AMERICAN CONSTITUTIONALISM
VOLUME II: RIGHTS AND LIBERTIES
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Supplementary Material

Chapter 11: The Contemporary Era—Individual Rights/Personal Freedom and Public Morality/Right to Die (and Right to Life)

Washington v. Glucksberg, 521 U.S. 702 (1997)

Harold Glucksberg was a doctor who practiced in the state of Washington. Glucksberg and some of his colleagues believed that they should have the right to help terminally ill patients end their lives if the patients made that request. They refrained from doing so because Washington law declared, "A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide." Glucksberg in 1994 filed a lawsuit against the state of Washington, claiming that the Washington statute unconstitutionally prohibited doctors from providing life-ending assistance to terminally ill patients suffering painful and debilitating illnesses. The federal district court found a right to die, but that decision was reversed by the Court of Appeals for the Ninth Circuit. Glucksberg appealed to the Supreme Court of the United States.

Numerous organizations and individuals sought to influence the Supreme Court's decision on the constitutional right to die. Prominent law professors, philosophers, right-to-die advocates, liberal public interest groups, pro-choice organizations, and liberal religious groups filed briefs urging the justices to find a constitutional right to die. The United States, many national officials, many states, pro-life organizations, and conservative religious groups filed briefs urging the justices to sustain the Washington law. Glucksberg split the public health community. The brief signed by the American Counseling Association asserted,

> *Mental health professionals who work with terminally ill patients are as concerned as others that decisions to hasten death not be impulsive or ambivalent, and that they be made free from any coercion or undue influence. Such dangers may largely be avoided through appropriate state regulation, including mandatory waiting periods and the involvement of mental health professionals in evaluation and counseling. With a strong commitment to patient autonomy as a guiding principle, mental health professionals are uniquely suited to serve as counselors and advocates for terminally ill patients in the face of any improper pressure. Moreover, appropriate safeguards may be put in place without denying patients who are in a position to make free, informed, and intelligent end-of-life decisions the opportunity to do so.*

The brief of the American Medical Association declared,

> *The court of appeals would confer upon health care professionals the awesome responsibility of deciding who, among the many patients who would request physician-assisted suicide, are eligible to obtain the assistance of a physician in killing themselves. The power to assist in intentionally taking the life of a patient is antithetical to the central mission of healing that guides both medicine and nursing. It is a power that most health care professionals do not want and could not control. Once established, the right to physician-assisted suicide would create profound danger for many ill persons with undiagnosed depression and inadequately treated pain, for whom physician-assisted suicide rather than good palliative care could become the norm. At greatest risk would be those with the least access to palliative care—the poor, the elderly, and members of minority groups.*

The Supreme Court unanimously declared that the Washington ban against assisted suicide was not unconstitutional on its face. Chief Justice Rehnquist insisted that various state interests justified a general ban non state assisted suicide. What were those interests? How strong are they? All the justices

in Glucksberg *recognized some fundamental right to die. What was the right to die recognized by Chief Justice Rehnquist? What was the right to die recognized by the concurring opinion? Who has the better of the argument? Compare the briefs by medical doctors and psychologists? Why do they come to different conclusions on the right to die? How would you evaluate their conclusions if you were writing the* Glucksberg *opinion?*

CHIEF JUSTICE REHNQUIST delivered the opinion of the Court.

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We begin, as we do in all due process cases, by examining our Nation's history, legal traditions, and practices. . . . In almost every State—indeed, in almost every western democracy—it is a crime to assist a suicide. The States' assisted-suicide bans are not innovations. Rather, they are longstanding expressions of the States' commitment to the protection and preservation of all human life. . . . Indeed, opposition to and condemnation of suicide—and, therefore, of assisting suicide—are consistent and enduring themes of our philosophical, legal, and cultural heritages. . . .

