SUPREME COURT OF THE UNITED STATES

Nos. 96–110 AND 95–1858

WASHINGTON, ET AL., PETITIONERS
96–110 *v.*
HAROLD GLUCKSBERG ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

DENNIS C. VACCO, ATTORNEY GENERAL OF NEW YORK, ET AL., PETITIONERS
95–1858 *v.*
TIMOTHY E. QUILL ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

[June 26, 1997]

JUSTICE STEVENS, concurring in the judgments.

The Court ends its opinion with the important observation that our holding today is fully consistent with a continuation of the vigorous debate about the "morality, legality, and practicality of physician-assisted suicide" in a democratic society. *Ante,* at 32. I write separately to make it clear that there is also room for further debate about the limits that the Constitution places on the power of the States to punish the practice.

I

The morality, legality, and practicality of capital punishment have been the subject of debate for many years. In 1976, this Court upheld the constitutionality of the practice in cases coming to us from Georgia,[1] Florida[2], and Texas.[3] In those cases we concluded that a State does have the power to place a lesser value on some lives than on others; there is no absolute requirement that a State treat all human life as having an equal right to preservation. Because the state legislatures had sufficiently narrowed the category of lives that the State could terminate, and had enacted special procedures to ensure that the defendant belonged in that limited category, we concluded that the statutes were not unconstitutional on their face. In later cases coming to us from each of those States, however, we found that some applications of the statutes were unconstitutional.[4]

Today, the Court decides that Washington's statute prohibiting assisted suicide is not invalid "on its face," that is to say, in all or most cases in which it might be applied.[5] That holding, however, does not foreclose the possibility that some applications of the statute might well be invalid.

As originally filed, this case presented a challenge to the Washington statute on its face and as it applied to three terminally ill, mentally competent patients and to four physicians who treat terminally ill patients. After the District Court issued its opinion holding that the statute placed an undue burden on the right to commit physician-assisted suicide, see *Compassion in Dying* v.

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[1] *Gregg* v. *Georgia*, 428 U. S. 153 (1976)

[2] *Proffitt* v. *Florida*, 428 U. S. 242 (1976).

[3] *Jurek* v. *Texas*, 428 U. S. 262 (1976).

[4] See, *e.g.*, *Godfrey* v. *Georgia*, 446 U. S. 420 (1980); *Enmund* v. *Florida*, 458 U. S. 782 (1982); *Penry* v. *Lynaugh*, 492 U. S. 302 (1989).

[5] See *ante*, at 3, n. 5.

Washington, 850 F. Supp. 1454, 1462, 1465 (WD Wash. 1994), the three patients died. Although the Court of Appeals considered the constitutionality of the statute "as applied to the prescription of life-ending medication for use by terminally ill, competent adult patients who wish to hasten their deaths," *Compassion in Dying* v. *Washington*, 79 F. 3d 790, 798 (CA9 1996), the court did not have before it any individual plaintiff seeking to hasten her death or any doctor who was threatened with prosecution for assisting in the suicide of a particular patient; its analysis and eventual holding that the statute was unconstitutional was not limited to a particular set of plaintiffs before it.

The appropriate standard to be applied in cases making facial challenges to state statutes has been the subject of debate within this Court. See *Janklow* v. *Planned Parenthood, Sioux Falls Clinic*, 517 U. S. ___ (1996). Upholding the validity of the federal Bail Reform Act of 1984, the Court stated in *United States* v. *Salerno*, 481 U. S. 739 (1987), that a "facial challenge to a legislative Act is, of course, the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the Act would be valid." *Id.*, at 745.[6] I do not believe the Court has ever actually applied such a strict standard,[7] even in *Salerno* itself, and

[6] If the Court had actually applied the *Salerno* standard in this action, it would have taken only a few paragraphs to identify situations in which the Washington statute could be validly enforced. In *Salerno* itself, the Court would have needed only to look at whether the statute could be constitutionally applied to the arrestees before it; any further analysis would have been superfluous. See Dorf, Facial Challenges to State and Federal Statutes, 46 Stan. L. Rev. 235, 239–240 (1994) (arguing that if the *Salerno* standard were taken literally, a litigant could not succeed in her facial challenge unless she also succeeded in her as applied challenge).

