/* Here is the full text of the United State's Supreme Court's opinion in The Nancy Beth Cruzan case. You may have heard of this case, in which Nancy's parents sought to stop artificial life support for their daughter, who was living but had no cognitive function. This case is the first by the U.S. Supreme Court to discuss living wills, and we include it since one of the primary foci of the Home Legal Guide is living wills. In addition this opinion contains a good discussion of durable power of attorney laws for healthcare.*/

NANCY BETH CRUZAN, BY HER PARENTS AND CO-GUARDIANS, LESTER L. CRUZAN, ET UX., PETITIONERS v. DIRECTOR, MISSOURI
-
DEPARTMENT OF HEALTH, ET AL.

ON WRIT OF CERTIORARI TO THE SUPREME COURT OF MISSOURI

[June 25, 1990]

CHIEF JUSTICE REHNQUIST delivered the opinion of the Court.

Petitioner Nancy Beth Cruzan was rendered incompetent as a result of severe injuries sustained during an automobile accident. Co-petitioners Lester and Joyce Cruzan, Nancy's parents and co-guardians, sought a court order directing the withdrawal of their daughter's artificial feeding and hydration equipment after it became apparent that she had virtually no chance of recovering her cognitive faculties. The Supreme Court of Missouri held that because there was no clear and convincing evidence of Nancy's desire to have life-sustaining treatment withdrawn under such circumstances, her parents lacked authority to effectuate such a request. We granted certiorari, 492 U. S. ---- (1989) ,
and now affirm.

On the night of January 11, 1983, Nancy Cruzan lost control of her car as she traveled down Elm Road in Jasper County, Missouri. The vehicle overturned, and Cruzan was discovered lying face down in a ditch without detectable respiratory or cardiac function. Paramedics were able to restore her breathing and heartbeat at the accident site, and she was transported to a hospital in an unconscious state. An attending neurosurgeon diagnosed her as having sustained probable cerebral contusions compounded by significant anoxia (lack of oxygen). The Missouri trial court in this case found that permanent brain damage generally results after 6 minutes in an anoxic state; it was estimated that Cruzan was deprived of oxygen from 12 to 14 minutes. She remained in a coma for approximately three weeks and then progressed to an unconscious state in which she was able to orally ingest some nutrition. In order to ease feeding and further the recovery, surgeons implanted a gastrostomy feeding and hydration tube in Cruzan with the consent of her then husband. Subsequent rehabilitative efforts proved unavailing. She now lies in a Missouri state hospital in what is commonly referred to as a persistent vegetative state: generally, a condition in which a person exhibits motor reflexes but evinces no indications of significant cognitive function. (Footnote 1)

Petitioners also adumbrate in their brief a claim based on the Equal Protection Clause of the Fourteenth Amendment to the effect that Missouri has impermissibly treated incompetent patients dif-

ferently from competent ones, citing the statement in Cleburne v. Cleburne Living Center, Inc., 473 U. S. 432, 439 (1985), that the clause is ``essentially a direction that all persons similarly situated should be treated alike.'' The differences between the choice made by a competent person to refuse medical treatment, and the choice made for an incompetent person by someone else to refuse medical treatment, are so obviously different that the State is warranted in establishing rigorous procedures for the latter class of cases which do not apply to the former class. The State of Missouri is bearing the cost of her care.

After it had become apparent that Nancy Cruzan had virtually no chance of regaining her mental faculties her parents asked hospital employees to terminate the artificial nutrition and hydration procedures. All agree that such a removal would cause her death. The employees refused to honor the request without court approval. The parents then sought and received authorization from the state trial court for termination. The court found that a person in Nancy's condition had a fundamental right under the State and Federal Constitutions to refuse or direct the withdrawal of ``death prolonging procedures.'' App. to Pet. for Cert. A99. The court also found that Nancy's ``expressed thoughts at age twenty-five in somewhat serious conversation with a housemate friend that if sick or injured she would not wish to continue her life unless she could live at least halfway normally suggests that given her present condition she would not wish to continue on with her nutrition and hydration.'' Id., at A97-A98.

The Supreme Court of Missouri reversed by a divided vote. The court recognized a right to refuse treatment embodied in the common-law doctrine of informed consent, but expressed skepticism about the application of that doctrine in the circumstances of this case. Cruzan v. Harmon, 760 S. W. 2d 408, 416-417 (Mo. 1988) (en banc). The court also declined to read a broad right of privacy into the State Constitution which would ``support the right of a person to refuse medical treatment in every circumstance,'' and expressed doubt as to whether such a right existed under the United States Constitution. Id., at 417-418. It then decided that the Missouri Living Will statute, Mo. Rev. Stat. 459.010 et seq. (1986), embodied a state policy strongly favoring the preservation of life. 760 S. W. 2d, at 419-420.
The court found that Cruzan's statements to her roommate regarding her desire to live or die under certain conditions were ``unreliable for the purpose of determining her intent,'' id., at 424, ``and thus insufficient to support the co-guardians claim to exercise substituted judgment on Nancy's behalf.'' Id., at 426. It rejected the argument that Cruzan's parents were entitled to order the termination of her medical treatment, concluding that ``no person can assume that choice for an incompetent in the absence
of the formalities required under Missouri's Living Will statutes or the clear and convincing, inherently reliable evidence absent here.'' Id., at 425. The court also expressed its

view that ``[b]road policy questions bearing on life and death are more properly addressed by representative assemblies'' than judicial bodies. Id., at 426.

