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, *et al.*,
Respondents.

On Writ of Certiorari to the Missouri Supreme Court

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS, AMERICAN COLLEGE OF SURGEONS, AMERICAN MEDICAL WOMEN'S ASSOCIATION, AMERICAN SOCIETY FOR PARENTERAL & ENTERAL NUTRITION, MISSOURI STATE MEDICAL ASSOCIATION, AND MISSOURI STATE NEUROSURGICAL SOCIETY AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Amici curiae will address the following question:

Whether the fundamental right protected by the Due Process Clause of the Fourteenth Amendment of a patient in a persistent vegetative state to have life-prolonging treatment withdrawn is outweighed solely by a state's general interest in prolonging life.

TABLE OF CONTENTS

TABLE OF CONTENTS—Continued

TABLE OF CONTENTS—Continued

TABLE OF AUTHORITIES

Cases: Page

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

Statutory Provisions

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

TABLE OF AUTHORITIES—Continued

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INTEREST OF THE *AMICI CURIAE*

Amicus American Medical Association ("AMA") is a private, voluntary, non-profit organization of physicians. The AMA was founded in 1846 to promote the science and art of medicine and to improve the public health. Its 280,000 members—over half of all physicians currently licensed to practice medicine—practice in all fields of medical specialization. One of the AMA's ethical opinions, Opinion 2.20, App. at 1a, which was adopted (as Opinion 2.18) in 1986, is directly relevant to the matter before this Court.

The American Academy of Family Physicians ("AAFP") is a private, voluntary, non-profit professional organization, representing more than 65,000 family physicians throughout this country. The AAFP was founded in 1947 and was instrumental in the establishment of family practice as a primary medical specialty. Family practice is a specialty in breadth which builds upon the strengths of traditional general practice by emphasizing wellness and disease prevention. The Academy's interest stems from the potentially significant impact of this case on the family physicians' responsibility to and relationship with the families they serve.

The American Association of Neurological Surgeons ("AANS") is a private, voluntary, non-profit, professional association. The AANS was founded in 1931 to promote the advancement of, and the pursuit of excellence in, neurological surgery and related sciences. The AANS represents approximately 3,000 neurosurgeons who practice throughout the world. Because the neurological surgeon is routinely called upon to evaluate injuries to the brain and convey diagnoses and recommendations regarding appropriate medical treatment to patients and their families or guardians, the AANS issued a position statement in May 1987 entitled "The Withdrawal of Medical Treatment," App. at 2a-3a, that is directly relevant to the matter before this Court.

The American College of Surgeons ("ACS") is a voluntary, non-profit, scientific and educational association organized to improve the care of the surgical patient. Founded in 1913 by surgical leaders in the United States and Canada, ACS has become the largest surgical organization in the world with approximately 50,000 members, called Fellows, who are physician-specialists practicing surgery in one of its recognized branches. The objectives of ACS, as stated in its Articles of Incorporation, are "to maintain an association of surgeons, not for pecuniary profit, but for the benefit of humanity by advancing the science of surgery and the ethical and competent prac-

tice of its art." The interest of ACS stems from the relationship between its Fellows and patients for whom its Fellows provide surgical care and the families of those patients.

The American Medical Women's Association ("AMWA") is a non-profit organization of 12,000 women physicians and medical students, one of whose primary missions is to promote quality health care for women. AMWA's concerns in this matter stem from its potential impact on the geriatric population in this country, a significant majority of whom are women. AMWA is also concerned with patient autonomy with respect to carrying out treatment options consistent with a patient's ethical beliefs. AMWA favors a policy which balances technological advancements with the humane aspects of the art of medicine.

The American Society for Parenteral and Enteral Nutrition ("A.S.P.E.N.") is a private, voluntary, non-profit education and clinical association of health professionals with a special expertise in parenteral (intravenous) and enteral (tube) nutrition. The Society engages in a wide range of activities in order to provide optimal nutrition support to patients, including the estimated one million patients who receive enteral feeding each year. Its 5,300 members represent the fields of medicine, pharmacy, nursing and dietetics and provide specialized nutrition services to many patients, including some with severe brain damage, whose digestive tracts are partially or wholly dysfunctional. For those patients in this category who are in a persistent vegetative state, the Society joins the *amici* in this brief.

The Missouri State Medical Association ("MSMA") is a private, voluntary, non-profit organization of physicians and medical students. It was founded in 1850 to serve its members through promotion of the science and art of medicine, protection of the health of the public, and betterment of the medical profession in Missouri. The MSMA has 5,500 physicians and medical student members, including approximately 80% of physicians in Mis-

souri. In response to the Missouri Supreme Court's decision, the MSMA has adopted a resolution, entitled "Right to Forego Life Support," App. at 4a-5a, urging the Missouri legislature to permit the withdrawal of life-prolonging medical treatment in the circumstances present in this and similar cases.

The Missouri State Neurosurgical Society ("MSNS") is a private, voluntary, non-profit organization of the neurological surgeons within the State of Missouri. Its purpose is to represent the interest of the neurosurgeons throughout the state. At the present time, the MSNS has approximately 75 members and therefore represents the vast majority of the neurological surgeons practicing in Missouri. Its interest here stems from the fact that, when an individual suffers a severe brain injury, a neurosurgeon will generally be the principal physician who is called upon to evaluate and treat the individual.

In developing their positions on the withdrawal of life support, *amici* necessarily struggled with the same profound and troubling issues that are presented for review by petitioners in this Court. The purpose of this brief is to provide an understanding of the relevant medical facts and a discussion of the reasons why, in the view of *amici*, this Court should recognize a right under the United States Constitution of patients to refuse life-prolonging medical treatment in the event of permanent unconsciousness.[1]

STATEMENT

On January 11, 1983, Nancy Cruzan suffered an automobile accident that left her "lifeless and not breathing" for between 6 and 20 minutes. Pet. App. A90, A93. Paramedics arriving by ambulance at the site of her accident first administered cardiopulmonary resuscitation, then inserted a tube in her trachea for respiratory support and an intravenous catheter into her bloodstream to deliver medication and sodium bicarbonate. *Id.* at A91.

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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. The parties' letters of consent have been filed with the Clerk of the Court.

These emergency measures restored Nancy Cruzan's breathing and heartbeat, but not her consciousness.

Over the next few weeks and months, physicians took additional steps to promote a return to consciousness. On February 7, 1983, a surgeon implanted a gastrostomy tube in Nancy Cruzan's stomach, *id.*, so that nutritional formula could be pumped directly into her gastrointestinal tract. Although health care personnel at the St. John's Regional Medical Center in Joplin, Missouri then attempted numerous rehabilitative measures over a six-week period, they ultimately discharged her as "essentially unimproved and unresponsive to rehabilitation." *Id.* at A93.

After interim stays at a private residence, a nursing home and two hospitals, she was admitted on October 19, 1983, to the Mount Vernon State Hospital, where she remains today. *Id.* at A93. In the more than six years that have passed since the paramedics restored her breathing and heartbeat, she has never regained consciousness. Her muscles are atrophying. Her arms and legs are contracting, and her fingernails sometimes cut into her wrists. *Id.* Much of the tissue in the upper hemisphere of her brain has been destroyed. The damage to her brain is irreversible, progressive and leaves no hope for any future recovery of consciousness. *Id.* at A94.

Nancy Cruzan is permanently unconscious, existing in what is termed a persistent vegetative state. Her parents, seeking to implement the treatment decision they believe she would want made, have sought authority to discontinue the artificial provision of nutritional formula that keeps their daughter in this state. The Missouri Supreme Court denied that authority, holding that Nancy Cruzan's fundamental rights were not at issue because 1) she had not formally acted to exercise them prior to her accident, 2) her parents lacked legal authority to obtain the order they sought, and 3) the State has an overriding interest in prolonging life.

MEDICAL BACKGROUND

Nancy Cruzan's condition, and the resulting legal dilemma concerning the nature and timing of her death, are in significant measure the products of recent advances in medical technology. Until the latter part of this century, medicine had relatively little treatment to offer the dying and the vast majority of persons died at home rather than in the hospital.[2] P. Aries, *Hour of Our Death* 584 (1981); E. Kubler-Ross, *On Death and Dying* 5-10 (1969). In the years following the Second World War, however, advances in medical technology made it possible to save and extend lives that would formerly have been lost.

The resuscitation and life-prolonging techniques used in this case, for example, have been developed for the most part over the past 30 years.[3] These techniques have made it possible for medicine to save the lives of those who, in earlier generations, would have died soon after an accident comparable to the one suffered here. They also have forced medicine, and society, to face the difficult question of what may be done when life-saving and life-prolonging techniques fail to bring about the desired recovery and leave the patient in a state of permanent unconsciousness.

The Persistent Vegetative State

The persistent vegetative state can best be understood as one of the conditions in which patients have suffered a loss of consciousness. Loss of consciousness is typically

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[2] In 1985, 83% of deaths in Americans age 65 or over occurred in a hospital or nursing home. Sager, Easterling, *et al.*, *Changes in the Location of Death After Passage of Medicare's Prospective Payment System: A National Study*, 320 New Eng. J. Med. 433, 435 (1989).

[3] *See Standards and Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC)*, 255 J.A.M.A. 2905, 2905 (1986); A.S.P.E.N. Board of Directors, *Guidelines for the Use of Enteral Nutrition in the Adult Patient*, 11 J. Parenteral & Enteral Nutrition 435, 436 (1987); *Enteral and Tube Feeding* 1-9 (J. Rombeau & M. Caldwell ed. 1984).

characterized in terms of its duration—brief or sustained —and its degree—partial or total. *Cecil Textbook of Medicine* 2061 (J. Wyngaarden & L. Smith 18th ed. 1988) (*"Cecil"*).

There are three major categories of sustained and total loss of consciousness: brain death, coma and the vegetative state.[4] In all three, the cerebral hemispheres, which are responsible for conscious behavior, do not function. Accordingly, the patient has no thoughts, feelings, sensations, desires or emotions. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment* 174 (1983) (*"President's Commission"*). There is no purposeful action, social interaction, memory, pain or suffering. *Id.* at 174-75, 181. In other words, the patient has lost all awareness of self and environment. F. Plum & J. Posner, *The Diagnosis of Stupor and Coma* 1 (3d ed. 1982) (*"Stupor and Coma"*).[5]

Brain death, coma and the vegetative state differ in the extent to which there is function of the brainstem, the part of the brain that controls unconscious activity.[6] In brain death, there is a complete and irreversible loss of brainstem function.[7] R. Adams & M. Victor, *Principles of Neurology* 234 (2d ed. 1981). As a consequence, the brain is no longer able to regulate what are known as the body's "vegetative" functions, which include the

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[4] Syncope (a faint), seizure and concussion are common causes of brief and total impairment of consciousness. *Cecil* at 2073-76. Dementia, on the other hand, is a condition in which there is a partial and sustained loss of consciousness. *Id.* at 2061.