[7] In other cases and in other contexts, we have imposed a significantly lesser burden on the challenger. The most lenient standard that we have applied requires the challenger to establish that the invalid applications of a statute "must not only be real, but substantial as well,

the Court does not appear to apply *Salerno* here. Nevertheless, the Court does conceive of respondents' claim as a facial challenge—addressing not the application of the statute to a particular set of plaintiffs before it, but the constitutionality of the statute's categorical prohibition against "aid[ing] another person to attempt suicide." *Ante,* at 18 (internal quotation marks omitted) (citing Wash. Rev. Code §9A.36.060(1) (1994)). Accordingly, the Court requires the plaintiffs to show that the interest in liberty protected by the Fourteenth Amendment "includes a right to commit suicide which itself includes a right to assistance in doing so." *Ante,* at 18.

History and tradition provide ample support for refusing to recognize an open-ended constitutional right to commit suicide. Much more than the State's paternalistic interest in protecting the individual from the irrevocable consequences of an ill-advised decision motivated by temporary concerns is at stake. There is truth in John Donne's observation that "No man is an island."[8] The State

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judged in relation to the statute's plainly legitimate sweep." *Broadrick* v. *Oklahoma,* 413 U. S. 601, 615 (1973). As the Court's opinion demonstrates, Washington's statute prohibiting assisted suicide has a "plainly legitimate sweep." While that demonstration provides a sufficient justification for rejecting respondents' facial challenge, it does not mean that every application of the statute should or will be upheld.

[8] "Who casts not up his eye to the sun when it rises? but who takes off his eye from a comet when that breaks out? Who bends not his ear to any bell which upon any occasion rings? but who can remove it from that bell which is passing a piece of himself out of this world? No man is an island, entire of itself; every man is a piece of the continent, a part of the main. If a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if a manor of thy friend's or of thine own were; any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee." J. Donne, Meditation No. 17, Devotions Upon Emergent Occasions 86, 87 (A. Raspa ed. 1987).

has an interest in preserving and fostering the benefits that every human being may provide to the community—a community that thrives on the exchange of ideas, expressions of affection, shared memories and humorous incidents as well as on the material contributions that its members create and support. The value to others of a person's life is far too precious to allow the individual to claim a constitutional entitlement to complete autonomy in making a decision to end that life. Thus, I fully agree with the Court that the "liberty" protected by the Due Process Clause does not include a categorical "right to commit suicide which itself includes a right to assistance in doing so." *Ante*, at 18.

But just as our conclusion that capital punishment is not always unconstitutional did not preclude later decisions holding that it is sometimes impermissibly cruel, so is it equally clear that a decision upholding a general statutory prohibition of assisted suicide does not mean that every possible application of the statute would be valid. A State, like Washington, that has authorized the death penalty and thereby has concluded that the sanctity of human life does not require that it always be preserved, must acknowledge that there are situations in which an interest in hastening death is legitimate. Indeed, not only is that interest sometimes legitimate, I am also convinced that there are times when it is entitled to constitutional protection.

II

In *Cruzan* v. *Director, Mo. Dept. of Health*, 497 U. S. 261 (1990), the Court assumed that the interest in liberty protected by the Fourteenth Amendment encompassed the right of a terminally ill patient to direct the withdrawal of life-sustaining treatment. As the Court correctly observes today, that assumption "was not simply deduced from abstract concepts of personal autonomy." *Ante*, at 21. Instead, it was supported by the common-law tradition protecting the individual's general right to refuse unwanted medical treatment. *Ibid*. We have recognized, however, that this common-law right to refuse treatment is neither absolute nor always sufficiently weighty to overcome valid countervailing state interests. As Justice Brennan pointed out in his *Cruzan* dissent, we have upheld legislation imposing punishment on persons refusing to be vaccinated, 497 U. S., at 312, n. 12, citing *Jacobson* v. *Massachusetts*, 197 U. S. 11, 26–27 (1905), and as JUSTICE SCALIA pointed out in his concurrence, the State ordinarily has the right to interfere with an attempt to commit suicide by, for example, forcibly placing a bandage on a self-inflicted wound to stop the flow of blood. 497 U. S., at 298. In most cases, the individual's constitutionally protected interest in his or her own physical autonomy, including the right to refuse unwanted medical treatment, will give way to the State's interest in preserving human life.