We granted certiorari to consider the question of whether Cruzan has a right under the United States Constitution which would require the hospital to withdraw life-sustaining treatment from her under these circumstances.

At common law, even the touching of one person by another without consent and without legal justification was a battery. See W. Keeton, D. Dobbs, R. Keeton, & D. Owen, Prosser and Keeton on Law of Torts 9, pp. 39-42 (5th ed. 1984). Before the turn of the century, this Court observed that ``[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.'' Union Pacific R. Co. v. Botsford, 141 U. S. 250, 251 (1891).

This notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment. Justice Cardozo, while on the Court of Appeals of New York, aptly described this doctrine: ``Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.'' Schloendorff v. Society of New York Hospital, 211 N. Y. 125, 129-30, 105 N. E. 92, 93 (1914). The informed consent doctrine has become firmly entrenched in American tort law. See Dobbs, Keeton, & Owen, supra, 32, pp. 189-192; F. Rozovsky, Consent to Treatment, A Practical Guide 1-98 (2d ed. 1990).

The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment. Until about 15 years ago and the seminal decision in In re Quinlan, 70 N. J. 10, 355 A. 2d 647, cert. denied sub nom., Garger v. New Jersey, 429 U. S. 922 (1976), the number of right-to-refuse-treatment decisions were relatively few. (Footnote 2)

Most of the earlier cases involved patients who refused medical treatment forbidden by their religious beliefs, thus implicating First Amendment rights as well as common law rights of self-determination. (Footnote 3)

More recently, however, with the advance of medical technology capable of sustaining life well past the point where natural forces would have brought certain death in earlier times, cases involving the right to refuse life-sustaining treatment have burgeoned. See 760 S. W. 2d, at 412, n. 4 (collecting 54 reported decisions from 1976-1988).

In the Quinlan case, young Karen Quinlan suffered severe brain damage as the result of anoxia, and entered a persistent vegetative state. Karen's father sought judicial approval to disconnect his daughter's respirator. The New Jersey Supreme Court granted the relief, holding that Karen had a right of privacy grounded in the Federal Constitution to terminate treatment. In re Quinlan, 70 N. J., at 38-42, 355 A. 2d at 662-664. Recognizing that this right was not absolute, however, the court balanced it against asserted state interests. Noting that the State's interest ``weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims,'' the court concluded that the state interests had to give way in that case. Id., at 41, 355 A. 2d, at 664. The court also concluded that the ``only practical way'' to prevent the loss of Karen's privacy right due to her incompetence was to allow her guardian and family to decide ``whether she would exercise it in these circumstances.'' Ibid.

/* This was the first case to bring this to the forefront of public attention. */

After Quinlan, however, most courts have based a right to refuse treatment either solely on the common law right to informed consent or on both the common law right and a constitutional privacy right. See L. Tribe, American Constitutional Law 15-11, p. 1365 (2d ed. 1988). In Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N. E. 2d 417 (1977), the Supreme Judicial Court of Massachusetts relied on both the right of privacy and the right of informed consent to permit the withholding of chemotherapy from a profoundly-retarded 67-year-old man suffering from leukemia. Id., at 737-738, 370 N. E. 2d, at 424. Reasoning that an incompetent person retains the same rights as a competent individual ``because the value of human dignity extends to both,'' the court adopted a ``substituted judgment'' standard whereby courts were to determine what an incompetent individual's decision would have been under the circumstances. Id., at 745, 752-753, 757-758, 370 N. E. 2d, at 427, 431, 434.

