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

REHNQUIST, Chief Justice.

The question presented in this case is whether Washington's prohibition against "causing" or "aiding" a suicide offends the Fourteenth Amendment to the United States Constitution. We hold that it does not.

It has always been a crime to assist a suicide in the state of Washington. In 1854, Washington's first Territorial Legislature outlawed "assisting another in the commission of self-murder." Today, Washington law provides: "A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide." Wash. Rev. Code §9A.36.060(1) (1994). "Promoting a suicide attempt" is a felony, punishable by up to five years' imprisonment and up to a $10,000 fine. . . .

Petitioners in this case are the state of Washington and its Attorney General. Respondents Harold Glucksberg, M.D., Abigail Halperin, M.D., Thomas A. Preston, M.D., and Peter Shalit, M.D., are physicians who practice in Washington. These doctors occasionally treat terminally ill, suffering patients, and declare that they would assist these patients in ending their lives if not for Washington's assisted-suicide ban. In January 1994, respondents, along with three gravely ill, pseudonymous plaintiffs who have since died and Compassion in Dying, a nonprofit organization that counsels people considering physician-assisted suicide, sued in the United States district court, seeking a declaration that Wash. Rev. Code §9A.36.060(1) (1994) is, on its face, unconstitutional.

The plaintiffs asserted "the existence of a liberty interest protected by the Fourteenth Amendment which extends to a personal choice by a mentally competent, terminally ill adult to commit physician-assisted suicide." . . . [T]he district court agreed and concluded that Washington's assisted-suicide ban is unconstitutional because it "places an undue burden on the exercise of [that] constitutionally protected liberty interest." . . .

A panel of the court of appeals for the Ninth Circuit reversed. . . . Compassion in Dying v. Washington, 49 F.3d 586, 591 (1995). The Ninth Circuit reheard the case en banc, reversed the panel's decision, and affirmed the district court. Compassion in Dying v. Washington, 79 F.3d 790, 798 (1996). . . . The court . . . concluded that "the Constitution encompasses a due process liberty interest in controlling the time and manner of one's death . . . " [and] that the state's assisted-suicide ban was unconstitutional "as applied to terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians." . . . We granted certiorari and now reverse.

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. . . .

More specifically, for over 700 years, the Anglo-American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide. [The court continues by noting that English law initially treated suicide as a form of murder, with the person's real and personal property being forfeited to the king. Only the personal property was forfeited, however, if the suicide was motivated by serious illness. Beginning in 1701, the colonies, and later the states, rescinded their laws criminalizing suicide because of the unfairness to the decedent's family, rather than out of any acceptance of suicide.]

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. . . . And the prohibitions against assisting suicide never contained exceptions for those who were near death. . . . 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. . . .

The Washington statute at issue in this case, Wash. Rev. Code §9A.36.060 (1994), was enacted in 1975 as part of a revision of that state's criminal code. . . . In 1991, Washington voters rejected a ballot initiative which, had it passed, would have permitted a form of physician-assisted suicide. . . .

California voters rejected an assisted-suicide initiative similar to Washington's in 1993. On the other hand, in 1994, voters in Oregon enacted, also through ballot initiative, that state's "Death With Dignity Act," which legalized physician-assisted suicide for competent, terminally ill adults. Since the Oregon vote, many proposals to legalize assisted-suicide have been and continue to be introduced in the states' legislatures, but none has been enacted. And just last year, Iowa and Rhode Island joined the overwhelming majority of states explicitly prohibiting assisted suicide. . . .

Attitudes toward suicide itself have changed since [the thirteenth century], but our laws have consistently condemned, and continue to prohibit, assisting suicide. . . . 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*, 497 U.S., at 278-279.

But we "have 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." *Collins*, 503 U.S., at 125. 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," ibid., 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," *Moore*, 431 U.S. at 503 (plurality opinion), and "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if they were sacrificed," Palko v. Connecticut, 302 U.S. 319, 325, 326 (1937). Second, we have required in substantive-due-process cases a "careful description" of the asserted fundamental liberty interest. *Flores*, 507 U.S. at 302. . . .

Turning to the claim at issue here, the court of appeals stated that "properly analyzed, the first issue to be resolved is whether there is a liberty interest in determining the time and manner of one's death," or, in other words, "is there a right to die?" Similarly, respondents assert a "liberty to choose how to die" and a right to "control of one's final days," and describe the asserted liberty as "the right to choose a humane, dignified death," and "the liberty to shape death." . . .