Cruzan, however, was not the normal case. Given the irreversible nature of her illness and the progressive character of her suffering,[9] Nancy Cruzan's interest in refusing medical care was incidental to her more basic interest in controlling the manner and timing of her death. In finding that her best interests would be served by cutting off the nourishment that kept her alive, the trial court did more than simply vindicate Cruzan's interest in

[9] See 497 U. S., at 332, n. 2.

refusing medical treatment; the court, in essence, authorized affirmative conduct that would hasten her death. When this Court reviewed the case and upheld Missouri's requirement that there be clear and convincing evidence establishing Nancy Cruzan's intent to have life-sustaining nourishment withdrawn, it made two important assumptions: (1) that there was a "liberty interest" in refusing unwanted treatment protected by the Due Process Clause; and (2) that this liberty interest did not "end the inquiry" because it might be outweighed by relevant state interests. *Id.*, at 279. I agree with both of those assumptions, but I insist that the source of Nancy Cruzan's right to refuse treatment was not just a common-law rule. Rather, this right is an aspect of a far broader and more basic concept of freedom that is even older than the common law.[10] This freedom embraces, not merely a person's right to refuse a particular kind of unwanted treatment, but also her interest in dignity, and in determining the character of the memories that will survive long after her death.[11] In recognizing that the State's

[10] "[N]either the Bill of Rights nor the laws of sovereign States create the liberty which the Due Process Clause protects. The relevant constitutional provisions are limitations on the power of the sovereign to infringe on the liberty of the citizen. The relevant state laws either create property rights, or they curtail the freedom of the citizen who must live in an ordered society. Of course, law is essential to the exercise and enjoyment of individual liberty in a complex society. But it is not the source of liberty, and surely not the exclusive source.

"I had thought it self-evident that all men were endowed by their Creator with liberty as one of the cardinal unalienable rights. It is that basic freedom which the Due Process Clause protects, rather than the particular rights or privileges conferred by specific laws or regulations." *Meachum* v. *Fano*, 427 U. S. 215, 230 (1976) (STEVENS, J., dissenting).

[11] "Nancy Cruzan's interest in life, no less than that of any other person, includes an interest in how she will be thought of after her death by those whose opinions mattered to her. There can be no doubt that

interests did not outweigh Nancy Cruzan's liberty interest in refusing medical treatment, *Cruzan* rested not simply on the common-law right to refuse medical treatment, but—at least implicitly—on the even more fundamental right to make this "deeply personal decision," 497 U. S., at 289 (O'CONNOR, J., concurring).

Thus, the common-law right to protection from battery, which included the right to refuse medical treatment in most circumstances, did not mark "the outer limits of the substantive sphere of liberty" that supported the Cruzan family's decision to hasten Nancy's death. *Planned Parenthood of Southeastern Pa.* v. *Casey*, 505 U. S. 833, 848 (1992). Those limits have never been precisely defined. They are generally identified by the importance and character of the decision confronted by the individual, *Whalen* v. *Roe*, 429 U. S. 589, 599–600, n. 26 (1977). Whatever the outer limits of the concept may be, it definitely includes protection for matters "central to personal dignity and autonomy." *Casey*, 505 U. S., at 851. It includes,

> "the individual's right to make certain unusually important decisions that will affect his own, or his family's, destiny. The Court has referred to such decisions as implicating `basic values,' as being `fundamental,' and as being dignified by history and

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her life made her dear to her family and to others. How she dies will affect how that life is remembered." *Cruzan* v. *Director, Mo. Dept. of Health*, 497 U. S. 261, 344 (1990) (STEVENS, J., dissenting).

"Each of us has an interest in the kind of memories that will survive after death. To that end, individual decisions are often motivated by their impact on others. A member of the kind of family identified in the trial court's findings in this case would likely have not only a normal interest in minimizing the burden that her own illness imposes on others, but also an interest in having their memories of her filled predominantly with thoughts about her past vitality rather than her current condition." *Id.*, at 356.