More specifically, for over 700 years, the Anglo-American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide. In the 13th century, Henry de Bracton, one of the first legal-treatise writers, observed that "[j]ust as a man may commit felony by slaying another so may he do so by slaying himself." . . . Centuries later, Sir William Blackstone . . . referred to suicide as "self-murder" and "the pretended heroism, but real cowardice, of the Stoic philosophers, who destroyed themselves to avoid those ills which they had not the fortitude to endure. . . ." W. Blackstone, Commentaries.

For the most part, the early American Colonies adopted the common-law approach. For example, the legislators of the Providence Plantations, which would later become Rhode Island, declared, in 1647, that "[s]elf-murder is by all agreed to be the most unnatural, and it is by this present Assembly declared, to be that, wherein he that doth it, kills himself out of a premeditated hatred against his own life or other humor: . . . his goods and chattels are the king's custom, but not his debts nor lands; but in case he be an infant, a lunatic, mad or distracted man, he forfeits nothing." . . .

That suicide remained a grievous, though nonfelonious, wrong is confirmed by the fact that colonial and early state legislatures and courts did not retreat from prohibiting assisting suicide. Swift, in his early 19th-century treatise on the laws of Connecticut, stated that "[i]f one counsels another to commit suicide, and the other by reason of the advice kills himself, the advisor is guilty of murder as principal." . . . And the prohibitions against assisting suicide never contained exceptions for those who were near death. . . .

The earliest American statute explicitly to outlaw assisting suicide was enacted in New York in 1828 . . . and many of the new States and Territories followed New York's example. . . . By the time the Fourteenth Amendment was ratified, it was a crime in most States to assist a suicide. . . . In this century, the Model Penal Code also prohibited "aiding" suicide, prompting many States to enact or revise their assisted-suicide bans.

Though deeply rooted, the States' assisted-suicide bans have in recent years been reexamined and, generally, reaffirmed. . . . Many States, for example, now permit "living wills," surrogate health-care decisionmaking, and the withdrawal or refusal of life-sustaining medical treatment. . . . At the same time, however, voters and legislators continue for the most part to reaffirm their States' prohibitions on assisting suicide.

[T]he States are currently engaged in serious, thoughtful examinations of physician-assisted suicide and other similar issues. For example, New York State's Task Force on Life and the Law—an ongoing, blue-ribbon commission composed of doctors, ethicists, lawyers, religious leaders, and interested laymen—was convened in 1984 and commissioned with "a broad mandate to recommend public policy on issues raised by medical advances." . . . After studying physician-assisted suicide, however, the Task Force unanimously concluded that "[l]egalizing assisted suicide and euthanasia would

pose profound risks to many individuals who are ill and vulnerable. . . [T]he potential dangers of this dramatic change in public policy would outweigh any benefit that might be achieved." . . . .

Attitudes toward suicide itself have changed since Bracton, but our laws have consistently condemned, and continue to prohibit, assisting suicide. Despite changes in medical technology and notwithstanding an increased emphasis on the importance of end-of-life decisionmaking, we have not retreated from this prohibition. Against this backdrop of history, tradition, and practice, we now turn to respondents' constitutional claim.

The Due Process Clause guarantees more than fair process, and the "liberty" it protects includes more than the absence of physical restraint. . . . The Clause also provides heightened protection against government interference with certain fundamental rights and liberty interests. . . . In a long line of cases, we have held that, in addition to the specific freedoms protected by the Bill of Rights, the "liberty" specially protected by the Due Process Clause includes the rights to marry, to have children, to direct the education and upbringing of one's children, to marital privacy, to use contraception, to bodily integrity, and to abortion, We have also assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment. *Cruzan*.