/* One of the reasons for relying on state law is so that the U.S. Supreme Court cannot review the case. Unless a party can show that the U.S. Constitution is impacted, the U.S. Supreme Court can not review the same. Some Judges (and I have no idea at all here and I'm making a general comment) will go to great lengths to cite state law as the source of their decision to avoid involving federal courts, especially if they are concerned that the federal courts may disagree with their ruling. */

Distilling certain state interests from prior case law--the preservation of life, the protection of the interests of innocent

third parties,the prevention of suicide, and the maintenance of the ethical integrity of the medical profession--the court recognized the first interest as paramount and noted it was greatest when an affliction was curable,``as opposed to the State interest where, as here, the issue is not whether, but when,
for how long, and at what cost to the individual [a] life may be briefly extended.'' Id., at 742, 370 N. E. 2d, at 426.
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In In re Storar 52 N. Y. 2d 363, 420 N. E. 2d 64, cert. denied,
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454 U. S. 858 (1981), the New York Court of Appeals declined to base a right to refuse treatment on a constitutional privacy right. Instead, it found such a right ``adequately supported'' by the informed consent doctrine. Id., at 376-377, 420 N. E. 2d,
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at 70. In In re Eichner (decided with In re Storar, supra) an
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83-year-old man who had suffered brain damage from anoxia entered a vegetative state and was thus incompetent to consent to the removal of his respirator. The court, however, found it unnecessary to reach the question of whether his rights could be exercised by others since it found the evidence clear and convincing from statements made by the patient when competent that he ``did not want to be maintained in a vegetative coma by use of a respirator.'' Id., at 380, 420 N. E. 2d, at 72. In the companion
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Storar case, a 52-year-old man suffering from bladder cancer had
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been profoundly retarded during most of his life. Implicitly rejecting the approach taken in Saikewicz, supra, the court
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reasoned that due to such life-long incompetency, ``it is unrealistic to attempt to determine whether he would want to continue potentially life prolonging treatment if he were competent.'' 52 N. Y. 2d, at 380, 420 N. E. 2d, at 72. As the evidence showed that the patient's required blood transfusions did not involve excessive pain and without them his mental and physical abilities would deteriorate, the court concluded that it should not ``allow an incompetent patient to bleed to death because someone, even someone as close as a parent or sibling, feels that this is best for one with an incurable disease.'' Id., at 382, 420 N. E. 2d,
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at 73.

Many of the later cases build on the principles established in Quinlan, Saikewicz and Storar/Eichner. For instance, in In re
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Conroy, 98 N. J. 321, 486 A. 2d 1209 (1985), the same court that
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decided Quinlan considered whether a nasogastric feeding tube
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could be removed from an 84-year-old incompetent nursing-home
resident suffering irreversible mental and physical ailments. While recognizing that a federal right of privacy might apply in the case, the court, contrary to its approach in Quinlan, decided
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to base its decision on the common-law right to self-determination and informed consent. 98 N. J., at 348, 486 A. 2d,

at 1223. ``On balance, the right to self-determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death. Most of the cases that have held otherwise, unless they involved the interest in protecting innocent third parties, have concerned the patient's competency to make a rational and considered choice.'' Id., at 353-354, 486 A. 2d, at 1225.

Reasoning that the right of self-determination should not be lost merely because an individual is unable to sense a violation of it, the court held that incompetent individuals retain a right to refuse treatment. It also held that such a right could be exercised by a surrogate decisionmaker using a ``subjective'' standard when there was clear evidence that the incompetent person would have exercised it. Where such evidence was lacking, the court held that an individual's right could still be invoked in certain circumstances under objective ``best interest'' standards. Id., at 361-368, 486 A. 2d, at 1229-1233. Thus, if some trustworthy evidence existed that the individual would have wanted to terminate treatment, but not enough to clearly establish a person's wishes for purposes of the subjective standard, and the burden of a prolonged life from the experience of pain and suffering markedly outweighed its satisfactions, treatment could be terminated under a ``limited-objective'' standard. Where no trustworthy evidence existed, and a person's suffering would make the administration of life-sustaining treatment inhumane, a ``pure-objective'' standard could be used to terminate treatment. If none of these conditions obtained, the court held it was best to err in favor of preserving life. Id., at 364-368, 486 A. 2d, at 1231-1233.

The court also rejected certain categorical distinctions that had been drawn in prior refusal-of-treatment cases as lacking substance for decision purposes: the distinction between actively hastening death by terminating treatment and passively allowing a person to die of a disease; between treating individuals as an initial matter versus withdrawing treatment afterwards; between ordinary versus extraordinary treatment; and between treatment by artificial feeding versus other forms of life-sustaining medical procedures. Id., at 369-374, 486 N. E. 2d, at 1233-1237. As to the last item, the court acknowledged the ``emotional significance'' of food, but noted that feeding by implanted tubes is a ``medical procedur[e] with inherent risks and possible side effects, instituted by skilled health-care providers to compensate for impaired physical functioning'' which analytically was equivalent to artificial breathing using a respirator. Id., at 373, 486 A. 2d, at 1236. (Footnote 4)

In contrast to Conroy, the Court of Appeals of New York recently refused to accept less than the clearly expressed wishes of a patient before permitting the exercise of her right to refuse treatment by a surrogate decisionmaker. In re Westchester County Medical Center on behalf of O'Connor, 531 N. E. 2d 607 (1988)

(O'Connor). There, the court, over the objection of the patient's family members, granted an order to insert a feeding tube into a 77-year-old woman rendered incompetent as a result of several strokes. While continuing to recognize a common-law right to refuse treatment, the court rejected the substituted judgment approach for asserting it ``because it is inconsistent with our fundamental commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another. Consequently, we adhere to the view that, despite its pitfalls and inevitable uncertainties, the inquiry must always be narrowed to the patient's expressed intent, with every effort made to minimize the opportunity for error.'' Id., at 530, 531 N. E. 2d, at 613 (citation omitted). The court held that the record lacked the requisite clear and convincing evidence of the patient's expressed intent to withhold life-sustaining treatment. Id., at 531-534, 531 N. E. 2d, at 613-615.