[5] Other terms have been used to describe brain death, coma and the vegetative state, but they are not widely used. For example, cerebral death has been used as a synonym for both the vegetative state and brain death. *Stupor and Coma* at 313.

[6] If the brain's structure is analogized to a mushroom, the cerebral hemispheres correspond to the mushroom's cap and the brainstem to the mushroom's stem.

[7] There is also a complete and irreversible loss of cerebral hemisphere function.

functions of the heart, lungs, kidneys, and intestinal tract and certain reflex actions. *Stupor and Coma* at 313; *President's Commission* at 175. Mechanical measures or other artificial support can maintain vegetative functions temporarily, but only for a few days or, rarely, for a few weeks after brain death. *Stupor and Coma* at 313.

Patients in a vegetative state, on the other hand, maintain relatively normal brainstem function. Cranford, *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, 18 Hastings Ctr. Rep. 27, 28 (Feb./Mar. 1988). These patients can breathe air, digest food and produce urine without any assistance. *President's Commission* at 175. They experience cycles of sleeping, in which their eyes are closed, and waking, in which their eyes are open. Dougherty, Rawlinson, *et al.*, *Hypoxic-Ischemic Brain Injury and the Vegetative State: Clinical and Neuropathologic Correlation*, 31 Neurology 991, 992 (1981). Their eyes may move from side to side, seemingly fixating on others in the room, but without maintaining the fixation in any consistent or purposeful manner. *Principles of Neurology* at 233. They may smile, utter unintelligible sounds or move their limbs sporadically. Jennett & Plum, *Persistent Vegetative State After Brain Damage*, 1 Lancet 734, 734 (1972). Vegetative state patients also manifest a range of reflex reactions to noxious stimuli; they will grimace, cough, gag and move their limbs. In addition, their pupils constrict in response to light. *President's Commission* at 175; Cranford, 18 Hastings Ctr. Rep. at 28; Levy, Knill-Jones & Plum, *The Vegetative State and Its Prognosis Following Nontraumatic Coma*, 315 Annals N.Y. Acad. Sci. 293, 293 (1978).

While all of this activity gives the appearance of consciousness, there is none. Vegetative state patients may *react* to sounds, movements and normally painful stimuli, but they do not *feel* any pain or *sense* anybody or anything. Cranford, 18 Hastings Ctr. Rep. at 31. Vegetative state patients, in short, appear awake but are completely unaware.

Coma may be viewed as a condition intermediate between brain death and the vegetative state. The brainstem retains some function, but not the range of activity seen in the vegetative state.[8] For example, coma is a sleep-like state in which the eyes remain closed. *Stupor and Coma* at 5. The patient's breathing is impaired, and many reflexes are absent. *Principles of Neurology* at 232-33.

Coma and the vegetative state differ also in their duration. Coma rarely lasts more than 2-4 weeks, *Stupor and Coma* at 3, by which time the patient either dies,[9] enters a vegetative state or regains some degree of consciousness. The duration of the vegetative state, on the other hand, frequently lasts for more than a few weeks, in which case it may be characterized as a persistent vegetative state. *Id.* at 6. Some experts would not characterize a vegetative state as persistent until it has lasted for a year. Berrol, *Evolution and the Persistent Vegetative State*, 1 J. Head Trauma Rehab. 7, 12 (1986).

Patients may survive in a persistent vegetative state for years. In one study, 20% were still alive after one year, *Stupor and Coma* at 345; in another study, 27% were still alive after five years. Higashi, Hatano, *et al.*, *Five-Year Follow-Up Study of Patients with Persistent Vegetative State*, 44 J. Neurol. Neurosurg. & Psych. 552 553 (1981). Nancy Cruzan has been alive more than six years since her vegetative state began.[10]

The persistent vegetative state may be caused by a variety of brain-damaging conditions, including head in-

[8] The extent of brainstem injury in coma varies from one patient to another. *Principles of Neurology* at 232-33.

[9] The majority of patients with a coma that lasts for at least 6 hours do not survive. Levy, Bates, *et al.*, *Prognosis in Nontraumatic Coma*, 94 Annals Int. Med. 293, 294-95 (1981); *Cecil* at 2072.

[10] Karen Quinlan survived for ten years in a persistent vegetative state, L. A. Times, June 12, 1985, Part 1, at 4, col. 1, and Elaine Esposito, died after 37 years in a persistent vegetative state. *President's Commission* at 177 n.16.

jury, brain tumor, stroke, meningitis or Alzheimer's disease.[11] Higashi, Sakata, *et al.*, *Epidemiological Studies on Patients with a Persistent Vegetative State*, 40 J. Neurol. Neurosurg. & Psych. 876, 877 (1977). One of the most common causes of the persistent vegetative state, and the cause of Nancy Cruzan's condition, is "hypoxia-ischemia": that is, an inadequate delivery of oxygen to the brain by the blood circulation, on account of cardiac arrest, respiratory arrest, carbon monoxide poisoning, hypotensive shock or other derangements.[12] Bates, *Predicting Recovery from Medical Coma*, 33 Brit. J. Hosp. Med. 276, 278 (1985). While brainstem cells can survive for 15-20 minutes without oxygen, cells in the cerebral hemispheres can survive for only 4-6 minutes. Cranford & Smith, *Some Critical Distinctions Between Brain Death and the Persistent Vegetative State*, 6 Ethics Sci. & Med. 199, 203 (1979). Consequently, a temporary deprivation of oxygen to the brain may spare the brainstem while seriously damaging the cerebral hemispheres.

The diagnosis of the persistent vegetative state is based on repeated physical examinations of the patient, and can be made with a reasonably high degree of medical certainty by skilled neurologists, even though there are currently no laboratory studies or tests that unequivocally confirm the diagnosis of a persistent vegetative state. Cranford, 18 Hastings Ctr. Rep. at 29-30. An electroencephalogram ("EEG")[13] may show a wide range of abnormality while CAT scans and other scanning techniques cannot distinguish the brain damage in a persistent vegetative state from other conditions of severe damage in which the patient retains somewhat greater

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[11] Although only a minority of comas evolve into a vegetative state, the development of the vegetative state is in most cases preceded by coma.

[12] There may be inadequate delivery of oxygen to the brain either because the blood carries insufficient oxygen, as in respiratory arrest or carbon monoxide poisoning, or because there is insufficient blood flow to the brain, as in cardiac arrest or hypotensive shock.

[13] An EEG is a test that measures electrical activity in the brain.

degrees of function. Cranford, 18 Hastings Ctr. Rep. at 30.

The prognosis of a patient in a persistent vegetative state depends upon a number of factors, primarily the cause and the duration of the condition.[14] For example, patients, like Nancy Cruzan, whose brain damage resulted from hypoxia-ischemia, do poorly. In one study of patients in a coma from hypoxia-ischemia, 23 patients were in a vegetative state after one month. Over the next five months, 17 died, four remained vegetative and the remaining two improved only slightly. The two who improved were able to utter a rare comprehensible word, but they never responded to others. Dougherty, Rawlinson, *et al.*, 31 Neurology at 997. Similarly, in another study of hypoxic-ischemic coma patients, of the 15 who were vegetative after one month, none regained independent function. Levy, Caronna, *et al.*, *Predicting Outcome From Hypoxic-Ischemic Coma*, 253 J.A.M.A. 1420, 1423 (1985). Most patients who recover from an hypoxic-ischemic coma do so in fact without entering a vegetative state. *Id.* at 1422.

The chance of a recovery decreases as the duration of the persistent vegetative state increases. Once a patient has been in a persistent vegetative state for more than three months after hypoxia-ischemia, "[t]he diagnosis of permanent unconsciousness can usually be made with a high degree of medical certainty . . . ." *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).

Significant recovery from a persistent vegetative state caused by hypoxia-ischemia is rare. Although an estimated *100,000* patients in this country have been in a persistent vegetative state as a result of hypoxia-ischemia over the past 20 years, there are only *three* recoveries

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[14] Another important factor is the extent of brainstem function detected in the early time period after the brain injury.

documented in the medical literature.[15] Moreover, none of those who have recovered from a persistent vegetative state caused by hypoxia-ischemia was in the persistent vegetative state nearly as long as Nancy Cruzan has been. The latest that recovery has begun is 22 months after the hypoxia-ischemia. Snyder, Cranford, *et al., Delayed Recovery From Postanoxic Persistent Vegetative State*, 14 Annals Neurol. 152 (1983). By comparison, it has been more than six years since Nancy's automobile accident. Pet. App. A6.[16]

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[15] In one case, a woman who had been a graduate student began to recover seven weeks after injury and eventually was able to live alone and work as a receptionist. Shuttleworth, *Recovery to Social and Economic Independence From Prolonged Postanoxic Vegetative State*, 33 Neurology 372 (1983). Another patient regained the ability to speak but had a limited ability to concentrate or remember recent events or learn new information. Rosenberg, Johnson & Brenner, *Recovery of Cognition After Prolonged Vegetative State*, 2 Annals Neurol. 167, 168 (1977) (reporting a patient who began to recover 17 weeks after injury). *See also* Snyder, Cranford, *et al., Delayed Recovery From Postanoxic Persistent Vegetative State*, 14 Annals. Neurol. 152 (1983) (describing patient whose recovery began 22 weeks after injury and whose personality returned to normal).

[16] Patients whose vegetative state resulted from other causes have more favorable outcomes than those whose injury was caused by hypoxia-ischemia. Victims of head trauma have the best prognosis, and among those patients, recovery is more common in children than adults. Indeed, the chances of recovery are still significant up until one year after the head injury for patients less than 20 years old. Bricolo, Turazzi, *et al., Prolonged Posttraumatic Unconsciousness*, 52 J. Neurosurg. 625, 632 (1980). See also Alberico, Ward *et al., Outcome After Severe Head Injury*, 67 J. Neurosurg. 648 (1987).

The possibility of recovery after a long delay is also greater in patients whose persistent vegetative state was caused by a head injury rather than by hypoxia-ischemia. One patient, who was 18 years old at the time of injury, emerged from her persistent vegetative state 30 months after injury. Arts, Van Dongen, *et al., Unexpected Improvement After Prolonged Posttraumatic Vegetative State*, 48 J. Neurol. Neurosurg. & Psych. 1300 (1985). In another case, which was not well documented, six years passed after the

Enteral Nutrition and Feeding Tubes

Enteral nutrition is a term commonly used to describe the provision of liquid formula diets by tube or mouth into the gastrointestinal tract. A.S.P.E.N. Board of Directors, 11 J. Parenteral & Enteral Nutrition at 436. Given to patients in a rudimentary way for hundreds of years, enteral nutrition has been frequently used only in the last fifteen years, largely because of improvements in delivery systems and the development of nutritionally complete formulas. *Id.*

Although patients in a persistent vegetative state are unable to eat food or drink fluids, their gastrointestinal tracts function normally. *President's Commission* at 175. Consequently, they can digest food and absorb fluids that are placed into their stomachs.[17]

The most commonly used and the simplest device for supplying food and water to a patient's stomach is the nasogastric tube. *By No Extraordinary Means* 25 (J. Lynn ed. 1986). The nasogastric tube is a long, slender and pliable plastic tube whose distal section is passed through the patient's nose, throat and esophagus and into the stomach. *Id.* Liquid food and fluids can then be delivered to the patient through the tube.