Respondents contend that in *Cruzan* we "acknowledged that competent, dying persons have the right to direct the removal of life-sustaining medical treatment and thus hasten death" and that "the constitutional principle behind recognizing the patient's liberty to direct the withdrawal of artificial life support applies at least as strongly to the choice to hasten impending death by consuming lethal medication." . . .

The right assumed in *Cruzan*, however, 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. In *Cruzan* itself, we recognized that most states outlawed assisted suicide—and even more do today—and we certainly gave no intimation that the right to refuse unwanted medical treatment could be somehow transmuted into a right to assistance in committing suicide.

Respondents also rely on *Casey*. There, the Court's opinion concluded that "the essential holding of Roe v. Wade should be retained and once again reaffirmed." *Casey*, 505 U.S., at 846. . . . In reaching this conclusion, the opinion discussed in some detail this Court's substantive-due-process tradition of interpreting the due process clause to protect certain fundamental rights and "personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education," and noted that many of those rights and liberties "involve the most intimate and personal choices a person may make in a lifetime."

The court of appeals, like the district court, found *Casey* "highly instructive" and "almost prescriptive" for determining "what liberty interest may inhere in a terminally ill person's choice to commit suicide":

> "Like the decision of whether or not to have an abortion, the decision how and when to die is one of 'the most intimate and personal choices a person may make in a lifetime,' a choice 'central to personal dignity and autonomy.'" [79 F.3d, at 813-814.]

Similarly, respondents emphasize the statement in *Casey* that:

> "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." [*Casey*, 505 U.S., at 851.]

By choosing this language, the Court's opinion in *Casey* described, in a general way and in light of our prior cases, those personal activities and decisions that this Court has identified as so deeply rooted in our history and traditions, or so fundamental to our concept of constitutionally ordered liberty, that they are protected by the Fourteenth Amendment. The opinion moved from the recognition that liberty necessarily includes freedom of conscience and belief about ultimate considerations to the observation that "though the abortion decision may originate within the zone of conscience and belief, it is more than a philosophic exercise." *Casey*, 505 U.S., at 852. 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. As the court below recognized, 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. . . .

. . . The court of appeals also recognized Washington's interest in protecting life, but held that the "weight" of this interest depends on the "medical condition and the wishes of the person whose life is at stake." Washington, however, has rejected this sliding-scale approach and, through its assisted-suicide ban, insists that all persons' lives, from beginning to end, regardless of physical or mental condition, are under the full protection of the law. As we have previously affirmed, the states "may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy,"

Cruzan, 497 U.S., at 282. This remains true, as *Cruzan* makes clear, even for those who are near death.

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. The New York Task Force, however, expressed its concern that, because depression is difficult to diagnose, physicians and medical professionals often fail to respond adequately to seriously ill patients' needs. 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. In contrast to the court of appeals' conclusion that "the integrity of the medical profession would [not] be threatened in any way by [physician-assisted suicide]," the American Medical Association, like many other medical and physicians' groups, has concluded that "physician-assisted suicide is fundamentally incompatible with the physician's role as healer." American Medical Association, Code of Ethics §2.211 (1994). 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. . . . We have recognized [in *Cruzan*] . . . the real risk of subtle coercion and undue influence in end-of-life situations. . . . 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.

The state's interest here goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and "societal indifference." The state's assisted-suicide ban reflects and reinforces its policy that the lives of terminally ill, disabled, and elderly people must be no less valued than the lives of the young and healthy, and that a seriously disabled person's suicidal impulses should be interpreted and treated the same way as anyone else's.

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. . . . The court of appeals' decision, and its expansive reasoning, provide ample support for the state's concerns. The court noted, for example, that the "decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself," that "in some instances, the patient may be unable to self-administer the drugs and . . . administration by the physician . . . may be the only way the patient may be able to receive them,'" and that not only physicians,

but also family members and loved ones, will inevitably participate in assisting suicide. Thus, it turns out that what is couched as a limited right to "physician-assisted suicide" is likely, in effect, a much broader license, which could prove extremely difficult to police and contain.