But we "ha[ve] always been reluctant to expand the concept of substantive due process because guideposts for responsible decisionmaking in this unchartered area are scarce and open-ended." By extending constitutional protection to an asserted right or liberty interest, we, to a great extent, place the matter outside the arena of public debate and legislative action. We must therefore "exercise the utmost care whenever we are asked to break new ground in this field," lest the liberty protected by the Due Process Clause be subtly transformed into the policy preferences of the Members of this Court,

Our established method of substantive-due-process analysis has two primary features: First, we have regularly observed that the Due Process Clause specially protects those fundamental rights and liberties which are, objectively, "deeply rooted in this Nation's history and tradition." . . . Second, we have required in substantive-due-process cases a "careful description" of the asserted fundamental liberty interest. . . .

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We now inquire whether this asserted right has any place in our Nation's traditions. Here, we are confronted with a consistent and almost universal tradition that has long rejected the asserted right, and continues explicitly to reject it today, even for terminally ill, mentally competent adults. To hold for respondents, we would have to reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every State. . . .

. . .

The right assumed in *Cruzan v. Director, Missouri Department of Health* (1990) . . . was not simply deduced from abstract concepts of personal autonomy. Given the common-law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment, our assumption was entirely consistent with this Nation's history and constitutional traditions. The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct. . . .

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. . . That many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected and *Casey* did not suggest otherwise.

The history of the law's treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it. That being the case, our decisions lead us to conclude that the asserted "right" to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause. The Constitution also requires, however, that Washington's assisted-suicide ban be rationally related to legitimate government interests. This requirement is unquestionably met here. . . . Washington's assisted-suicide ban implicates a number of state interests.

First, Washington has an "unqualified interest in the preservation of human life." The State's prohibition on assisted suicide, like all homicide laws, both reflects and advances its commitment to this interest.

Relatedly, all admit that suicide is a serious public-health problem, especially among persons in otherwise vulnerable groups. . . . The State has an interest in preventing suicide, and in studying, identifying, and treating its causes. . . .

Those who attempt suicide—terminally ill or not—often suffer from depression or other mental disorders. . . . Research indicates, however, that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated. . . . Thus, legal physician-assisted suicide could make it more difficult for the State to protect depressed or mentally ill persons, or those who are suffering from untreated pain, from suicidal impulses.

The State also has an interest in protecting the integrity and ethics of the medical profession. . . . [T]he American Medical Association, like many other medical and physicians' groups, has concluded that "[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer." . . . And physician-assisted suicide could, it is argued, undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming. . . .

Next, the State has an interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and mistakes. . . . If physician-assisted suicide were permitted, many might resort to it to spare their families the substantial financial burden of end-of-life health-care costs.

. . .

Finally, the State may fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia. The Court of Appeals struck down Washington's assisted-suicide ban only "as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors." Washington insists, however, that the impact of the court's decision will not and cannot be so limited. If suicide is protected as a matter of constitutional right, it is argued, "every man and woman in the United States must enjoy it."

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Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society. . . .

JUSTICE SOUTER, concurring in the judgment.

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[Justice Harlan's dissent in *Poe v. Ullman* (1961)] is important for three things that point to our responsibilities today. The first is Justice Harlan's respect for the tradition of substantive due process review itself, and his acknowledgment of the Judiciary's obligation to carry it on. For two centuries American courts, and for much of that time this Court, have thought it necessary to provide some degree of review over the substantive content of legislation under constitutional standards of textual breadth. . . .

. . . The second of the dissent's lessons is a reminder that the business of such review is not the identification of extratextual absolutes but scrutiny of a legislative resolution (perhaps unconscious) of clashing principles, each quite possibly worthy in and of itself, but each to be weighed within the history of our values as a people. It is a comparison of the relative strengths of opposing claims that informs the judicial task, not a deduction from some first premise. Thus informed, judicial review still has no warrant to substitute one reasonable resolution of the contending positions for another, but authority to supplant the balance already struck between the contenders only when it falls outside the realm of the reasonable. . . . [T]he dissent's third [point is that] explicit attention to detail that is no less essential to the intellectual discipline of substantive due process review than an understanding of the basic need to account for the two sides in the controversy and to respect legislation within the zone of reasonableness.