In order to reduce the complications from tube feedings,[18] a gastrostomy tube is generally implanted once it

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injury before the patient's family observed signs of consciousness. Tanhehco & Kaplan, *Physical and Surgical Rehabilitation of Patient After 6-Year Coma,* 63 Arch. Phys. Med. Rehab. 36 (1982).

[17] Supplying nutrition and hydration directly into the bloodstream (parenteral nutrition) is used when the patient's gastrointestinal tract is not functioning properly and enteral nutrition is not feasible. Enteral nutrition is used when feasible because it is less expensive, carries a smaller risk of infection and is a more direct and therefore a more effective way to deliver nutrition. *Nutrition in Clinical Surgery* 44 (M. Deitel 2d ed. 1985).

[18] Nasogastric tubes pose several potential complications. They may induce vomiting or regurgitation with subsequent aspiration (inhalation) of the stomach's contents into the lungs. *By No*

becomes apparent that artificial feeding will be needed for a prolonged period of time (more than about four weeks).[19] *Enteral and Tube Feeding* 275 (J. Rombeau & M. Caldwell ed. 1984). A gastrostomy tube is introduced directly into the patient's stomach through incisions in the abdominal wall and the surface of the stomach. *Nutrition in Clinical Surgery* 66-72 (M. Deitel 2d ed. 1985). While gastrostomy tubes generally have fewer complications than nasogastric tubes during their use, they may obstruct the intestinal tract, erode and pierce the stomach wall or cause leakage of the stomach's contents into the abdominal cavity. *Id.* at 66-67. In addition, gastrostomy tube feedings may cause pneumonia from reflux of the stomach's contents into the lung. *Enteral and Tube Feeding* at 553.

Tube feedings can be prepared by pulverizing regular food in a blender. Typically, however, commercially prepared formulas are used because they ensure a consistent level of quality, reduce the risk of bacterial contamination and have a smoother texture that facilitates flow through the feeding tube. *Surgical Nutrition* 726 (J. Fischer ed. 1983). For most patients, the physician may choose from a number of formulas that will meet the patient's nutritional requirements. *Nutrition in Clinical Surgery* at 79.

Initially in tube feeding, there is a trial period during which the type of formula and the method of administration are tailored to the particular patient. *Surgical Nutrition* at 748. Some formulas may not be tolerated because of food allergies or lactose intolerance. In addition,

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Extraordinary Means at 25. Primarily because the stomach's contents are acidic, aspiration can damage the lung tissue, thereby increasing the patient's susceptibility to lung infection (aspiration pneumonia). *Harrison's Principles of Internal Medicine* 1076 (E. Braunwald, *et al.*, 11th ed. 1987). Nasogastric tubes commonly irritate the lining of the nose, throat and esophagus and may cause bleeding that is sometimes severe. *By No Extraordinary Means* at 25.

[19] A gastrostomy tube was implanted in Nancy Cruzan approximately three weeks after her injury. Pet. Ex. 10.

if the formula is delivered too rapidly or without sufficient dilution, the patient will suffer from vomiting, diarrhea or other gastrointestinal problems. *Id.*

Because persistent vegetative state patients cannot sense thirst, hunger or satiety, they are unable to regulate their intake of food and water. Consequently, their metabolic status must be regularly monitored. In hospitals, daily records are kept of the patient's weight, fluid intake and fluid output. *Surgical Nutrition* at 749, 751. In addition, blood tests are performed on a weekly basis to check the levels of sodium, potassium, calcium and other electrolytes. *Id.* at 751. See generally A.S.P.E.N., *Standards For Nutrition Support—Hospitalized Patients* (1988). In nursing homes, however, staffing limitations may result in somewhat less frequent monitoring.

The clear weight of medical opinion recognizes that artificially provided nutrition and hydration constitute medical treatment. For example, the AMA's Ethical Opinion 2.20, App. at 1a, expressly defines the artificial provision of nutrition and hydration as medical treatment that may be withdrawn from a person in a persistent vegetative state. The AMA's position is consistent with other prominent organizations and commissions, including co-*amici*,[20] the President's Commission for the Study of Ethical Problems in Medicine and Behavioral Research,[21] the Hastings Center [22] and the American Academy of Neurology.[23]

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[20] *See, e.g.*, A.S.P.E.N. Board of Directors, 11 J. Parenteral & Enteral Nutrition at 439 ("Enteral nutrition should not be used whenever aggressive nutritional support is not desired by the patient or his legal guardian, and when such action is in accordance with hospital policy and existing laws.").

[21] *President's Commission* at 189-96.

[22] The Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying*, 26-30, 61 (1987).

[23] *Position of the American Academy of Neurology*, 39 Neurology at 125.

As others have recognized, gastrostomy tube feedings have more in common with other medical procedures than with typical ways of providing nutrition. *McConnell* v. *Beverly Enterprises-Connecticut*, 209 Conn. 692, 553 A.2d 596, 602-03 (1989); *Barber* v. *Superior Court*, 147 Cal. App. 3d 1006, 1016-17, 195 Cal. Rptr. 484 (1983). Although the nutrients being supplied the patient are, like oxygen, something that each of us needs, the means by which they are provided here is inherently medical.[24] Enteral nutrition requires monitoring by experienced health professionals to ensure that nutritional needs are being met and to recognize and prevent the many gastrointestinal and metabolic complications that may occur. *Enteral and Tube Feeding* at 542-65; Cataldi-Betcher, Seltzer, *et al.*, *Complications Occurring During Enteral Nutrition Support: A Prospective Study*, 7 J. Parenteral & Enteral Nutrition 546 (1983). The treatment is provided by health care professionals in direct response to the patient's underlying abnormal health condition—severe deterioration of the brain causing a permanent loss of consciousness and an inability to chew or swallow.[25] In sum, providing specialized nutrition support through tube feeding into the gastrointestinal tract is a medical therapy.

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[24] Artificial provision of nutrition is in essence no different than other treatments that are widely accepted as medical in nature. Like gastrostomy tubes, ventilators provide an essential element of life—oxygen—and do so without curing the underlying disease. Similarly, dialysis provides for the essential process of waste disposal, also without reversing the damage done by disease. No one would doubt that these are medical treatments. *See Gray* v. *Romeo*, 697 F. Supp. 580, 586-87 (D.R.I. 1988) and cases cited therein.

[25] The cost of the medical devices and formulas used in enteral feeding is reimbursable under Medicare, 42 U.S.C. § 1395u note (1989), and the enteral formulas are regulated by the Food and Drug Administration as "medical foods." 21 U.S.C. § 360ee (1989).

SUMMARY OF ARGUMENT

I.

This Court has long recognized that the "liberty" protected by the Due Process Clause of the Fourteenth Amendment guarantees to individuals and families the right to make certain highly personal decisions free from unwarranted governmental intrusion. *Loving* v. *Virginia*, 388 U.S. 1 (1967). Mindful of the need for judicial restraint in interpreting the substantive reach of the Due Process Clauses, this Court has identified only those liberty interests that are deeply rooted in our nation's history and that are essential to a scheme of ordered liberty as being fundamental and therefore deserving of special constitutional protection. *E.g.*, *Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925).

The right that Nancy Cruzan and her parents seek to have vindicated is plainly a personal and important one that it is deeply rooted in the common law. It is comparable in import to the kinds of rights that this Court has historically protected. For over a century, the common law has protected the right of all persons to control medical treatment affecting their body. From the initial decisions finding that operations performed without consent constitute battery, to the evolution of an elaborate doctrine requiring that the consent obtained be "informed," to the wide-spread protection of the patient's right to refuse treatment (even when such a refusal will lead to death), courts have consistently recognized the overriding importance of protecting each individual's right to autonomy and self-determination. This common law respect for autonomy and self-determination also undergirds the decisions of this Court protecting the freedom of individuals to make certain important personal choices, *Carey* v. *Population Services Int'l*, 431 U.S. 678, 688-89 (1977), and protecting the individual's right to control nonconsensual invasions of bodily integrity. *Winston* v. *Lee*, 470 U.S. 753, 766 (1985). Accordingly, a person's right to receive and to refuse medical treat-

ment in accordance with his wishes is one of the basic liberties that satisfies this Court's standard for receiving fundamental constitutional protection.

II.

The Missouri Supreme Court's requirement that a person must have left an explicit directive ordering life-prolonging treatment withdrawn in the event of permanent unconsciousness fails to provide both the patient and her family a fundamentally fair opportunity to protect the patient's rights. *Santosky* v. *Kramer*, 455 U.S. 745 (1982). While a living will or other formal declaration would provide compelling evidence of a person's wishes, the failure to execute such a declaration is no evidence that a person lacks any preference about whether treatment should be provided, or that others, and in particular the family, are not aware of the patient's preference.

Missouri's arbitrary rule further violates Due Process by foreclosing the patient's family from participating in the treatment decision being made. In particular, this Court has consistently protected the fundamental interest of parents in determining the care their children should receive, and courts traditionally have accorded parents a similar interest in the treatment decisions of incompetent family members. *Parham* v. *J.R.*, 442 U.S. 584 (1979). The Missouri Supreme Court is unique among state supreme courts in holding, in effect, that the parents' views about the treatment they think their daughter would have wanted and the parents' desire to protect their daughter's right to treatment in accordance with her preference are irrelevant to deciding whether an incompetent patient would choose to continue receiving medical care.

III.

Missouri's asserted interest in the unqualified preservation of life is not sufficient to warrant the profound intrusion into the lives of patients and families that its decision causes. Although the State professes an interest in protecting the patient's rights, its decision fails to ad-

dress the most important right this patient currently possesses—the right to reject medical care including life-prolonging treatment. Far from protecting the patient, the decision to exclude as inherently unreliable all of the evidence concerning Nancy Cruzan's wishes has resulted in a decision that is flatly inconsistent with everything the record tells about what Nancy Cruzan would have wanted.

Other states have adopted a variety of different rules and procedures designed to strike an appropriate balance between protecting the rights of patients and families and safeguarding the state's interest in prolonging life and protecting vulnerable citizens. *E.g. In re Gardner*, 534 A.2d 947 (Me. 1987); *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987). This Court need not pre-empt state initiatives in reversing the decision below, because Missouri's unique approach sweeps far more broadly than is necessary to protect the interests of persistent vegetative state patients and severely handicapped individuals. Indeed, in insisting upon imposing treatments without due regard for the patient's wishes, Missouri is effectively undermining the most valuable protection—respect for patient autonomy—that vulnerable persons have against the state.