This concern is further supported by evidence about the practice of euthanasia in the Netherlands. The Dutch government's own study revealed that in 1990, there were 2,300 cases of voluntary euthanasia (defined as "the deliberate termination of another's life at his request"), 400 cases of assisted suicide, and more than 1,000 cases of euthanasia without an explicit request. In addition to these latter 1,000 cases, the study found an additional 4,941 cases where physicians administered lethal morphine overdoses without the patients' explicit consent. This study suggests that, despite the existence of various reporting procedures, euthanasia in the Netherlands has not been limited to competent, terminally ill adults who are enduring physical suffering, and that regulation of the practice may not have prevented abuses in cases involving vulnerable persons, including severely disabled neonates and elderly persons suffering from dementia. . . . Washington, like most other states, reasonably ensures against this risk by banning, rather than regulating, assisting suicide.

We need not weigh exactingly the relative strengths of these various interests. They are unquestionably important and legitimate, and Washington's ban on assisted suicide is at least reasonably related to their promotion and protection. We therefore hold that Wash. Rev. Code §9A.36.060(1) (1994) does not violate the Fourteenth Amendment, either on its face or "as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors." 79 F.3d, at 838.[24]

. . . 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. The decision of the en banc court of appeals is reversed, and the case is remanded for further proceedings consistent with this opinion. . . .

Vacco v. Quill
521 U.S. 793 (1997)

REHNQUIST, Chief Justice.

In New York, as in most states, it is a crime to aid another to commit or attempt suicide, but patients may refuse even lifesaving medical treatment. The question presented by this case is whether New York's prohibition on assisting

24. . . . We emphasize that we today reject the court of appeals' specific holding that the statute is unconstitutional "as applied" to a particular class. Justice Stevens agrees with this holding, but would not "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." Our opinion does not absolutely foreclose such a claim. However, given our holding that the due process clause of the Fourteenth Amendment does not provide heightened protection to the asserted liberty interest in ending one's life with a physician's assistance, such a claim would have to be quite different from the ones advanced by respondents here.

suicide therefore violates the equal protection clause of the Fourteenth Amendment. We hold that it does not.

Petitioners are various New York public officials. Respondents Timothy E. Quill, Samuel C. Klagsbrun, and Howard A. Grossman are physicians who practice in New York. They assert that although it would be "consistent with the standards of [their] medical practices" to prescribe lethal medication for "mentally competent, terminally ill patients" who are suffering great pain and desire a doctor's help in taking their own lives, they are deterred from doing so by New York's ban on assisting suicide. Respondents, and three gravely ill patients who have since died, sued the state's Attorney General in the United States district court. They urged that because New York permits a competent person to refuse life-sustaining medical treatment, and because the refusal of such treatment is "essentially the same thing" as physician-assisted suicide, New York's assisted-suicide ban violates the equal protection clause.

The district court disagreed: "It is hardly unreasonable or irrational for the state to recognize a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing device." . . .

The court of appeals for the Second Circuit reversed. The court determined that, despite the assisted-suicide ban's apparent general applicability, "New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths," because "those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs." . . . We granted certiorari and now reverse.

The equal protection clause commands that no state shall "deny to any person within its jurisdiction the equal protection of the laws." This provision creates no substantive rights. Instead, it embodies a general rule that states must treat like cases alike but may treat unlike cases accordingly. If a legislative classification or distinction "neither burdens a fundamental right nor targets a suspect class, we will uphold [it] so long as it bears a rational relation to some legitimate end." Romer v. Evans, 517 U.S. (slip op., at 10) (1996).

New York's statutes outlawing assisting suicide affect and address matters of profound significance to all New Yorkers alike. They neither infringe fundamental rights nor involve suspect classifications. These laws are therefore entitled to a "strong presumption of validity." Heller v. Doe, 509 U.S. 312, 319 (1993).

On their faces, neither New York's ban on assisting suicide nor its statutes permitting patients to refuse medical treatment treat anyone differently than anyone else or draw any distinctions between persons. Everyone, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; no one is permitted to assist a suicide. Generally speaking, laws that apply evenhandedly to all "unquestionably comply" with the equal protection clause. New York City Transit Authority v. Beazer, 440 U.S. 568, 587 (1979).