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After the *Poe* dissent, as before it, this enforceable concept of liberty would bar statutory impositions even at relatively trivial levels when governmental restraints are undeniably irrational as unsupported by any imaginable rationale. . . . Such instances are suitably rare. The claims of arbitrariness that mark almost all instances of unenumerated substantive rights are those resting on "certain interests requir[ing] particularly careful scrutiny of the state needs asserted to justify their abridgment[,] . . . In the face of an interest this powerful a State may not rest on threshold rationality or a presumption of constitutionality, but may prevail only on the ground of an interest sufficiently compelling to place within the realm of the reasonable a refusal to recognize the individual right asserted. . . .

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[C]onstitutional review, not judicial lawmaking, is a court's business here. The weighing or valuing of contending interests in this sphere is only the first step, forming the basis for determining whether the statute in question falls inside or outside the zone of what is reasonable in the way it resolves the conflict between the interests of state and individual. . . . It is only when the legislation's justifying principle, critically valued, is so far from being commensurate with the individual interest as to be arbitrarily or pointlessly applied that the statute must give way. . . .

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. . . Common-law method tends to pay respect instead to detail, seeking to understand old principles afresh by new examples and new counterexamples. . . . Exact analysis and characterization of any due process claim are critical to the method and to the result.

So, in *Poe*, Justice Harlan viewed it as essential to the plaintiffs' claimed right to use contraceptives that they sought to do so within the privacy of the marital bedroom. This detail in fact served two crucial and complementary functions, and provides a lesson for today. It rescued the individuals' claim from a breadth that would have threatened all state regulation of contraception or intimate relations; extramarital intimacy, no matter how privately practiced, was outside the scope of the right Justice Harlan would have recognized in that case. It was, moreover, this same restriction that allowed the interest to be valued as an aspect of a broader liberty to be free from all unreasonable intrusions into the privacy of the home and the family life within it, a liberty exemplified in constitutional provisions such as the Third and Fourth Amendments, in prior decisions of the Court involving unreasonable intrusions into the home and family life, and in the then-prevailing status of marriage as the sole lawful locus of intimate relations.

. . .

We may therefore classify Justice Harlan's example of proper analysis in any of these ways: as applying concepts of normal critical reasoning, as pointing to the need to attend to the levels of generality at which countervailing interests are stated, or as examining the concrete application of principles for fitness with their own ostensible justifications. . . . For here we are faced with an individual claim not to a right on the part of just anyone to help anyone else commit suicide under any circumstances, but to the right of a narrow class to help others also in a narrow class under a set of limited circumstances. And the claimants are met with the State's assertion, among others, that rights of such narrow scope cannot be recognized without jeopardy to individuals whom the State may concededly protect through its regulations.

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[The] liberty interest in bodily integrity was phrased in a general way by then-Judge Cardozo when he said, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body" in relation to his medical needs. The familiar examples of this right derive from the common law of battery and include the right to be free from medical invasions into the body, as well as a right generally to resist enforced medication. Constitutional recognition of the right to bodily integrity underlies the assumed right, good against the State, to require physicians to terminate artificial life support and the affirmative right to obtain medical intervention to cause abortion. . . .

The analogies between the abortion cases and this one are several. Even though the State has a legitimate interest in discouraging abortion, the Court recognized a woman's right to a physician's counsel and care. Like the decision to commit suicide, the decision to abort potential life can be made irresponsibly and under the influence of others, and yet the Court has held in the abortion cases that

physicians are fit assistants. Without physician assistance in abortion, the woman's right would have too often amounted to nothing more than a right to self-mutilation, and without a physician to assist in the suicide of the dying, the patient's right will often be confined to crude methods of causing death, most shocking and painful to the decedent's survivors.