Finally, the Missouri Supreme Court erred in disregarding the substantial impact that its decision will have on the ethical practice of medicine. For over 2,000 years, the predominant responsibility of the physician has not been to preserve life at all costs but to serve the patient's needs while respecting the patient's autonomy and dignity. By requiring physicians to provide treatment that a patient and family both reject, the state unduly intrudes into the physician-patient relationship and threatens to undermine the mutual trust between patient, family and physician that is critical in today's technologically complex medical environment.

ARGUMENT

I. A PERSON IN A PERSISTENT VEGETATIVE STATE HAS A FUNDAMENTAL RIGHT, PROTECTED BY THE GUARANTEE OF LIBERTY IN THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT, TO HAVE LIFE-PROLONGING MEDICAL TREATMENT WITHDRAWN.

This Court previously has not addressed the question whether a person in a persistent vegetative state has a constitutional right to refuse life-prolonging medical treatment. With the exception of the Missouri Supreme Court, however, state supreme courts and other courts have unanimously concluded that the right is protected by the common law, by state constitutions and by the Due Process Clause of the Fourteenth Amendment.[26] There is therefore a broad consensus that the right asserted by petitioners in this case is "deeply rooted in this Nation's history and tradition," *Moore* v. *City of East Cleveland*, 431 U.S. 494, 503 (1977) (opinion of Powell, J.), and is part of the "rational continuum" of privacy and liberty rights to which this Court has consistently ac-

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[26] *See Gray* v. *Romeo*, 697 F. Supp. 580 (D.R.I. 1988); *Rasmussen* v. *Fleming*, 154 Ariz. 207, 741 P.2d 677 (1986) (en banc); *In re Gardner*, 534 A.2d 947 (Me. 1987); *In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987); *Brophy* v. *New England Sinai Hospital*, 398 Mass. 417, 497 N.E.2d 626 (1986); *John F. Kennedy Memorial Hospital* v. *Bludworth*, 452 So.2d 921 (Fla. 1984); *In re Torres*, 357 N.W.2d 332 (Minn. 1984); *In re* L.H.R., 253 Ga. 439, 321 S.E.2d 716 (1984); *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983), *modified on other grounds*, *In re Hamlin*, 102 Wash. 2d 810, 689 P. 2d 1372 (1984); *In re Storar (Eichner* v. *Dillon)*, 52 N.Y.2d 363, 420 N.E.2d 64, *cert. denied*, 454 U.S. 858 (1981); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976); *Corbett* v. *D'Alessandro*, 487 So.2d 368 (Fla Dist. Ct. App. 1986); *In re Drabick*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (1988); *Delio* v. *Westchester County Medical Center*, 129 A.D.2d 1, 516 N.Y.S.2d 677 (1987); *Leach* v. *Akron General Medical Center*, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980); *Severns* v. *Wilmington Medical Center*, 425 A.2d 156 (Del. Ch. 1980).

corded constitutional protection, *Poe v. Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting).

Certainly, the court must be cautious in determining whether a particular right should be accorded fundamental status and thereby removed from ordinary governmental regulation. Nevertheless, in *Michael H.* v. *Gerald D.*, 109 S. Ct. 2333 (1989), the Court last Term reaffirmed that "[i]t is an established part of our constitutional jurisprudence that the term 'liberty' in the Due Process Clause extends beyond freedom from physical restraint" to include those interests that are " 'so rooted in the traditions and conscience of our people as to be ranked as fundamental.' " 109 S. Ct. at 2341 (plurality opinion) (quoting *Snyder* v. *Massachusetts*, 291 U.S. 97, 105 (1934)). The long common law history of protection for the right of an individual to control medical treatment decisions, and the enduring theme of this Court's substantive due process jurisprudence "that freedom of personal choice in matters of family life is a fundamental liberty interest protected by the Fourteenth Amendment," *Santosky*, 455 U.S. at 753, demonstrate that the right at issue here is of fundamental constitutional stature.

A. The Individual's Fundamental Privacy And Liberty Right To Be Free Of Governmental Interference Extends To Medical Treatment Decisions And Includes The Right To Have Life-Prolonging Medical Treatment Withdrawn.

This Court has long recognized that, as part of the "liberty" protected by the Constitution's Due Process Clauses, the Constitution guarantees to each individual certain areas or zones of privacy which remain free from unjustified government interference or intrusion. See *Carey*, 431 U.S. at 684. The Court's privacy and liberty rulings rest on the theory that the constitutional text does not, on its face, specify all rights that warrant constitutional protection from executive or legislative intervention. *Michael H.*, 109 S. Ct. 2333.

In defining the scope of the right of liberty guaranteed by the Due Process Clause, this Court has drawn on the two basic principles that underlie the common law right to refuse medical treatment. These principles—the right to make certain important, personal decisions, and the right to bodily integrity—are each in turn components of the fundamental right of each person to self-determination or autonomy, the protection of which is integral to western political thought and to the structure of our Constitution. See *Olmstead* v. *United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) ("[T]he right to be let alone" is "the most comprehensive of rights and the right most valued by civilized men"); *Fitzgerald* v. *Porter Memorial Hospital*, 523 F.2d 716, 719-20 (7th Cir. 1975), *cert. denied*, 425 U.S. 916 (1976) ("[T]he origins of the American heritage of freedom [lie in] the abiding interest in individual liberty that makes certain state intrusions on the citizen's right to decide how he will live his own life intolerable"); J. Rawls, *A Theory of Justice* 251-59 (1972); J.S. Mill, *On Liberty* 68 (Penguin ed. 1988).

1. Under this court's holdings, the individual has been given the right "to make certain unusually important decisions that will affect his own, or his family's, destiny." *Fitzgerald*, 523 F.2d at 719; *Cleveland Board of Education* v. *LaFleur*, 414 U.S. 632, 639-40 (1974). Where state laws have unjustifiably interfered with the individual's right to make such inherently personal decisions, the Court has not hesitated to strike those statutes as antithetical to the individual liberty protected by the Due Process Clause. See *Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925); *Meyer* v. *Nebraska*, 262 U.S. 390 (1923); *Griswold* v. *Connecticut*, 381 U.S. 479 (1965); *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972); *Loving* v. *Virginia*, 388 U.S. 1 (1967); see also *Skinner* v. *Oklahoma*, 316 U.S. 535, 541 (1942).

There are few decisions that can have as momentous an impact on a person's destiny as decisions about medical care. Medical treatment decisions may profoundly affect the patient's physical or psychological well-being. They

can mean "the difference between a life of pain and a life of pleasure." [27]

In particular, the decision whether to use available means to prolong a vegetative existence or a terminal condition indefinitely is profoundly intimate and personal.[28] It is a decision inextricably bound with an individual's beliefs about the meaning and purpose of life, with a patient's views about death or dying and about the individual's attitudes toward family and close friends. See, *e.g.*, *Death in America* xv (D. Stannard ed. 1975). It is also a decision central to the basic human project of defining one's character and taking responsibility for one's action. 1 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Making Health Care Decisions* 46 (1982).

Implicated in this decision are the individual's beliefs about the importance of retaining a core of human dignity as an essential prerequisite of meaningful life. For many individuals, there is an unacceptable loss of dignity from being unable to maintain even minimal intellectual functioning, physical control or personal hygiene and being utterly dependent on other individuals and medical technology for survival. A patient may wish to avoid the "ultimate horror . . . of being maintained in limbo, in a sterile room, by machines controlled by strangers." *Torres*, 357 N.W.2d at 340 (quoting Steel, *The Right To Die:*

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[27] *Andrews* v. *Ballard*, 498 F. Supp. 1038, 1047 (S.D. Tex. 1980).

[28] In decisions about life-prolonging medical treatments when the patient is terminally ill, the course of action that will best promote the patient's well-being rests on subjective judgments that only the patient is in a position to make. The patient with advanced metastatic cancer must decide whether to undertake another round of painful, nauseating and debilitating chemotherapy for the prospect that it might prolong life for another few months. The patient with terminal kidney disease must decide whether to remain hospitalized and dialyzed during the final stages of illness or to surrender to death a few days or weeks earlier at home with the family at the bedside. These are not judgments the state should make for the individual.

New Option in California, 93 Christian Century (July-Dec. 1986)).

Also at stake is the individual's freedom to minimize the suffering of others. Many individuals would prefer to spare their parents, spouses and children the emotional burden of being subjected to the anguish of a bedside vigil that may last for years and the psychological disturbances that can result from that experience. Carnwath & Johnson, *Psychiatric Morbidity Among Spouses of Patients With Stroke*, 294 Brit. Med. J. 409 (1987); Livingston, *Families Who Care*, 291 Brit. Med. J. 919 (1985). Finally, people care about the memories they leave behind them. Many individuals would choose withdrawal of treatment in the absence of any hope of recovery so that they would be recalled by family and friends most vividly as they were before becoming persistently vegetative. Although the welter of personal concerns implicated by this decision resist easy summary, the personal liberty interests implicated by the decision are of great and immediate consequence to the individual.

2. A right to decline life-prolonging medical treatments finds support as well from this Court's recognition that the individual has a fundamental interest in controlling invasions of his bodily integrity. In *Winston* v. *Lee*, 470 U.S. 753 (1985), for example, the Court held that a state could not compel a criminal defendant to undergo minor surgery for the removal of a bullet. In addition to the health risks posed by the surgery, the Court found that the surgery would constitute a "severe" intrusion into the defendant's interests in "personal privacy and bodily integrity." *Id.* at 763-66. This Court has also found that compelled blood tests or stomach pumping, and even physically non-invasive medical procedures like breathalyzer tests and urinalyses, implicate constitutional concerns about an individual's personal privacy and bodily integrity. *Skinner* v. *Railway Labor Executives' Ass'n*, 109 S. Ct. 1402, 1412-13 (1989); *Schmerber* v. *California*, 384 U.S. 757, 772 (1966); *Rochin* v. *California*, 342 U.S. 165, 173-74 (1952).

The life-sustaining medical procedures imposed on a patient in a persistent vegetative state similarly intrude on that patient's bodily integrity and privacy. The intrusion on bodily integrity stems from the invasiveness of the procedure: Nancy Cruzan is nourished not by means of food offered and willingly accepted, but by a tube surgically inserted into her stomach through which formula is regularly pumped. The Massachusetts Supreme Judicial Court recognized that in these circumstances a person may reasonably conclude that "the burden of maintaining the corporeal existence degrades the very humanity it was meant to serve." *Brophy* v. *New England Sinai Hospital*, 398 Mass. 417, 497 N.E.2d 626, 635 (1986).