> tradition. The character of the Court's language in these cases brings to mind the origins of the American heritage of freedom—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." *Fitzgerald* v. *Porter Memorial Hospital,* 523 F. 2d 716, 719–720 (CA7 1975) (footnotes omitted), cert. denied, 425 U. S. 916 (1976).

The *Cruzan* case demonstrated that some state intrusions on the right to decide how death will be encountered are also intolerable. The now-deceased plaintiffs in this action may in fact have had a liberty interest even stronger than Nancy Cruzan's because, not only were they terminally ill, they were suffering constant and severe pain. Avoiding intolerable pain and the indignity of living one's final days incapacitated and in agony is certainly "[a]t the heart of [the] liberty . . . to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." *Casey,* 505 U. S., at 851.

While I agree with the Court that *Cruzan* does not decide the issue presented by these cases, *Cruzan* did give recognition, not just to vague, unbridled notions of autonomy, but to the more specific interest in making decisions about how to confront an imminent death. Although there is no absolute right to physician-assisted suicide, *Cruzan* makes it clear that some individuals who no longer have the option of deciding whether to live or to die because they are already on the threshold of death have a constitutionally protected interest that may outweigh the State's interest in preserving life at all costs. The liberty interest at stake in a case like this differs from, and is stronger than, both the common-law right to refuse medical treatment and the unbridled interest in deciding whether to live or die. It is an interest in deciding how, rather than whether, a critical threshold shall be crossed.

III

The state interests supporting a general rule banning the practice of physician-assisted suicide do not have the same force in all cases. First and foremost of these interests is the "`unqualified interest in the preservation of human life,' " *ante,* at 24, (quoting *Cruzan,* 497 U. S., at 282,) which is equated with "`the sanctity of life,'" *ante,* at 25, (quoting the American Law Institute, Model Penal Code §210.5, Comment 5, p. 100 (Official Draft and Revised Comments 1980)). That interest not only justifies—it commands—maximum protection of every individual's interest in remaining alive, which in turn commands the same protection for decisions about whether to commence or to terminate life-support systems or to administer pain medication that may hasten death. Properly viewed, however, this interest is not a collective interest that should always outweigh the interests of a person who because of pain, incapacity, or sedation finds her life intolerable, but rather, an aspect of individual freedom.

Many terminally ill people find their lives meaningful even if filled with pain or dependence on others. Some find value in living through suffering; some have an abiding desire to witness particular events in their families' lives; many believe it a sin to hasten death. Individuals of different religious faiths make different judgments and choices about whether to live on under such circumstances. There are those who will want to continue aggressive treatment; those who would prefer terminal sedation; and those who will seek withdrawal from life-support systems and death by gradual starvation and dehydration. Although as a general matter the State's interest in the contributions each person may make to society outweighs the person's interest in ending her life, this interest does not have the same force for a terminally ill patient faced not with the choice of whether to live, only of how to die. Allowing the

individual, rather than the State, to make judgments " `about the "quality" of life that a particular individual may enjoy.'" *ante,* at 25 (quoting *Cruzan,* 497 U. S., at 282), does not mean that the lives of terminally-ill, disabled people have less value than the lives of those who are healthy, see *ante,* at 28. Rather, it gives proper recognition to the individual's interest in choosing a final chapter that accords with her life story, rather than one that demeans her values and poisons memories of her. See Brief for Bioethicists as *Amici Curiae* 11; see also R. Dworkin, Life's Dominion 213 (1993) ("Whether it is in someone's best interests that his life end in one way rather than another depends on so much else that is special about him—about the shape and character of his life and his own sense of his integrity and critical interests—that no uniform collective decision can possibly hope to serve everyone even decently").