Other courts have found state statutory law relevant to the resolution of these issues. In Conservatorship of Drabick, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840, cert. denied, ---- U. S. ---- (1988), the California Court of Appeal authorized the removal of a nasogastric feeding tube from a 44-year-old man who was in a persistent vegetative state as a result of an auto accident. Noting that the right to refuse treatment was grounded in both the common law and a constitutional right of privacy, the court held that a state probate statute authorized the patient's conservator to order the withdrawal of life-sustaining treatment when such a decision was made in good faith based on medical advice and the conservatee's best interests. While acknowledging that ``to claim that [a patient's] `right to choose' survives incompetence is a legal fiction at best,'' the court reasoned that the respect society accords to persons as individuals is not lost upon incompetence and is best preserved by allowing others ``to make a decision that reflects [a patient's] interests more closely than would a purely technological decision to do whatever is possible.''(Footnote 5)

/* You might be surprised that a state probate code has something to do with a case like this. Often probate codes include matters regarding orphans and guardianships.*/

Id., at 208, 245 Cal. Rptr., at 854-855. See also In re Conservatorship of Torres, 357 N. W. 2d 332 (Minn. 1984) (Minnesota court had constitutional and statutory authority to authorize a conservator to order the removal of an incompetent individual's respirator since in patient's best interests).

In In re Estate of Longeway, 123 Ill. 2d 33, 549 N. E. 2d 292 (1989), the Supreme Court of Illinois considered whether a 76-year-old woman rendered incompetent from a series of strokes had a right to the discontinuance of artificial nutrition and hydra-

tion. Noting that the boundaries of a federal right of privacy were uncertain, the court found a right to refuse treatment in the doctrine of informed consent. Id., at 43-45, 549 N. E. 2d, at 296-297. The court further held that the State Probate Act impliedly authorized a guardian to exercise a ward's right to refuse artificial sustenance in the event that the ward was terminally ill and irreversibly comatose. Id., at 45-47, 549 N. E. 2d, at 298. Declining to adopt a best interests standard for deciding when it would be appropriate to exercise a ward's right because it ``lets another make a determination of a patient's quality of life,'' the court opted instead for a substituted judgment standard. Id., at 49, 549 N. E. 2d, at 299. Finding the ``expressed intent'' standard utilized in O'Connor, supra, too rigid, the court noted that other clear and convincing evidence of the patient's intent could be considered. 133 Ill. 2d, at 50-51, 549 N. E. 2d, at 300. The court also adopted the ``consensus opinion [that] treats artificial nutrition and hydration as medical treatment.'' Id., at 42, 549 N. E. 2d, at 296. Cf. McConnell v. Beverly Enterprises-Connecticut, Inc., 209 Conn. 692, 705, 553 A. 2d 596, 603 (1989) (right to withdraw artificial nutrition and hydration found in the Connecticut Removal of Life Support Systems Act, which ``provid[es] functional guidelines for the exercise of the common law and constitutional rights of self-determination''; attending physician authorized to remove treatment after finding that patient is in a terminal condition, obtaining consent of family, and considering expressed wishes of patient).

/* As noted in our review of the living will laws for the states, Connecticut's law is particularly week. You need not only to have a living will but also to have consent of one's family for life

sustaining treatment to be ended. */

As these cases demonstrate, the common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment. Beyond that, these decisions demonstrate both similarity and diversity in their approach to decision of what all agree is a perplexing question with unusually strong moral and ethical overtones. State courts have available to them for decision a number of sources--state constitutions, statutes, and common law--which are not available to us. In this Court, the question is simply and starkly whether the United States Constitution prohibits Missouri from choosing the rule of decision which it did. This is the first case in which we have been squarely presented with the issue of whether the United States Constitution grants what is in common parlance referred to as a ``right to die.'' We follow the judicious counsel of our decision in Twin City Bank v. Nebeker, 167 U. S. 196, 202 (1897), where we said that in deciding ``a question of such magnitude and importance . . . it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject.''