B. Recognition Of A Fundamental Right To Make Decisions About Medical Treatment, Including The Right To Have Life-Prolonging Medical Care Withdrawn, Is Supported By The History And Traditions Of This Nation.

The right of a competent adult to control medical decisions affecting her body is deeply rooted in Anglo-American law, and is grounded in the importance our society has traditionally accorded the autonomy of the individual. "Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment." *Natanson* v. *Kline*, 186 Kan. 393, 350 P.2d 1093, 1104, *clarified*, 187 Kan. 186, 354 P.2d 670 (1960). As this Court stated nearly a century ago, in holding that a court could not compel a person to submit to a surgical examination:

> No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.

Union Pacific Ry. Co. v. *Botsford*, 141 U.S. 250, 251 (1891).[29]

Historically, the common law has protected this right in the medical context by considering any medical treatment performed without consent to constitute a battery, excusable only in emergency circumstances. W. Keeton, *Prosser & Keeton on the Law of Torts* 190 (5th ed. 1984).[30] In this century, the common law has developed further protection for patients through the doctrine of informed consent to medical treatment, which requires a physician to disclose to the patient all appropriate information about the medical procedures being proposed in advance of obtaining consent.[31] As with the requirement of consent, "[t]he root premise" of informed consent "is the concept, fundamental in American jurisprudence, that '(e)very human being of adult years and sound mind has

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[29] The statutory law of this country has also recognized the importance of the individual's interest in being able freely to decide whether to accept care recommended by a physician. In order to protect the privacy of patients in their medical care, for example, *Developments in the Law—Privileged Communications*, 98 Harv. L. Rev. 1450, 1531 (1985), 40 of the states and the District of Columbia have enacted statutes that recognize a physician-patient privilege. *Id.* at 1532.

[30] *See Slater & Baker* v. *Stapleton*, 95 Eng. Rep. 860 (K.B. 1767) (two physicians held liable for disuniting partially healed fracture without patient's consent); *see also Mohr* v. *Williams*, 95 Minn. 261, 104 N.W. 12, 15-16 (1905). The battery analysis has been applied not only to nonconsensual surgical intervention, but to any form of medical treatment imposed against the patient's will. *Winters* v. *Miller*, 446 F.2d 65, 68 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971) (giving patient forced medication over her objections constituted common law assault and battery); *Cooper* v. *Roberts*, 220 Pa. Super. 260, 286 A.2d 647, 649 & n.2 (1971) (same duty of disclosure applies whether or not the gastroscopic examination at issue could technically be termed a surgical operation).

[31] *See generally* P. Appelbaum, C. Lidz & A. Meisel, *Informed Consent: Legal Theory and Clinical Practice* (1987); J. Katz, *The Silent World of Doctor and Patient* (1984); Schultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 Yale L.J. 219 (1985).

a right to determine what shall be done with his own body. . . .' " *Canterbury* v. *Spence*, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) (quoting *Schloendorff* v. *Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92, 93 (1914) (Cardozo, J.)).

The principle of informed consent and its corollary right to refuse treatment have traditionally not been qualified by the "nature or purpose of the treatment, or the gravity of the consequences [to the individual] of acceding to or foregoing it." [32] *Tune* v. *Walter Reed Army Medical Hospital*, 602 F. Supp. 1452, 1455 (D.D.C. 1985). Patients have been entitled to decline "even cure" if the treatment would entail what for them would be intolerable burdens, "however unwise [their] sense of values may be to others." *In re Gardner*, 534 A.2d 947, 951 (Me. 1987) (quoting *Downer* v. *Veilleux*, 322 A.2d 82, 91 (Me. 1974)).

In accordance with these principles, state courts have consistently held that the patient's right to refuse even life-saving and life-prolonging treatment outweighs the state's interest in preserving life.[33] In the relatively rare

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[32] The right historically has been qualified to protect innocent third parties, such as minor dependents of the patient. *See* notes 34 and 50, *infra*.

[33] According to one estimate, the right to refuse medical treatment has been upheld in more than 80 court decisions. *See* Wanzer, Federman, *et al.*, *The Physician's Responsibility Toward Hopelessly Ill Patients*, 320 New Eng. J. Med. 844, 844 (1989). For cases involving patients in a persistent vegetative state, *see* cases, *supra*, note 26; for cases involving terminally ill, incompetent patients, *see In re Beth Israel Medical Center*, 136 Misc. 2d 931, 519 N.Y.S. 2d 511 (Sup. Ct. 1987); *In re L.H.R.*, 253 Ga. 439, 321 S.E.2d 716 (1984); *Superintendent of Belchertown State School* v. *Saikewicz*, 373 Mass. 728. 370 N.E.2d 417 (1977); for cases involving competent patients, *see Satz* v. *Perlmutter*, 379 So.2d 359 (Fla. 1980); *Bouvia* v. *Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); *St. Mary's Hospital* v. *Ramsey*, 465 So.2d 666 (Fla. Dist. Ct. App. 1985); *Bartling* v. *Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984); *In re Lydia E. Hall Hospital*, 116 Misc. 2d 477, 455 N.Y.S.2d 706 (1982); *Lane* v. *Candura*, 6 Mass. App.

instances where courts have refused to uphold the patient's refusal, the courts' decisions typically have been based on the need to protect minors dependent on the patient.[34] Furthermore, over the past decade, most state legislatures have taken steps to facilitate the ability of patients in certain circumstances to exercise their right to refuse life-prolonging medical treatment. At least 38 states now have "living will" acts, which allow patients to dictate in advance whether their lives will be prolonged in the event they become terminally ill, and at least 15 states have statutes that enable persons to authorize a surrogate decisionmaker to make health care decisions for them in the event of incompetency. Wanzer, Federman *et al.*, *The Physician's Responsibility Toward Hopelessly Ill Patients*, 320 New Eng. J. Med. 844, 844 (1989); Areen, *The Legal Status of Consent Obtained From Families of Adult Patients to Withhold or Withdraw Treatment*, 258 J.A.M.A. 229, 230 (1987). Like many of these statutes, the Missouri Living Will Act expressly states that the procedures it provides are entirely cumulative, and do not displace or preempt a person's common law right to refuse treatment.[35]

377, 376 N.E.2d 1232 (1978); *In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785 (1978); *In re Yetter*, 62 Pa. D. & C. 619 (1973) *In re Brown*, 478 So.2d 1033 (Miss. 1985); *see also Tune* v. *Walter Reed Army Medical Hosp.*, 602 F. Supp. 1452 (D.D.C. 1985).

[34] *See, e.g., Powell* v. *Columbian Presbyterian Medical Center*, 49 Misc. 2d 215, 267 N.Y.S.2d 450, 451 (1965) (transfusion ordered where patient's spouse and minor children objected to patient's refusal and patient's objection was not to transfusion itself but to signing the authorization). *Cf. In re Westchester County Medical Center*, 72 N.Y.2d 517, 531 N.E.2d 607 (1988) (recognizing the right to have treatment withheld, but refusing to authorize it in this instance because of ambiguity surrounding the wishes of the patient, who was neither unconscious nor terminally ill).

[35] *See* Mo. Ann. Stat. § 459.055 (Vernon 1988). Statutes providing for surrogate decisionmakers, such as Illinois' Powers of Attorney for Health Care Act, also expressly state that their provisions are cumulative. *See, e.g.*, Ill. Ann. Stat. ch. 110 1/2, ¶ 804-3 (Smith Hurd 1989).

C. The Right To Have Life-Prolonging Medical Treatment Withdrawn Is Not Lost Upon Incompetency.

By its terms, the Fourteenth Amendment applies to "any person," and it is well-established that the protection of an individual's liberty is not lost upon incompetency. *Youngberg* v. *Romeo*, 457 U.S. 307, 314-15 & n.16 (1982); *cf. Thompson* v. *Oklahoma*, 108 S. Ct. 2687, 2693 n.23 (1988) (plurality opinion).[36] Indeed, a judicial doctrine that constrains the protection afforded to incompetent patients plainly invites a serious challenge under the Equal Protection Clause. See *In re Eichner*, 73 A.D.2d 431, 465, 426 N.Y.S.2d 517, 542 (N.Y. App. Div. 1980), *modified on other grounds sub nom. In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, *cert. denied*, 454 U.S. 858 (1981).

Accordingly, a person who, prior to losing competency, has made a decision not to be kept alive by artificial treatment is entitled to have that decision honored. A person should not lose the right to have that choice enforced simply because of incompetence at the time withdrawal of treatment is to occur. The fact that one is not consciously aware that one's body is being invaded or one's dignity destroyed is no reason to countenance such an invasion. Were the State of Missouri to propose performing medical experiments upon one of its patients being kept alive in a persistent vegetative state, there is little doubt that a permanent restraining order would quickly issue. "There are limits to the extent to which a legislatively represented majority may conduct biological experiments

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[36] Among the state cases so holding are *In re Conroy*, 98 N.J. 321, 486 A.2d 1209, 1229 (1985); *Foody* v. *Manchester Memorial Hospital*, 40 Conn. Supp. 127, 482 A.2d 713, 718 (1984); *In re L.H.R.*, 253 Ga. 439, 321 S.E.2d 716, 722 (1984); *In re Torres*, 357 N.W.2d 332, 339 (Minn. 1984); *John F. Kennedy Memorial Hospital* v. *Bludworth*, 452 So.2d 921, 923 (Fla. 1984); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738, 742 (1983), *modified on other grounds, In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372, 1376 (1984); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, 664, *cert. denied*, 429 U.S. 922 (1976).

at the expense of the dignity and personality and natural powers of a minority." *Skinner*, 316 U.S. at 546 (Jackson, J., concurring). See *United States* v. *Stanley*, 483 U.S. 669, 709 (1987) (O'Connor, J., concurring in part and dissenting in part); *Poe*, 367 U.S. at 555 (Harlan, J., dissenting).

Like the prohibition on experimentation without consent, the prohibition on treatment without consent " 'must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both.' " *Brophy*, 497 N.E.2d at 634 (quoting *Superintendent of Belchertown State School* v. *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417, 427 (1977)). For these reasons, every state supreme court, except Missouri's, that has reached the issue has concluded that an incompetent patient has a fundamental right to have life-prolonging medical treatment withdrawn.[37]

II. DUE PROCESS REQUIRES THAT INCOMPETENT PATIENTS BE GIVEN A REASONABLE OPPORTUNITY TO HAVE IMPLEMENTED THE TREATMENT CHOICE THEY WOULD HAVE WANTED.