Similarly, the State's legitimate interests in preventing suicide, protecting the vulnerable from coercion and abuse, and preventing euthanasia are less significant in this context. I agree that the State has a compelling interest in preventing persons from committing suicide because of depression, or coercion by third parties. But the State's legitimate interest in preventing abuse does not apply to an individual who is not victimized by abuse, who is not suffering from depression, and who makes a rational and voluntary decision to seek assistance in dying. Although, as the New York Task Force report discusses, diagnosing depression and other mental illness is not always easy, mental health workers and other professionals expert in working with dying patients can help patients cope with depression and pain, and help patients assess their options. See Brief for Washington State Psychological Association et al. as *Amici Curiae* 8–10.

Relatedly, the State and *amici* express the concern that patients whose physical pain is inadequately treated will be more likely to request assisted suicide. Encouraging the

development and ensuring the availability of adequate pain treatment is of utmost importance; palliative care, however, cannot alleviate all pain and suffering. See Orentlicher, Legalization of Physician Assisted Suicide: A Very Modest Revolution, 38 Boston College L. Rev. (Galley, p. 8) (1997) ("Greater use of palliative care would reduce the demand for assisted suicide, but it will not eliminate [it]"); see also Brief for Coalition of Hospice Professionals as *Amici Curiae* 8 (citing studies showing that "[a]s death becomes more imminent, pain and suffering become progressively more difficult to treat"). An individual adequately informed of the care alternatives thus might make a rational choice for assisted suicide. For such an individual, the State's interest in preventing potential abuse and mistake is only minimally implicated.

The final major interest asserted by the State is its interest in preserving the traditional integrity of the medical profession. The fear is that a rule permitting physicians to assist in suicide is inconsistent with the perception that they serve their patients solely as healers. But for some patients, it would be a physician's refusal to dispense medication to ease their suffering and make their death tolerable and dignified that would be inconsistent with the healing role See Block & Billings, Patient Request to Hasten Death, 154 Archives Internal Med. 2039, 2045 (1994) (A doctor's refusal to hasten death "may be experienced by the [dying] patient as an abandonment, a rejection, or an expression of inappropriate paternalistic authority"). For doctors who have long-standing relationships with their patients, who have given their patients advice on alternative treatments, who are attentive to their patient's individualized needs, and who are knowledgeable about pain symptom management and palliative care options, see Quill, Death and Dignity, A Case of Individualized Decision Making, 324 New England J. of Med. 691–694 (1991), heeding a patient's desire to assist in

her suicide would not serve to harm the physician-patient relationship. Furthermore, because physicians are already involved in making decisions that hasten the death of terminally ill patients—through termination of life support, withholding of medical treatment, and terminal sedation—there is in fact significant tension between the traditional view of the physician's role and the actual practice in a growing number of cases.[12]

As the New York State Task Force on Life and the Law recognized, a State's prohibition of assisted suicide is justified by the fact that the "`ideal'" case in which "patients would be screened for depression and offered treatment, effective pain medication would be available, and all

[12] I note that there is evidence that a significant number of physicians support the practice of hastening death in particular situations. A survey published in the New England Journal of Medicine, found that 56% of responding doctors in Michigan preferred legalizing assisted suicide to an explicit ban. Bachman et al., Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia, 334 New England J. Med. 303–309 (1996). In a survey of Oregon doctors, 60% of the responding doctors supported legalizing assisted suicide for terminally ill patients. See Lee et al., Legalizing Assisted Suicide—Views of Physicians in Oregon, 335 New England J. Med. 310–315 (1996). Another study showed that 12% of physicians polled in Washington State reported that they had been asked by their terminally ill patients for prescriptions to hasten death, and that, in the year prior to the study, 24% of those physicians had complied with such requests. See Back, Wallace, Starks, & Perlman, Physician-Assisted Suicide and Euthanasia in Washington State, 275 JAMA 919–925 (1996); see also Doukas, Waterhouse, Gorenflo, & Seld, Attitudes and Behaviors on Physician-Assisted Death: A Study of Michigan Oncologists, 13 J. Clinical Oncology 1055 (1995) (reporting that 18% of responding Michigan oncologists reported active participation in assisted suicide); Slome, Moulton, Huffine, Gorter, & Abrams, Physicians' Attitudes Toward Assisted Suicide in AIDS, 5 J. Acquired Immune Deficiency Syndromes 712 (1992) (reporting that 24% of responding physicians who treat AIDS patients would likely grant a patient's request for assistance in hastening death).