The Fourteenth Amendment provides that no State shall ``deprive any person of life, liberty, or property, without due process of

law.'' The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions. In Jacobson v. Massachusetts, 197 U. S. 11, 24-30 (1905), for instance, the Court balanced an individual's liberty interest in declining an unwanted smallpox vaccine against the State's interest in preventing disease. Decisions prior to the incorporation of the Fourth Amendment into the Fourteenth Amendment analyzed searches and seizures involving the body under the Due Process Clause and were thought to implicate substantial liberty interests. See, e. g., Breithaupt v. Abrams, 352 U. S. 432, 439 (1957) (``As against the right of an individual that his person be held inviolable . . . must be set the interests of society . . .'').

Just this Term, in the course of holding that a State's procedures for administering antipsychotic medication to prisoners were sufficient to satisfy due process concerns, we recognized that prisoners possess ``a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment.'' Washington v. Harper, ---- U. S. ----, ---- (1990) (slip op., at 9); see also id., at ---- (slip op., at 17) (``The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty''). Still other cases support the recognition of a general liberty interest in refusing medical treatment. Vitek v. Jones, 445 U. S. 480, 494 (1980) (transfer to mental hospital coupled with mandatory behavior modification treatment implicated liberty interests); Parham v. J. R., 442 U. S. 584, 600 (1979) (``a child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment'').

But determining that a person has a ``liberty interest'' under the Due Process Clause does not end the inquiry; ``whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests.'' Youngberg v. Romeo, 457 U. S. 307, 321 (1982). See also Mills v. Rogers, 457 U. S. 291, 299 (1982).

Petitioners insist that under the general holdings of our cases, the forced administration of life-sustaining medical treatment, and even of artificially-delivered food and water essential to life, would implicate a competent person's liberty interest. Although we think the logic of the cases discussed above would embrace such a liberty interest, the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and

nutrition.

/* This is an important idea expressed by the Court, although it is what attorney's and Judges refer to as "dicta." That is things which are stated which are not part of the actual decision and necessary to the court's holding. However, it is certainly quite likely that the Court would rule this way if presented with the question, and such dicta are quite persuasive. */

Petitioners go on to assert that an incompetent person should possess the same right in this respect as is possessed by a competent person. They rely primarily on our decisions in Parham v. J. R., supra, and Youngberg v. Romeo, 457 U. S. 307 (1982). In Parham, we held that a mentally disturbed minor child had a liberty interest in ``not being confined unnecessarily for medical treatment,'' 442 U. S., at 600, but we certainly did not intimate that such a minor child, after commitment, would have a liberty interest in refusing treatment. In Youngberg, we held that a seriously retarded adult had a liberty interest in safety and freedom from bodily restraint, 457 U. S., at 320. Youngberg, however, did not deal with decisions to administer or withhold medical treatment.

The difficulty with petitioners' claim is that in a sense it begs the question: an incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right. Such a ``right'' must be exercised for her, if at all, by some sort of surrogate. Here, Missouri has in effect recognized that under certain circumstances a surrogate may act for the patient in electing to have hydration and nutrition withdrawn in such a way as to cause death, but it has established a procedural safeguard to assure that the action of the surrogate conforms as best it may to the wishes expressed by the patient while competent. Missouri requires that evidence of the incompetent's wishes as to the withdrawal of treatment be proved by clear and convincing evidence. The question, then, is whether the United States Constitution forbids the establishment of this procedural requirement by the State. We hold that it does not.

Whether or not Missouri's clear and convincing evidence requirement comports with the United States Constitution depends in part on what interests the State may properly seek to protect in this situation. Missouri relies on its interest in the protection and preservation of human life, and there can be no gainsaying this interest. As a general matter, the States--indeed, all civilized nations--demonstrate their commitment to life by treating homicide as serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide. We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically-able adult to starve to death.

But in the context presented here, a State has more particular interests at stake. The choice between life and death is a dee-

ply personal decision of obvious and overwhelming finality. We believe Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements. It cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment. Not all incompetent patients will have loved ones available to serve as surrogate decisionmakers. And even where family members are present, ``[t]here will, of course, be some unfortunate situations in which family members will not act to protect a patient.'' In re Jobes, 108 N. J. 394, 419, 529 A. 2d 434, 477 (1987). A State is entitled to guard against potential abuses in such situations. Similarly, a State is entitled to consider that a judicial proceeding to make a determination regarding an incompetent's wishes may very well not be an adversarial one, with the added guarantee of accurate factfinding that the adversary process brings with it. See Ohio v. Akron Center for Reproductive Health, ---- U. S. ----, ---- (1990) (slip op., at 10-11). Finally, we think a State may properly decline to make judgments about the ``quality'' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.

