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The U.S. Supreme Court's 1997 Decisions on Assisted Suicide

In 1997 the U.S. Supreme Court upheld two state laws absolutely prohibiting assisted suicide. The Court found that Washington state's law does not violate constitutional guarantees of "liberty" (*Washington v. Glucksberg*) and that New York's similar law does not violate constitutional guarantees of equal protection (*Vacco v. Quill*).

The Court did not decide whether a state may *permit* assisted suicide under the U.S. Constitution. Oregon's 1994 law permitting assisted suicide for certain patients had been found by one federal district court to violate equal protection; that ruling was not before the Supreme Court. See *Lee v. Oregon*, 891 F.Supp. 1429 (D. Or. 1995), *vacated on other grounds*, 107 F.3d 1382 (9th Cir. 1997), *cert. denied*, 118 S. Ct. 328 (1997). As Chief Justice Rehnquist said in his majority opinion in *Glucksberg*: "*Lee*, of course, is not before us... and we offer no opinion as to the validity of the *Lee* courts' reasoning. In *Vacco v. Quill*..., however, decided today, we hold that New York's assisted-suicide *ban* does *not* violate the Equal Protection clause." *Washington v. Glucksberg*, 521 U.S. 702 (1997) at 709 n. 7 (emphasis added). To this day no appellate court in the country has ruled on the constitutionality of a law like Oregon's.

The Court also did not say that only state legislatures may address this issue. In reviewing the Nation's longstanding tradition against assisted suicide, it cited federal enactments such as the Assisted Suicide Funding Restriction Act of 1997 alongside state laws. Illustrating the government's interest in protecting terminally ill patients, the Court favorably cited an earlier decision upholding the federal Food and Drug Administration's authority "to protect the terminally ill, no less than other patients," from life-endangering drugs. 521 U.S. at 729, quoting *United States v. Rutherford*, 442 U.S. 544, 558 (1979).

What the Court did rule is that laws prohibiting assisted suicide (whether state or federal) are constitutionally valid and serve several important and legitimate interests. Excerpts follow:

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

The question presented in this case is whether Washington's prohibition against "caus[ing]" or "aid[ing]" a suicide offends the Fourteenth Amendment to the United States Constitution. We hold that it does not. [521 U.S. at 705-6.]

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. [*Id.* at 710-11.]

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. [*Id.* at 723.]

…Washington's assisted-suicide ban implicates a number of state interests... First, Washington has an "unqualified interest in the preservation of human life." *Cruzan*, 497 U.S., at 282. The State's prohibition on assisted suicide, like all homicide laws, both reflects and advances its commitment to this interest. [*Id.* at 728.]

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. [*Id.* at 729-30.]

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. [*Id.* at 730.]

[L]egal 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. [*Id.* at 731.]

The State also has an interest in protecting the integrity and ethics of the medical profession... 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. [*Id.* at 731.]

Next, the State has an interest in protecting vulnerable groups -- including the poor, the elderly, and disabled persons -- from abuse, neglect, and mistakes. The Court of Appeals dismissed the State's concern that disadvantaged persons might be pressured into physician-assisted suicide as "ludicrous on its face."... We have recognized, however, the real risk of subtle coercion and undue influence in end-of-life situations. *Cruzan*, 497 U.S., at 281. Similarly, the New York Task Force warned that "[l]egalizing physician-assisted suicide would pose profound risks to many individuals who are ill and vulnerable... The risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group." ... 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. [*Id.* at 731-2.]

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." 49 F. 3d, at 592. 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. [*Id.* at 732.]

Finally, the State may fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia… [I]t 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. Washington's ban on assisting suicide prevents such erosion. [*Id.* at 732-3.]

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

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. [521 U.S. at 800.]

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. [*Id.* at 800-801.]

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. [*Id.* at 801.]

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. [*Id.* at 801-2.]

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. [*Id.* at 808.]