The " 'private realm of family life which the state cannot enter' . . . has been afforded both substantive and *procedural* protection." *Smith* v. *Organization of Foster Families for Equality & Reform*, 431 U.S. 816, 842 (1977) (empasis added, quotations and footnotes omitted). Missouri, however, has provided neither. In rejecting petitioners' request for an order directing that life-prolonging treatment be withdrawn, the Missouri Supreme Court held that, in the absence of a patient's explicit prior directive, it need not consider the significance of the views that Nancy Cruzan expressed prior to her accident nor the testimony of her parents, sister and close friends as to what she would have wanted. Pet. App. A37, A42-A43. In effect, the State has seized on Nancy Cruzan's failure formally to record her preferences as a basis for imposing upon her its own judgment as to what constitutes

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[37] *See supra* notes 26, 33.

appropriate treatment. This approach fails to afford Nancy Cruzan and her parents the kind of fair opportunity to protect her fundamental right to have treatment withdrawn that the Due Process Clause requires.

"A fundamental requirement of due process is 'the opportunity to be heard' . . . at a meaningful time and in a meaningful manner." *Armstrong v. Manzo*, 380 U.S. 545, 552 (1965) (citation omitted). The type of hearing and accompanying procedures that due process requires vary, because "due process is flexible and calls for such procedural protections as the particular situation demands." *Morrissey* v. *Brewer*, 408 U.S. 471, 481 (1972). Nevertheless, to meet the dictates of due process, a state must provide procedures appropriate to "the nature of the ultimate decision that is being made." *Parham* v. *J.R.*, 442 U.S. 584, 608 (1979); see *Stanley* v. *Illinois*, 405 U.S. 645, 650-51 (1972); *Mathews* v. *Eldridge*, 424 U.S. 319, 334-35 (1976); *Goldberg* v. *Kelly*, 397 U.S. 254, 263 (1970). By demanding the execution of an express directive equivalent to a living will, Missouri unreasonably limits the means by which a person can exercise the right to have treatment withdrawn.

A. Missouri Law Unconstitutionally Limits A Person's Ability To Exercise The Fundamental Right To Refuse Life-Prolonging Medical Treatment.

The theoretical possibility that Nancy Cruzan could have executed an express prior directive is not a constitutionally sufficient means to protect her interests. Relatively few persons have executed living wills.[38] As one court has explained, "the typically human characteristics of procrastination and reluctance to contemplate the need for . . . arrangements [such as living wills] . . . makes [such wills] a tool which will all too often go unused by those who might desire it." *Barber* v. *Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484, 489 (1983).

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[38] Wanzer, Federman, *et al.*, *The Physician's Responsibility Toward Hopelessly Ill Patients*, 320 New Eng. J. Med. 844, 845 (1989).

A natural reluctance to plan formally for one's death is particularly understandable in a young person, and the expectation that a healthy 25 year old will have taken formal steps to record her treatment choices about an eventuality as unlikely as being sustained in a persistent vegetative state is extremely unreasonable.[39]

Second, the fact that a person has not executed a written document or provided a comparable oral directive does not mean that person has no developed views about the withdrawal of life-prolonging treatment or that those views are unknown to others. It is precisely in relaxed, unforced conversations with family and close friends when a person will most likely reveal private thoughts about such questions as being sustained in a vegetative state. *E.g.*, *In re Conroy*, 98 N.J. 321, 486 A.2d 1209, 1230 (1985) (it is error to disregard evidence of patient's statements to friends concerning artificial prolongation of lives of others who were terminally ill). It is evidence of just such conversations that petitioners introduced at trial here, and that the trial court and other courts have found to constitute convincing evidence of a person's preferences. *E.g.*, Pet. App. A97-A98; *Gardner*, 534 A.2d at 953; *Gray*, 697 F. Supp. at 583; *Brophy*, 497 N.E.2d at 632 n.22.

Third, the patient's treatment choice may be plain from evidence other than personal statements on that subject. A person's views on death and dying are inextricably connected with views on life and how it should be lived. Family members are uniquely qualified to weigh and certify the validity of these elements of expression, not only because of their unique understanding of the patient's approach to life, but also because of the special, familial

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[39] The expectation is all the more unreasonable given that Missouri did not have a living will statute at the time of Nancy Cruzan's accident, nor would the living will statute that Missouri did pass in 1985 have applied to her present condition. *See* Mo. Ann. Stat. §§ 459.010 *et seq.* (Vernon 1988); Johnson, *The Death-Prolonging Procedures Act and Refusal of Treatment in Missouri*, 30 St. Louis U.L.J. 805 (1986).

bonds that exist. *In re Jobes*, 108 N.J. 394, 529 A.2d 434, 445 (1987).[40]

Accordingly, the rule adopted by the vast majority of courts is that neither a written nor a highly specific oral expression by the patient is required. See, *e.g.*, *In re Drabick*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840, 859 (1988); *Foody* v. *Manchester Memorial Hospital*, 40 Conn. Supp. 127, 482 A.2d 713, 721 (1984). Instead, factors such as the patient's religious beliefs and values, consistent patterns of conduct in prior decisions about medical care, and reactions the patient voiced regarding medical treatment administered to others who became incompetent are all relevant to determining what the patient would want. *Conroy*, 486 A.2d at 1230; *In re Storar* (*Eichner* v. *Dillon*), 420 N.E.2d 64, 68, *cert. denied*, 454 U.S. 858 (1981).

Finally, Missouri's rule is inconsistent with all contemporary information about the decision most people would make if they were to find themselves in Nancy Cruzan's predicament. The available survey evidence suggests that most people would not want such treatment continued, and would want their families and others to have legal authority to request the withdrawal of life-support systems, including artificial nutrition and hydration.[41] The positions of the AMA [42] and co-*amici* and the

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[40] Western tradition has never required individuals to record precisely and in advance their basic beliefs about human dignity and life by which they wish to be remembered. *See* P. Aries, *Western Attitudes Toward Death: From the Middle Ages to the Present* 63-65 (1974).

[41] *See* surveys cited in *Jobes*, 529 A.2d at 446-47 n.11; Wanzer, Federman, *et al.*, 320 New Eng. J. Med. at 844; Brief of the Society for the Right to Die in Support of the Petition for Certiorari 8.

[42] According to AMA Ethics Opinion 2.20, when there are adequate safeguards to confirm the accuracy of a diagnosis of permanent unconsciousness and a decision to withdraw treatment ful-

overwhelming weight of opinion among health care professionals is that withdrawal of treatment in such circumstances is ethically permissible.[43] And, most important, such withdrawal is permitted in virtually all states that have considered the issue.[44] In these circumstances, the fundamental fairness required by the Due Process Clause precludes a state from imposing procedural prerequisites that predictably foreclose any realistic opportunity for persons to exercise their right to have life-prolonging treatment withdrawn.

B. Missouri Law Unconstitutionally Preempts The Right Of Incompetent Patients To Have Family Members Manage Their Treatments.

By imposing on Nancy Cruzan the treatment choice that the Missouri Supreme Court finds consistent with the policy of the Missouri legislature, the Missouri Supreme Court has effectively foreclosed Nancy Cruzan's parents from participating in the treatment decision made regarding their daughter. This decision contravenes the historic tradition of procedural protection that this Court has guaranteed to families in matters of unique importance to them. See *Pierce*, 268 U.S. at 535; *Meyer* v. *Nebraska*, 262 U.S. 390, 399, 402 (1923); *Wisconsin* v. *Yoder*, 406 U.S. 205, 213, 232 (1972).

This tradition recognizes that family members are generally best suited to determine what the incompetent patient would have chosen. Family members are most likely to have had conversations with the patient specifically about the withdrawal of life-prolonging treatment. In addition, because an individual's values are developed primarily in the context of the family, family members have the most intimate understanding of the patient's

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fils the previously expressed preferences of the patient, "it is not unethical to discontinue all means of life-prolonging medical treatment." App. at 1a.

[43] *See supra*, notes 20-23.

[44] *See supra*, note 33 (citing cases).

perspectives. Parents understand their children's values because they helped form them, and children understand their parents' values because they were taught them. Rhoden, *Litigating Life and Death*, 102 Harv. L. Rev. 375, 437-39 (1988). Family members best know the patient's philosophical, religious and moral views, the patient's values about life and the way it should be lived, and the patient's attitudes toward sickness, suffering, medical procedures and death. *See Jobes*, 529 A.2d at 445 (quoting Newman, *Treatment Refusals for the Critically Ill: Proposed Rules for the Family, the Physician and the State*, III N.Y.L.J. Human Rights Annual 45-46 (1985)).

Moreover, family members are generally the most concerned with the patient's welfare. "It is they who provide for the patient's comfort [and] care . . . and they who treat the patient as a person, rather than a symbol of a cause." *Jobes*, 529 A.2d at 445. Accordingly, the family has historically served as the "usual place of recourse for sick persons." Demos, *The American Family in Past Time*, 43 Am. Scholar 422, 424 (1974).

Recognizing the importance and intensity of family bonds,[45] this Court has consistently protected "[t]he fundamental liberty interest of natural parents in the care, custody, and management of their child." *Santosky* v. *Kramer*, 455 U.S. 745, 747-48 (1982). See *Prince* v. *Massachusetts*, 321 U.S. 158, 166 (1944) ("It is cardinal with us that the custody, care and nurture of the child reside first in the parents."). Hence, in *Parham* v. *J.R.*, 442 U.S. 584 (1979), the Court upheld state procedures for voluntary commitment to state mental hospitals of minor children precisely because these procedures accorded appropriate deference to the views of parents and

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[45] Family bonds have deep roots in American society. *See* Demos, 43 Am. Scholar at 425, 441 (stating that "[i]t is now clear that nuclear households have been the norm in America since the time of the first settlements," and concluding that trends in family life since then point to "a deep intensification of the parent-child bond").

medical professionals. See *id.* at 621 (Stewart, J., concurring). Similarly, in *Santosky* v. *Kramer*, 455 U.S. 745 (1982), the Court required states to employ the clear and convincing standard of proof before terminating the rights of natural parents to raise their children.

This constitutional respect for the role of parents in making decisions regarding the care and custody of their children has been recognized by the common law for centuries. *Parham*, 442 U.S. at 602 ("[H]istorically, [the common law] has recognized that natural bonds of affection lead parents to act in the best interests of their children. 1 W. Blackstone, *Commentaries*, *447; 2 J. Kent, *Commentaries on American Law* *90."); *id.* at 621 & n.1 (Stewart, J., concurring). Indeed, parents have traditionally enjoyed a strong presumption under the common law that they are the appropriate medical decisionmakers for their children. *Bowen* v. *American Hospital Ass'n*, 476 U.S. 610, 627 n.13 (1986). While the state must intervene to protect against abuse, parental decisions are almost never overturned as long as the parents choose from among professionally accepted treatment options. *Id.*[46]

Recognizing that the family's response to an incompetent family member is substantially similar to the family's concerns for a minor child, courts have asserted that the family, as surrogate decisionmaker, may exercise the incompetent patient's right to refuse medical treatment.[47]

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[46] This common law tradition has been codified in many states. Informed consent statutes routinely recognize family members as the appropriate decisionmakers for their minor children or other incompetent family members. *See, e.g.*, Ark Code Ann. § 20-9-602; Ga. Code Ann. § 88-2904; Idaho Code § 39-4303; La. Rev. Stat. Ann. § 40:1299.53.