In our view, Missouri has permissibly sought to advance these interests through the adoption of a ``clear and convincing'' standard of proof to govern such proceedings. ``The function of a standard of proof, as that concept is embodied in the Due Process Clause and in the realm of factfinding, is to `instruct the factfinder concerning the degree of confidence our society thinks he should have in the correctness of factual conclusions for a particular type of adjudication.' '' Addington v. Texas, 441 U. S. 418, 423 (1979) (quoting In re Winship, 397 U. S. 358, 370 (1970) (Harlan, J., concurring)). ``This Court has mandated an intermediate standard of proof--`clear and convincing evidence'--when the individual interests at stake in a state proceeding are both `particularly important' and `more substantial than mere loss of money.' '' Santosky v. Kramer, 455 U. S. 745, 756 (1982) (quoting Addington, supra, at 424). Thus, such a standard has been required in deportation proceedings, Woodby v. INS, 385 U. S. 276 (1966), in denaturalization proceedings, Schneiderman v. United States, 320 U. S. 118 (1943), in civil commitment proceedings, Addington, supra, and in proceedings for the termination of parental rights. Santosky, supra.

Petitioners also adumbrate in their brief a claim based on the Equal Protection Clause of the Fourteenth Amendment to the effect that Missouri has impermissibly treated incompetent patients differently from competent ones, citing the statement in Cleburne v.

Cleburne Living Center, Inc., 473 U. S. 432, 439 (1985), that the clause is ``essentially a direction that all persons similarly situated should be treated alike.'' The differences between the choice made by a competent person to refuse medical treatment, and the choice made for an incompetent person by someone else to refuse medical treatment, are so obviously different that the State is warranted in establishing rigorous procedures for the latter class of cases which do not apply to the former class. Further, this level of proof, ``or an even higher one, has traditionally been imposed in cases involving allegations of civil fraud, and in a variety of other kinds of civil cases involving such issues as . . . lost wills, oral contracts to make bequests, and the like.'' Woodby, supra, at 285, n. 18.

We think it self-evident that the interests at stake in the instant proceedings are more substantial, both on an individual and societal level, than those involved in a run-of-the-mine civil dispute. But not only does the standard of proof reflect the importance of a particular adjudication, it also serves as ``a societal judgment about how the risk of error should be distributed between the litigants.'' Santosky, supra, 455 U. S. at 755; Addington, supra, at 423. The more stringent the burden of proof a party must bear, the more that party bears the risk of an erroneous decision. We believe that Missouri may permissibly place an increased risk of an erroneous decision on those seeking to terminate an incompetent individual's life-sustaining treatment. An erroneous decision not to terminate results in a maintenance of the status quo; the possibility of subsequent developments such as advancments in medical science, the discovery of new evidence regarding the patient's intent, changes in the law, or simply the unexpected death of the patient despite the administration of life-sustaining treatment, at least create the potential that a wrong decision will eventually be corrected or its impact mitigated. An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible of correction. In Santosky, one of the factors which led the Court to require proof by clear and convincing evidence in a proceeding to terminate parental rights was that a decision in such a case was final and irrevocable. Santosky, supra, at 759. The same must surely be said of the decision to discontinue hydration and nutrition of a patient such as Nancy Cruzan, which all agree will result in her death.

It is also worth noting that most, if not all, States simply forbid oral testimony entirely in determining the wishes of parties in transactions which, while important, simply do not have the consequences that a decision to terminate a person's life does. At common law and by statute in most States, the parole evidence rule prevents the variations of the terms of a written contract by oral testimony. The statute of frauds makes unenforceable oral contracts to leave property by will, and statutes regulating the making of wills universally require that those instruments be in writing. See 2 A. Corbin, Contracts 398,

pp. 360-361 (1950); 2 W. Page, Law of Wills 19.3-19.5, pp. 61-71 (1960). There is no doubt that statutes requiring wills to be in writing, and statutes of frauds which require that a contract to make a will be in writing, on occasion frustrate the effectuation of the intent of a particular decedent, just as Missouri's requirement of proof in this case may have frustrated the effectuation of the not-fully-expressed desires of Nancy Cruzan. But the Constitution does not require general rules to work faultlessly; no general rule can.

In sum, we conclude that a State may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state. We note that many courts which have adopted some sort of substituted judgment procedure in situations like this, whether they limit consideration of evidence to the prior expressed wishes of the incompetent individual, or whether they allow more general proof of what the individual's decision would have been, require a clear and convincing standard of proof for such evidence. See, e. g., Longeway, 133 Ill. 2d, at 50- 51, 549 N. E. 2d at 300; McConnell, 209 Conn., at 707-710, 553 A. 2d at 604-605; O'Connor, 72 N. Y. 2d, at 529-530, 531 N. E. 2d, at 613; In re Gardner, 534 A. 2d 947, 952-953 (Me. 1987); In re Jobes, 108 N. J., at 412-413, 529 A. 2d, at 443; Leach v. Akron General Medical Center, 68 Ohio Misc. 1, 11, 426 N. E. 2d 809, 815 (1980).