. . . This idea of the physician as serving the whole person is a source of the high value traditionally placed on the medical relationship. Its value is surely as apparent here as in the abortion cases, for just as the decision about abortion is not directed to correcting some pathology, so the decision in which a dying patient seeks help is not so limited. The patients here sought not only an end to pain (which they might have had, although perhaps at the price of stupor) but an end to their short remaining lives with a dignity that they believed would be denied them by powerful pain medication, as well as by their consciousness of dependency and helplessness as they approached death. In that period when the end is imminent, they said, the decision to end life is closest to decisions that are generally accepted as proper instances of exercising autonomy over one's own body, instances recognized under the Constitution and the State's own law, instances in which the help of physicians is accepted as falling within the traditional norm.

The argument supporting respondents' position . . . progresses through three steps of increasing forcefulness. First, it emphasizes the decriminalization of suicide. Reliance on this fact is sanctioned under the standard that looks not only to the tradition retained, but to society's occasional choices to reject traditions of the legal past. While the common law prohibited both suicide and aiding a suicide, with the prohibition on aiding largely justified by the primary prohibition on self-inflicted death itself, the State's rejection of the traditional treatment of the one leaves the criminality of the other open to questioning that previously would not have been appropriate. The second step in the argument is to emphasize that the State's own act of decriminalization gives a freedom of choice much like the individual's option in recognized instances of bodily autonomy. One of these, abortion, is a legal right to choose in spite of the interest a State may legitimately invoke in discouraging the practice, just as suicide is now subject to choice, despite a state interest in discouraging it. The third step is to emphasize that respondents claim a right to assistance not on the basis of some broad principle that would be subject to exceptions if that continuing interest of the State's in discouraging suicide were to be recognized at all. Respondents base their claim on the traditional right to medical care and counsel, subject to the limiting conditions of informed, responsible choice when death is imminent, conditions that support a strong analogy to rights of care in other situations in which medical counsel and assistance have been available as a matter of course. There can be no stronger claim to a physician's assistance than at the time when death is imminent, a moral judgment implied by the State's own recognition of the legitimacy of medical procedures necessarily hastening the moment of impending death.

. . .

The State has put forward several interests to justify the Washington law as applied to physicians treating terminally ill patients, even those competent to make responsible choices: protecting life generally, discouraging suicide even if knowing and voluntary, and protecting terminally ill patients from involuntary suicide and euthanasia, both voluntary and nonvoluntary.

It is not necessary to discuss the exact strengths of the first two claims of justification in the present circumstances, for the third is dispositive for me. That third justification is different from the first two, for it addresses specific features of respondents' claim, and it opposes that claim not with a moral judgment contrary to respondents', but with a recognized state interest in the protection of nonresponsible individuals and those who do not stand in relation either to death or to their physicians as do the patients whom respondents describe. . . .

The mere assertion that the terminally sick might be pressured into suicide decisions by close friends and family members would not alone be very telling. Of course that is possible, not only because the costs of care might be more than family members could bear but simply because they might naturally wish to see an end of suffering for someone they love. But one of the points of restricting any right of assistance to physicians would be to condition the right on an exercise of judgment by someone qualified to assess the patient's responsible capacity and detect the influence of those outside the medical relationship.

. . . The case for the slippery slope is fairly made out here, not because recognizing one due process right would leave a court with no principled basis to avoid recognizing another, but because there is a plausible case that the right claimed would not be readily containable by reference to facts about the mind that are matters of difficult judgment, or by gatekeepers who are subject to temptation, noble or not.

. . . I take it that the basic concept of judicial review with its possible displacement of legislative judgment bars any finding that a legislature has acted arbitrarily when the following conditions are met: there is a serious factual controversy over the feasibility of recognizing the claimed right without at the same time making it impossible for the State to engage in an undoubtedly legitimate exercise of power; facts necessary to resolve the controversy are not readily ascertainable through the judicial process; but they are more readily subject to discovery through legislative factfinding and experimentation. It is assumed in this case, and must be, that a State's interest in protecting those unable to make responsible decisions and those who make no decisions at all entitles the State to bar aid to any but a knowing and responsible person intending suicide, and to prohibit euthanasia. How, and how far, a State should act in that interest are judgments for the State, but the legitimacy of its action to deny a physician the option to aid any but the knowing and responsible is beyond question.