[47] *See Foody* v. *Manchester Memorial Hospital*, 40 Conn. Supp. 127, 482 A.2d 713, 720-21 (1984) (family could lawfully act as substitute decisionmaker for 42-year-old irreversibly incompetent patient); *In re P.V.W.*, 424 So.2d 1015 (La. 1982) (parents of irreversibly brain-damaged infant may assert child's right to remove life support systems); *see also In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

Here, moreover, the parents seek not simply to authorize the treatment decision that they believe to be in their daughter's best interests, but the treatment decision they believe their daughter would want made.[48] Their stake in having the hospital honor their daughter's treatment preference is substantial indeed. The Court has long recognized "the importance of the familial relationship, to the individuals involved and to the society, [which] stems from the emotional attachments that derive from the intimacy of daily association." *Smith* v. *Organization of Foster Families*, 431 U.S. at 844. To disregard the parents' desire to protect their daughter's fundamental right is to disregard "the historic respect—indeed, sanctity would not be too strong a term—traditionally accorded to the relationships that develop within the unitary family." *Michael H.* v. *Gerald D.*, 109 S. Ct. 2333, 2342 (1989) (plurality opinion) (citing *Stanley* v. *Illinois*, 405 U.S. 645, 651 (1972)); *Quilloin* v. *Walcott*, 434 U.S. 246, 254-55 (1978); *Caban* v. *Mohammed*, 441 U.S. 380, 389 (1979); *Lehr* v. *Robertson*, 463 U.S. 248, 261 (1983)).[49]

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[48] Since *Quinlan*, most courts to reach the issue have concluded that surrogate decisionmakers should be guided by preferences that the patient may have expressed, like Nancy Cruzan, while competent. *See, e.g., Gray* v. *Romeo*, 697 F. Supp. 580, 587-88 (D.R.I. 1988); *In re Grant*, 109 Wash. 2d 545, 747 P.2d 445, 457 (1987) (en banc), *modified*, 757 P.2d 534 (1988); *Jobes*, 529 A.2d at 444; *Conroy*, 486 A.2d at 1229; *In re Storar*, 420 N.E.2d 156, 159 (Del. Ch. 1980). Long used in the administration of the estates of incompetent persons, *see Ex parte Whitbread in re Hinde, a Lunatic*, 35 Eng. Rep. 878 (1816), the principle of substituted judgment has regularly been applied in cases involving medical treatment as the best means of promoting the important underlying value of self-determination. *See* 1 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Making Health Care Decisions* 180 (1982).

[49] The State's desire to err on the side of life is understandable. But it is a sentiment that we all share, particularly for those we care most about. Consequently, it is a sentiment that family members will include in their decisionmaking on behalf of incompetent patients.

Missouri's unprecedented exclusion of family members from such a vital decision thus unconstitutionally deprives Nancy Cruzan of her right to have her parents meaningfully participate in the decisionmaking regarding her custody and to protect her fundamental rights.

III. THE STATE'S INTEREST IN THE UNQUALIFIED PROTECTION OF LIFE IS NOT SUFFICIENT TO JUSTIFY ABRIDGING PETITIONERS' RIGHTS, NOR ARE THE STATE'S MEANS OF PROTECTING THAT INTEREST NARROWLY TAILORED.

In reversing the decision of the state circuit court, the Missouri Supreme Court relied exclusively on its "unqualified" interest in life. Pet. App. A25, A29. The essence of its ruling is that a presumption in favor of prolonging treatment for all patients in a persistent vegetative state, which is rebuttable, if at all, only by means of a formal directive, is the only way adequately to protect the interests of those patients and of severely handicapped and other vulnerable citizens. The State's abstract commitment to life, however, is insufficient to outweigh the patient's right to have life-prolonging treatment withdrawn. In addition, the State's legitimate interest in protecting incompetent and severely handicapped patients can be fully protected by other means far less harmful to fundamental liberties.

A. The State's Abstract Interest In Protecting The Sanctity Of Life Does Not Outweigh An Individual's Right To Have Life-Prolonging Treatment Withdrawn.

The very existence of a fundamental right to refuse life-prolonging treatment means that the state's contrary interest in preserving life is not dispositive. To justify abridging a fundamental right, the state's interest must be "unrelated" to preventing individuals from exercising that right. *United States* v. *O'Brien*, 391 U.S. 367, 377 (1968).

The State's interest in protecting the health, safety and ultimately the lives of all of its citizens is well-established. In *Prince* v. *Massachusetts*, 321 U.S. 158 (1944), for example, the Court held that the state's interest in the welfare of minor children was a compelling basis for upholding a state child labor law that infringed on parental freedom to direct a child's activities. In that case, as in others upholding state intervention in otherwise personal and family matters,[50] courts have found compelling the state's need to protect the interests of the individual against interference by other family members.

In this case, however, the State has misconceived the legitimate bounds of its role as protector of the rights of the individual whose treatment is at issue. The State claims an interest in assuring Nancy Cruzan "a life of relatively normal duration." Pet. App. A26. Yet this interest has no meaning for Nancy Cruzan, except insofar as it appears she would have wanted such a life. Unlike a minor child whose life lies before her or a severely handicapped person who has at least some consciousness or prospect for consciousness, Nancy Cruzan will never become aware of her existence and her environment. There is thus no prospective benefit to her from continued treatment. Furthermore, in the same way that her ongoing treatment does not currently "burden" her, see Pet. App. A36-A37, the prolongation of her life through artificial means does not benefit her, for she is aware of neither her "burden" nor even her "life." It is only with reference to what medical care Nancy Cruzan would have wanted, therefore, that we can assess today whether the treatment now being provided her can meaningfully be said to further her interests.

The Missouri Supreme Court also relied, apart from its concerns about Nancy Cruzan, on its general interest in prolonging life. Pet. App. A25-A26, A36-A37. In this

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[50] *See, e.g., Jehovah's Witnesses* v. *King County Hosp.*, 278 F. Supp. 488 (W.D. Wash. 1967), *aff'd*, 390 U.S. 598 (1968); *In re Ivey II*, 319 So.2d 53 (Fla. Dist. Ct. App. 1975).

regard, some have argued that providing food and water to all individuals is a matter of overriding symbolic importance, crucial to the preservation of a caring and communal society. See, *e.g.*, Callahan, *On Feeding the Dying*, 13 Hastings Ctr. Rep. 22, 22 (Oct. 1983). The argument has force, but, for several reasons, is ultimately unpersuasive.

First, the argument essentially begs the question. The issue is whether the caring and communal qualities of a society would lead it to respect a patient's desire to have artificial nutrition and hydration withdrawn. The universally accepted duty of society to provide for those who want to be fed, which is a cornerstone of the symbolic argument, does not obviously translate into an obligation to impose tube feeding on those for whom it is unwelcome and who are "no longer able personally to prevent what is being done to [their] bodies." *Gardner*, 534 A.2d at 955.

Respect for the desire of a patient to have artificial nutrition and hydration withheld in the event of permanent unconsciousness serves the same fundamental and symbolic purpose that the provision of food and water to vulnerable individuals serves in other contexts. Society values the provision of food and water to other vulnerable individuals because it prevents suffering, promotes respect for individual dignity and integrity and shows that a person's misfortunes and dependent circumstances are no reason to deny the staples of existence. But this concern is rooted, ultimately, in concern for the individual as a person. That concern strongly counsels that society acquiesce in the judgment of the patient that the greater compassion, respect and concern for her humanity will be achieved by withdrawing technologically supplied nutrients.

That society should have a different response to the permanently unconscious reflects the fact that the symbolic importance of providing food and water to those in need arose out of a different historical context than the

one in which this case has arisen. For generations, the provision of food and water to those in need meant the provision of food and water to those who consciously sought it because they suffered from hunger and thirst. It is only recently, within the past 20 years, that advances in cardiopulmonary resuscitation have enabled society to recover and maintain heartbeats in individuals who will never be able to feed themselves again or feel hunger or thirst. Historically, it was essential to provide nutrients as a means to the recovery of health and the prevention of suffering. When a patient's unconsciousness becomes permanent, however, the provision of nutrients cannot serve either of these ends.

In sum, by insisting on treatment for persistent vegetative state patients without regard to their individual wishes and preferences, the state is protecting not the individual's interest, but rather its abstract commitment to life. In effect, the State is using one person without her consent to further general interests that could be fully protected without sacrificing her dignity and autonomy.[51] Such action is antithetical to the respect for individual autonomy that is "implicit in the concept of ordered liberty." *Palko* v. *Connecticut*, 302 U.S. 319, 325 (1937). The utilitarian goals that the State seeks to advance in this case can all be fully met, and in some cases better served, by procedures that do not abrogate the fundamental dignity and autonomy of the individual patient.

B. Missouri's Decision To Exclude As Inherently Unreliable All Evidence Of Patient Preferences That Are Not Formally Recorded Is Broader Than Neccessary To Avoid Arbitrary Decisionmaking.

In devising a legal framework in which decisions regarding life-prolonging treatment are made, states properly have an interest in adopting rules that "respect the

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[51] *See, e.g.*, I. Kant, *Critique of Practical Reason*, part I, II, 2, *reprinted in* M. Adler & C. Van Doren, *Great Treasury of Western Thought* 570 (1977) (every person is "an end in himself [and] can never be used merely as a means by any").

right to self-determination and yet protect incompetent patients" from decisions inconsistent with their views. *Jobes*, 529 A.2d at 437. But the rule adopted by the Missouri Supreme Court to exclude as "inherently unreliable" (Pet. App. A43) all evidence of a patient's preferences that is not formally recorded goes far beyond what is necessary—and in fact is inconsistent with—its asserted goal of avoiding arbitrary treatment decisions.

Although the Missouri Supreme Court does not expressly discuss the evidence in the record supporting the Circuit Court's judgment that Nancy Cruzan would not have wanted to be sustained for decades by an artificial feeding apparatus (see Pet. App. A37), the evidence in the record is precisely the sort that is likely to be available in most cases and that must be considered if any genuine attempt is to be made to determine the patient's wishes. The evidence includes testimony concerning Nancy's statements about never wanting to live in a persistent vegetative state as well as her family's testimony that, based on their knowledge of her, they believe she would choose to have her nutrition and hydration withdrawn. Her statements were not made aimlessly, but were pointedly made in response to recent deaths in her and in a friend's family.[52] They are comparable to statements relied on by other courts as persuasive evidence of a patient's preference. *E.g.*, *Gardner*, 534 A.2d at 953.