The Supreme Court of Missouri held that in this case the testimony adduced at trial did not amount to clear and convincing proof of the patient's desire to have hydration and nutrition withdrawn. In so doing, it reversed a decision of the Missouri trial court which had found that the evidence ``suggest[ed]'' Nancy Cruzan would not have desired to continue such measures, App. to Pet. for Cert. A98, but which had not adopted the standard of ``clear and convincing evidence'' enunciated by the Supreme Court. The testimony adduced at trial consisted primarily of Nancy Cruzan's statements made to a housemate about a year before her accident that she would not want to live should she face life as a ``vegetable,'' and other observations to the same effect. The observations did not deal in terms with withdrawal of medical treatment or of hydration and nutrition. We cannot say that the Supreme Court of Missouri committed constitutional error in reaching the conclusion that it did.

We are not faced in this case with the question of whether a State might be required to defer to the decision of a surrogate if competent and probative evidence established that the patient herself had expressed a desire that the decision to terminate life-sustaining treatment be made for her by that individual.

Petitioners also adumbrate in their brief a claim based on the Equal Protection Clause of the Fourteenth Amendment to the effect that Missouri has impermissibly treated incompetent patients differently from competent ones, citing the statement in Cleburne v.

Cleburne Living Center, Inc., 473 U. S. 432, 439 (1985), that the clause is ``essentially a direction that all persons similarly situated should be treated alike.'' The differences between the choice made by a competent person to refuse medical treatment, and the choice made for an incompetent person by someone else to refuse medical treatment, are so obviously different that the State is warranted in establishing rigorous procedures for the latter class of cases which do not apply to the former class.

Petitioners alternatively contend that Missouri must accept the ``substituted judgment'' of close family members even in the absence of substantial proof that their views reflect the views of the patient. They rely primarily upon our decisions in Michael H. v. Gerald D., 491 U. S. ---- (1989), and Parham v. J. R., 442 U. S. 584 (1979). But we do not think these cases support their claim. In Michael H., we upheld the constitutionality of California's favored treatment of traditional family relationships; such a holding may not be turned around into a constitutional requirement that a State must recognize the primacy of those relationships in a situation like this. And in Parham, where the patient was a minor, we also upheld the constitutionality of a state scheme in which parents made certain decisions for mentally ill minors. Here again petitioners would seek to turn a decision which allowed a State to rely on family decisionmaking into a constitutional requirement that the State recognize such decisionmaking. But constitutional law does not work that way.

No doubt is engendered by anything in this record but that Nancy Cruzan's mother and father are loving and caring parents. If the State were required by the United States Constitution to repose a right of ``substituted judgment'' with anyone, the Cruzans would surely qualify. But we do not think the Due Process Clause requires the State to repose judgment on these matters with anyone but the patient herself. Close family members may have a strong feeling--a feeling not at all ignoble or unworthy, but not entirely disinterested, either--that they do not wish to witness the continuation of the life of a loved one which they regard as hopeless, meaningless, and even degrading. But there is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been had she been confronted with the prospect of her situation while competent. All of the reasons previously discussed for allowing Missouri to require clear and convincing evidence of the patient's wishes lead us to conclude that the State may choose to defer only to those wishes, rather than confide the decision to close family members.

The judgment of the Supreme Court of Missouri is

Affirmed.

JUSTICE O'CONNOR, concurring.

I agree that a protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions, see ante at 13, and that the refusal of artificially delivered food and water is encompassed within that liberty interest. See ante, at 15. I write separately to clarify why I believe this to be so.

As the Court notes, the liberty interest in refusing medical treatment flows from decisions involving the State's invasions into the body. See ante, at 14. Because our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause. See, e. g., Rochin v. California, 342 U. S. 165, 172 (1952) (``Illegally breaking into the privacy of the petitioner, the struggle to open his mouth and remove what was there, the forcible extraction of his stomach's contents . . . is bound to offend even hardened sensibilities''); Union Pacific R. Co. v. Botsford, 141 U. S. 250, 251 (1891). Our Fourth Amendment jurisprudence has echoed this same concern. See Schmerber v. California, 384 U. S. 757, 772 (1966) (``The integrity of an individual's person is a cherished value of our society''); Winston v. Lee, 470 U. S. 753, 759 (1985) (``A compelled surgical intrusion into an individual's body for evidence . . . implicates expectations of privacy and security of such magnitude that the intrusion may be `unreasonable' even if likely to produce evidence of a crime''). The State's imposition of medical treatment on an unwilling competent adult necessarily involves some form of restraint and intrusion. A seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining measures or other medical interventions. Such forced treatment may burden that individual's liberty interests as much as any state coercion. See, e. g., Washington v. Harper, 494 U. S. ----, ---- (1990); Parham v. J. R., 442 U. S. 584, 600 (1979) (``It is not disputed that a child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment'').