The court of appeals, however, concluded that some terminally ill people—those who are on life-support systems—are treated differently than those who are not, in that the former may "hasten death" by ending treatment, but

the latter may not "hasten death" through physician-assisted suicide. This conclusion depends on the submission that ending or refusing lifesaving medical treatment "is nothing more nor less than assisted suicide." Unlike the court of appeals, we think the distinction between assisting suicide and withdrawing life-sustaining treatment, a distinction widely recognized and endorsed in the medical profession and in our legal traditions, is both important and logical; it is certainly rational.

The distinction comports with fundamental legal principles of causation and intent. First, when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication.

Furthermore, a physician who withdraws, or honors a patient's refusal to begin, life-sustaining medical treatment purposefully intends, or may so intend, only to respect his patient's wishes and "to cease doing useless and futile or degrading things to the patient when [the patient] no longer stands to benefit from them." Assisted Suicide in the United States, Hearing before the Subcommittee on the Constitution of the House Committee on the Judiciary, 104th Cong., 2d Sess., 368 (1996) (testimony of Dr. Leon R. Kass). The same is true when a doctor provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain. A doctor who assists a suicide, however, "must, necessarily and indubitably, intend primarily that the patient be made dead." Id. at 367. Similarly, a patient who commits suicide with a doctor's aid necessarily has the specific intent to end his or her own life, while a patient who refuses or discontinues treatment might not.

The law has long used actors' intent or purpose to distinguish between two acts that may have the same result. Put differently, the law distinguishes actions taken "because of" a given end from actions taken "in spite of" their unintended but foreseen consequences. . . .

Given these general principles, it is not surprising that many courts, including New York courts, have carefully distinguished refusing life-sustaining treatment from suicide. . . . Similarly, the overwhelming majority of state legislatures have drawn a clear line between assisting suicide and withdrawing or permitting the refusal of unwanted lifesaving medical treatment by prohibiting the former and permitting the latter. . . .

For all these reasons, we disagree with respondents' claim that the distinction between refusing lifesaving medical treatment and assisted suicide is "arbitrary" and "irrational." Granted, in some cases, the line between the two may not be clear, but certainty is not required, even were it possible. Logic and contemporary practice support New York's judgment that the two acts are different, and New York may therefore, consistent with the Constitution, treat them differently. By permitting everyone to refuse unwanted medical treatment while prohibiting anyone from assisting a suicide, New York law follows a longstanding and rational distinction.

New York's reasons for recognizing and acting on this distinction—including prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians' role as their patients' healers; protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to

end their lives; and avoiding a possible slide towards euthanasia—are discussed in greater detail in our opinion in *Glucksberg*. These valid and important public interests easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end.

The judgment of the court of appeals is reversed. . . .

O'CONNOR, Justice, concurring.*

Death will be different for each of us. For many, the last days will be spent in physical pain and perhaps the despair that accompanies physical deterioration and a loss of control of basic bodily and mental functions. Some will seek medication to alleviate that pain and other symptoms.

The Court frames the issue in this case as whether the due process clause of the Constitution protects a "right to commit suicide which itself includes a right to assistance in doing so," and concludes that our nation's history, legal traditions, and practices do not support the existence of such a right. I join the Court's opinions because I agree that there is no generalized right to "commit suicide." But respondents urge us to address the narrower question whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent death. I see no need to reach that question in the context of the facial challenges to the New York and Washington laws at issue here. The parties and amici agree that in these states a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death. In this light, even assuming that we would recognize such an interest, I agree that the 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. As the Court recognizes, states are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues. In such circumstances, "the . . . challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the 'laboratory' of the states . . . in the first instance." Cruzan v. Director, Missouri Department of Health, 497 U.S. 261, 292 (1990) (O'Connor, J., concurring) (citing New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932)). . . .

STEVENS, Justice, 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

*Justice Ginsburg concurs in the Court's judgments substantially for the reasons stated in this opinion. Justice Breyer joins this opinion except insofar as it joins the opinions of the Court.

"morality, legality, and practicality of physician-assisted suicide" in a democratic society. 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.

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, Florida, and Texas. 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.

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. . . .

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." The state 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. . . .

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. . . .

. . . 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. . . .

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. 443, 454 (1997) ("Greater use of palliative care would reduce the demand for assisted suicide, but it will not eliminate [it]"). 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. 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, 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.

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 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. . . .