The Missouri Supreme Court's decision to dismiss all of this evidence as inherently unreliable in order to "err on the side of preserving life" unconstitutionally restricts the patient's right to a decision consistent with her preferences. *Amici* do not dispute the state's basic prerogative to adopt a presumption in favor of treating incompetent patients whose treatment preferences are truly un-

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[52] *See, e.g.*, Tr. 388-402 (conversation with housemate 13 months before accident in which Nancy said she would never want to live in a persistent vegetative state); Tr. 536-63 (two conversations with sister in which Nancy said it is better in some instances to die than to endure life with serious disabilities).

known and unknowable. But in the guise of erring on the side of life, the State is in fact imposing on Nancy Cruzan its own judgment about what treatment she should have, and that judgment is squarely at odds with everything the record tells us about what she would have wanted. Far from protecting incompetent patients from arbitrary decisions to cut off treatment against their wishes, Missouri's rule guarantees that treatment will be imposed *against* the wishes of many people who have never formally recorded their preferences.

Other states have devised means that are far less destructive of these basic liberties but that still serve to protect incompetent patients from decisions they would not have wanted made. Some have used heightened evidentiary standards to evaluate the patient's statements regarding treatment.[53] Some require a court to consider whether an ombudsman or guardian ad litem should be appointed to assess what weight to place on family testimony and to guard against the possibility of a conflict of interest.[54] States should have latitude to experiment with various procedures and standards. But the procedures they adopt must not be so strict that, like the standard adopted below, they nullify for all practical purposes the individual's right to refuse life-sustaining treatment.[55] See generally Rhoden, *Litigating Life and Death*, 102 Harv. L. Rev. 375 (1988).

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[53] *See, e.g., In re Gardner*, 534 A.2d 947 (Me. 1987) (adopting clear and convincing standard); *In re Westchester County Medical Center*, 72 N.Y.2d 517, 531 N.E.2d 607 (1988); *In re Jobes*, 108 N.J. 394, 529 A.2d 434, 443 (1987); *Leach* v. *Akron General Medical Center*, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980).

[54] *See, e.g., Jobes*, 529 A.2d at 434, 447 (guardian needed only if there are no close family members and patient has not left clear and convincing evidence of wishes).

[55] For example, although the Court need not reach the issue to decide this case, *amici* note that a clear and convincing evidence standard, while appropriate for the medical diagnosis of whether a patient is in a persistent vegetative state, is potentially so strict a standard for evaluating patient wishes as to nullify the exercise

C. Protection Of A Persistent Vegetative State Patient's Right To Have Life-Prolonging Treatment Withdrawn Does Not Undermine The State's Interest In Protecting Severely Handicapped Persons.

Although the State professes an interest in protecting the right of the patient whose treatment is in question, its overriding concern is with the implications of its decision for other cases involving severely handicapped and other vulnerable persons. The Missouri Supreme Court's decision is premised on the view that to create a rule applicable only to persons in a persistent vegetative state is to make a "quality of life" determination, and that such determinations pose the danger that "persons with all manner of handicaps might find the *state* seeking to terminate their lives." Pet. App. A29 (emphasis added).

This view reflects the Missouri Supreme Court's failure to appreciate the significance of patient autonomy as a limiting principle against state abuses. So long as the principle of autonomy is the touchstone of decision making, handicapped persons who wish to have treatment prolonged will have that treatment prolonged with the full support of the medical community. The Court's unfounded fear that *state* action to terminate lives is a possible consequence of allowing a patient to exercise her right to have treatment withdrawn arises only because the state erroneously equates state protection of that

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of the right. Such nullification would occur if the standard operates to limit the exercise of the right to those who had formally recorded their views. An evidentiary standard that requires an individual to prove by clear and convincing evidence that he wants done what the vast majority of citizens would want done, *see, e.g., Jobes*, 529 A.2d at 446-47 n.11, raises significant due process concerns. *See Addington* v. *Texas*, 441 U.S. 418 (1979). Most courts that have adopted a clear and convincing standard have avoided these problems, however, by finding that evidence other than formal and explicit directives are sufficient to meet the relevant standard of proof. *See, e.g., In re Gardner*, 534 A.2d 947 (Me. 1987); *Foody* v. *Manchester Memorial Hospital*, 40 Conn. Supp. 127, 482 A.2d 713, 720-21 (1984).

patient's right with state endorsement of a general policy of withholding life-prolonging treatment.[56]

In fact, the Missouri Supreme Court's inadequate protection of patient autonomy poses the greatest danger to handicapped and vulnerable patients. As the tragic history of human experimentation teaches us, a State's willingness to impose treatments without due regard for a person's autonomy gravely threatens society's most vulnerable persons.[57]

The power of the autonomy principle in protecting vulnerable individuals is apparent in the cases where courts have intervened on behalf of a minor child. When parents have refused to give consent for the performance of such life-saving measures as a blood transfusion for their minor child, courts have not hesitated to order such measures.[58] The autonomy principle provides clear sup-

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[56] *Amici* do not believe that the logical or necessary extension of this principle of autonomy is to "honor" an individual's wish to commit suicide. All relevant final appellate decisions, as well as Opinion 2.20, recognize a legal and moral distinction between the withdrawal of life-prolonging medical treatment, including nutrition and hydration, and homicide or assisted suicide. *See, e.g., In re Gardner*, 534 A.2d at 956 (the "decision not to receive such [artificial feeding] procedures, far from constituting suicide, is a choice to allow to take its course the natural dying process set in motion by his physiological inability to chew or swallow"); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209, 1224 (N.J. 1985) ("Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury.") *See also* May, *The Right To Die and the Obligation to Care*, in Death and Decision (E. McMillan ed. 1978) 111, 126-28 (distinguishing suicide because, *inter alia*, it fundamentally expresses a felt need for complete transformation in life that can usually be achieved through therapy and care).

[57] *See generally* J. Katz, *Experimentation With Human Beings* (1972) (discussing human experiments conducted without consent on Jews, Blacks, and chronically ill patients).

[58] *See, supra*, note 50; *see also Custody of a Minor*, 375 Mass. 733, 379 N.E.2d 1053, 1063 (1978) (ordering chemotherapy treatment

port for such decisions, because such interventions are essential to enable the child to become an independent decisionmaker.[59]

Furthermore, the law's historic presumption that "natural bonds of affection lead parents to act in the best interests of their children" provides the appropriate point of departure. *Parham* v. *J.R.*, 442 U.S. 584, 602 (1979). As the Court explained in *Parham*:

> That some parents "may at times be acting against the interests of their children" . . . creates a basis for caution, but is hardly a reason to discard wholesale those pages of human experience that teach that parents generally do act in the child's best interests. . . . The statist notion that governmental power should supersede parental authority in *all* cases because *some* parents abuse and neglect children is repugnant to the American tradition.

Id. at 602-03 (emphasis in original). So too, in this case, the fact that some patients "may not be surrounded by the loving family with which [Nancy] is blessed." Pet. App. A10, is hardly a reason to deny Nancy and her family a fair opportunity to implement her right to have treatment withdrawn.

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for a child with leukemia when parents sought to use laetrile, and where chemotherapy was the only reasonable treatment that could save the child's life); *In re Vasko*, 238 A.D. 128, 263 N.Y.S. 552, 555 (1933) (ordering eye-removal operation for a child whose malignant growth would otherwise result in death).

[59] It is true that the autonomy principle alone does not provide a complete answer in cases in which the patient has never been competent and has no prospect of competency. *See, e.g., Saikewicz*, 370 N.E.2d 417, (treatment decision for person severely retarded at birth who had no prospect of attaining competency). But the mere existence of a more difficult case is no reason to abandon the core principle of autonomy which fairly reconciles the individual and governmental interests in cases involving patients who are or who have been competent, and whose rights of autonomy are meaningful and therefore must be of first importance.

D. The Supreme Court Of Missouri Erred In Ignoring The Substantial Impact Of Its Decision On The Practice Of Medicine.

The Missouri Supreme Court acknowledged that other state courts in analogous cases had considered the impact on the ethical practice of medicine as part of the assessment of the state's interest. Pet. App. A25, *citing Brophy*, 497 N.E.2d at 634. Without explanation, however, the court below held that this interest was irrelevant to its decision here. Pet. App. A25. *Amici* submit that the Missouri Supreme Court's decision poses a threat of serious harm to the integrity of the doctor/patient relationship and the practice of medicine.

The "core of professional physician ethics" since the time of Hippocrates has been the principle that the physician acts for the benefit of the patient. R. Veatch, *A Theory Of Medical Ethics* 22 (1981). See also Cassell, "What Is the Function of Medicine," in *Death and Decision* 35, 43 (E. McMullin ed. 1978) (for most of its history, medicine has functioned to preserve patient autonomy). This traditional understanding is embodied in the first of the seven Principles of Medical Ethics adopted by the American Medical Association, which form the framework for ethical opinions such as Opinion 2.20, App. at 1a. The AMA's First Principle states that "[a] physician shall be dedicated to providing competent medical service with compassion and respect for human dignity." Council on Ethical and Judicial Affairs, American Medical Association, *Current Opinion* ix (1989).

With the rapid advance in medical technology in this century, the importance of such a principle to the sound practice of medicine cannot be overemphasized. See Wanzer, Federman, *et al.*, 320 New Eng. J. Med. at 844. The very existence of and momentum behind such technology can generate an imperative that technology be used for its own sake, rather than for the benefit of the patient. The inevitable effect of such an imperative is to decrease the patient's trust in the physician, and to

impede the physician's efforts to carry out his fundamental responsibility to serve the patient.

Such are the risks presented here. The State of Missouri has insisted that physicians provide a patient with medical treatment that neither the patient nor the family wishes to have provided. This eventuality was not explained to the family, however, at the time they gave consent to the physician surgically to place the gastrostomy tube in Nancy Cruzan. Having authorized such treatment in order to give her every possible chance at recovery, Nancy Cruzan's parents now find themselves powerless to stop treatment that no longer serves its original purpose, and that they know their daughter would not have wanted. Such a result only exacerbates the distance and fear created by "the technologically complicated medical environment that often surrounds" the dying patient, *id.*, and increases the likelihood that, out of fear of losing control of their fate, patients and guardians will refuse consent for procedures that could have usefully served them. In the final analysis, the chief threat to the ethical practice of medicine lies not in technological advances in treatment but in the imposition and continuation of such treatment without due regard for the comfort, dignity and autonomy of the patient.

* * * *

Physicians will always strive vigorously to assist those who want help in their struggle against death. Nevertheless, the reality of modern science is that some patients, though permanently unconscious and thus without hope of recovery, can be sustained solely by means of medical treatment and sophisticated technology. For these patients, the ultimate judgment about the proper course of medical care should be made by those most directly affected—the patient or surrogate—and not by the state based on an abstract commitment to sustaining "life" in all cases.

CONCLUSION

The judgment of the Missouri Supreme Court should be reversed.

Respectfully submitted,

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