of the Missouri Supreme Court should be reversed.

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