The State's artificial provision of nutrition and hydration implicates identical concerns. Artificial feeding cannot readily be distinguished from other forms of medical treatment. See, e. g., Council on Ethical and Judicial Affairs, American Medical Association, AMA Ethical Opinion 2.20, Withholding or Withdrawing Life-Prolonging Medical Treatment, Current Opinions 13 (1989); The Hastings Center, Guidelines on the Termination of Life-

Sustaining Treatment and the Care of the Dying 59 (1987). Whether or not the techniques used to pass food and water into the patient's alimentary tract are termed ``medical treatment,'' it is clear they all involve some degree of intrusion and restraint. Feeding a patient by means of a nasogastric tube requires a physician to pass a long flexible tube through the patient's nose, throat and esophagus and into the stomach. Because of the discomfort such a tube causes, ``[m]any patients need to be restrained forcibly and their hands put into large mittens to prevent them from removing the tube.'' Major, The Medical Procedures for Providing Food and Water: Indications and Effects, in By No Extraordinary Means: The Choice to Forgo Life-Sustaining Food and Water 25 (J. Lynn ed. 1986). A gastrostomy tube (as was used to provide food and water to Nancy Cruzan, see ante, at 2) or jejunostomy tube must be surgically implanted into the stomach or small intestine. Office of Technology Assessment Task Force, Life-Sustaining Technologies and the Elderly 282 (1988). Requiring a competent adult to endure such procedures against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment. Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water.

I also write separately to emphasize that the Court does not today decide the issue whether a State must also give effect to the decisions of a surrogate decisionmaker. See ante, at 22, n. 13. In my view, such a duty may well be constitutionally required to protect the patient's liberty interest in refusing medical treatment. Few individuals provide explicit oral or written instructions regarding their intent to refuse medical treatment should they become incompetent.

/* This is not as it should be! Use this program if you have a strong desire to do so to make a living will. */

See 2 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions 241-242 (1982) (36% of those surveyed gave instructions regarding how they would like to be treated if they ever became too sick to make decisions; 23% put those instructions in writing) (Lou Harris Poll, September 1982); American Medical Association Surveys of Physician and Public Opinion on Health Care Issues 29-30 (1988) (56% of those surveyed had told family members their wishes concerning the use of life-sustaining treatment if they entered an irreversible coma; 15% had filled out a living will specifying those wishes).

States which decline to consider any evidence other than such instructions may frequently fail to honor a patient's intent. Such failures might be avoided if the State considered an equally probative source of evidence: the patient's appointment of a proxy to make health care decisions on her behalf. Delegating the authority to make medical decisions to a family member or friend is becoming a common method of planning for the future. See, e. g., Areen, The Legal Status of Consent Obtained from Families of Adult Patients to Withhold or Withdraw Treatment, 258 JAMA 229, 230 (1987). Several States have recognized the practical wisdom of such a procedure by enacting durable power of attorney sta-

tutes that specifically authorize an individual to appoint a surrogate to make medical treatment decisions.

Some state courts have suggested that an agent appointed pursuant to a general durable power of attorney statute would also be empowered to make health care decisions on behalf of the patient. See, e. g., In re Peter, 108 N. J. 365, 378-379, 529 A. 2d 419, 426 (1987); see also 73 Op. Md. Atty. Gen. No. 88-046 (1988) (interpreting Md. Est. & Trusts Code Ann. 13- 601 to 13-602 (1974), as authorizing a delegatee to make health care decisions). Other States allow an individual to designate a proxy to carry out the intent of a living will.

These procedures for surrogate decisionmaking, which appear to be rapidly gaining in acceptance, may be a valuable additional safeguard of the patient's interest in directing his medical care. Moreover, as patients are likely to select a family member as a surrogate, see 2 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions 240 (1982), giving effect to a proxy's decisions may also protect the ``freedom of personal choice in matters of . . . family life.'' Cleveland Board of Education v. LaFleur, 414 U. S. 632, 639 (1974).

Today's decision, holding only that the Constitution permits a State to require clear and convincing evidence of Nancy Cruzan's desire to have artificial hydration and nutrition withdrawn, does not preclude a future determination that the Constitution requires the States to implement the decisions of a patient's duly appointed surrogate. Nor does it prevent States from developing other approaches for protecting an incompetent individual's liberty interest in refusing medical treatment. As is evident from the Court's survey of state court decisions, see ante at 6-13, no national consensus has yet emerged on the best solution for this difficult and sensitive problem. Today we decide only that one State's practice does not violate the Constitution; the more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the ``laboratory'' of the States, New State Ice Co. v. Liebmann, 285 U. S. 262, 311 (1932) (Brandeis, J., dissenting), in the first instance.