patients would have a supportive committed family and doctor" is not the usual case. New York State Task Force on Life and the Law, When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context 120 (May 1994). Although, as the Court concludes today, these *potential* harms are sufficient to support the State's general public policy against assisted suicide, they will not always outweigh the individual liberty interest of a particular patient. Unlike the Court of Appeals, I would not say as a categorical matter that these state interests are invalid as to the entire class of terminally ill, mentally competent patients. I do not, however, foreclose the possibility that an individual plaintiff seeking to hasten her death, or a doctor whose assistance was sought, could prevail in a more particularized challenge. Future cases will determine whether such a challenge may succeed.

IV

In New York, a doctor must respect a competent person's decision to refuse or to discontinue medical treatment even though death will thereby ensue, but the same doctor would be guilty of a felony if she provided her patient assistance in committing suicide.[13] Today we hold that the Equal Protection Clause is not violated by the resulting disparate treatment of two classes of terminally ill people who may have the same interest in hastening death. I agree that the distinction between permitting death to ensue from an underlying fatal disease and causing it to occur by the administration of medication or other means provides a constitutionally sufficient basis for the State's classification.[14] Unlike the Court, however, see *Vacco, ante*, at 6–7, I am not persuaded that in all cases there will in fact be a significant difference between the intent of the physicians, the patients or the families in the two situations.

There may be little distinction between the intent of a terminally-ill patient who decides to remove her life-support and one who seeks the assistance of a doctor in ending her life; in both situations, the patient is seeking to hasten a certain, impending death. The doctor's intent might also be the same in prescribing lethal medication as it is in terminating life support. A doctor who fails to administer medical treatment to one who is dying from a disease could be doing so with an intent to harm or kill that patient. Conversely, a doctor who prescribes lethal medication does not necessarily intend the patient's death—rather that doctor may seek simply to ease the patient's suffering and to comply with her wishes. The

[13] See *Vacco* v. *Quill, ante*, at 1, nn. 1 and 2.

[14] The American Medical Association recognized this distinction when it supported Nancy Cruzan and continues to recognize this distinction in its support of the States in these cases.

illusory character of any differences in intent or causation is confirmed by the fact that the American Medical Association unequivocally endorses the practice of terminal sedation—the administration of sufficient dosages of pain-killing medication to terminally ill patients to protect them from excruciating pain even when it is clear that the time of death will be advanced. The purpose of terminal sedation is to ease the suffering of the patient and comply with her wishes, and the actual cause of death is the administration of heavy doses of lethal sedatives. This same intent and causation may exist when a doctor complies with a patient's request for lethal medication to hasten her death.[15]

Thus, although the differences the majority notes in causation and intent between terminating life-support and assisting in suicide support the Court's rejection of the respondents' facial challenge, these distinctions may be inapplicable to particular terminally ill patients and their doctors. Our holding today in *Vacco* v. *Quill* that the Equal Protection Clause is not violated by New York's classification, just like our holding in *Washington* v. *Glucksberg* that the Washington statute is not invalid on its face, does not foreclose the possibility that some applications of the New York statute may impose an intolerable intrusion on the patient's freedom.

There remains room for vigorous debate about the outcome of particular cases that are not necessarily

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[15] If a doctor prescribes lethal drugs to be self-administered by the patient, it not at all clear that the physician's intent is that the patient "be made dead," *ante*, at 7 (internal quotation marks omitted). Many patients prescribed lethal medications never actually take them; they merely acquire some sense of control in the process of dying that the availability of those medications provides. See Back, *supra* n. 12, at 922; see also Quill, 324 New England J. Med., at 693 (describing how some patients fear death less when they feel they have the option of physician-assisted suicide).

resolved by the opinions announced today. How such cases may be decided will depend on their specific facts. In my judgment, however, it is clear that the so-called "unqualified interest in the preservation of human life," *Cruzan*, 497 U. S., at 282, *Glucksberg*, *ante*, at 24, is not itself sufficient to outweigh the interest in liberty that may justify the only possible means of preserving a dying patient's dignity and alleviating her intolerable suffering.