. . .

Legislatures . . . , have superior opportunities to obtain the facts necessary for a judgment about the present controversy. Not only do they have more flexible mechanisms for factfinding than the Judiciary, but their mechanisms include the power to experiment, moving forward and pulling back as facts emerge within their own jurisdictions. There is, indeed, good reason to suppose that in the absence of a judgment for respondents here, just such experimentation will be attempted in some of the States.

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. . . The Court should accordingly stay its hand to allow reasonable legislative consideration. While I do not decide for all time that respondents' claim should not be recognized, I acknowledge the legislative institutional competence as the better one to deal with that claim at this time.

JUSTICE O'CONNOR, concurring.

. . . I join the Court's opinions because I agree that there is no generalized right to "commit suicide." . . . [T]he State's interests in protecting those who are not truly competent or facing imminent death, or those whose decisions to hasten death would not truly be voluntary, are sufficiently weighty to justify a prohibition against physician-assisted suicide. . . .

Every one of us at some point may be affected by our own or a family member's terminal illness. There is no reason to think the democratic process will not strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State's interests in protecting those who might seek to end life mistakenly or under pressure. . . .

In sum, there is no need to address the question whether suffering patients have a constitutionally cognizable interest in obtaining relief from the suffering that they may experience in the last days of their lives. There is no dispute that dying patients in Washington and New York can obtain palliative care, even when doing so would hasten their deaths. The difficulty in defining terminal illness and the risk that a dying patient's request for assistance in ending his or her life might not be truly voluntary justifies the prohibitions on assisted suicide we uphold here.

JUSTICE STEVENS, concurring in the judgments.

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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. That holding, however, does not foreclose the possibility that some applications of the statute might well be invalid.

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In *Cruzan v. Director, Mo. Dept. of Health* (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. . . . 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. . . . 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.

. . . [T]he 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. 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. In recognizing that the State's 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."

. . .

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." . . .

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,'" . . . 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.

. . . 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'" does not mean that the lives of terminally ill, disabled people have less value than the lives of those who are healthy. 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. . . .

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. . . .

. . .

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. For doctors who have longstanding 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, heeding a patient's desire to assist in her suicide would not serve to harm the physician-patient relationship. . . .

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. . . [A]lthough 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 . . . does not foreclose the possibility that some applications of the [Washington] statute may impose an intolerable intrusion on the patient's freedom.

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JUSTICE GINSBURG, concurring in the judgments

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JUSTICE BREYER, concurring in the judgments.

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. . . I would not reject the respondents' claim without considering a different formulation, for which our legal tradition may provide greater support. That formulation would use words roughly like a "right to die with dignity." But irrespective of the exact words used, at its core would lie personal control over the manner of death, professional medical assistance, and the avoidance of unnecessary and severe physical suffering—combined.

. . .

I do not believe, however, that this Court need or now should decide whether or a not such a right is "fundamental." That is because, in my view, the avoidance of severe physical pain (connected with death) would have to constitute an essential part of any successful claim and because, as Justice O'CONNOR points out, the laws before us do not *force* a dying person to undergo that kind of pain. Rather, the laws of New York and of Washington do not prohibit doctors from providing patients with drugs sufficient to control pain despite the risk that those drugs themselves will kill. And under these circumstances the laws of New York and Washington would overcome any remaining significant interests and would be justified, regardless.

. . .

Were the legal circumstances different—for example, were state law to prevent the provision of palliative care, including the administration of drugs as needed to avoid pain at the end of life—then the law's impact upon serious and otherwise unavoidable physical pain (accompanying death) would be more directly at issue. And as Justice O'CONNOR suggests, the Court might have to revisit its conclusions in these cases.