U.S. Supreme Court

Syllabus

VACCO, ATTORNEY GENERAL OF NEW YORK, et al. v. QUILL et al.

certiorari to the united states court of appeals for the second circuit

No. 95-1858.
Argued January 8, 1997
Decided June 26, 1997

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. Respondent New York physicians 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 assisted suicide ban. They, and three gravely ill patients who have since died, sued the State's Attorney General, claiming that the ban violates the Fourteenth Amendment's Equal Protection Clause. The Federal District Court disagreed, but the Second Circuit reversed, holding (1) that New York accords different treatment to those competent, terminally ill persons who wish to hasten their deaths by self administering prescribed drugs than it does to those who wish to do so by directing the removal of life support systems, and (2) that this supposed unequal treatment is not rationally related to any legitimate state interests.

Held: New York's prohibition on assisting suicide does not violate the Equal Protection Clause. Pp. 3-14.

(a) The Equal Protection Clause embodies a general rule that States must treat like cases alike but may treat unlike cases accordingly. E.g., Plyler v. Doe, 457 U.S. 202, 216 . The New York statutes outlawing assisted suicide neither infringe fundamental rights nor involve suspect classifications, e.g., Washington v. Glucksberg, ante, at 14-24, and are therefore entitled to a strong presumption of validity, Heller v. Doe, 509 U.S. 312, 319 . On their faces, neither the assisted suicide ban nor the law permitting patients to refuse medicaltreatment treats anyone differently from anyone else or draws 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, laws that apply evenhandedly to all unquestionably comply with equal protection. E.g., New York City Transit Authority v. Beazer, 440 U.S. 568, 587 . This Court disagrees with the Second Circuit's submission that ending or refusing lifesaving medical treatment "is nothing more nor less than assisted suicide." The distinction between letting a patient die and making that patient die is important, logical, rational, and well established: It comports with fundamental legal principles of causation, see, e.g., People v. Kevorkian, 447 Mich. 436, 470-472, 527 N. W. 2d 714, 728, cert. denied, 514 U.S. 1083 , and intent, see, e.g., United States v. Bailey, 444 U.S. 394, 403 -406; has been recognized, at least implicitly, by this Court in Cruzan v. Director, Mo. Dept. of Health, 497 U.S. 261, 278 -280; id., at 287-288 (O'Connor, J., concurring); and has been widely recognized and endorsed in the medical profession, the state courts, and the overwhelming majority of state legislatures, which, like New York's, have permitted the former while prohibiting the latter. The Court therefore disagrees with respondents' claim that the distinction is "arbitrary" and "irrational." The line between the two acts may not always 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. Pp. 3-13.

(b) New York's reasons for recognizing and acting on the distinction between refusing treatment and assisting a suicide--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 valid and important public interests that easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end. See Glucksberg, ante. Pp. 13-14.

80 F. 3d 716, reversed.

Rehnquist, C. J., delivered the opinion of the Court, in which O'Connor, Scalia, Kennedy, and Thomas, JJ., joined. O'Connor, J., filed a concurring opinion, in which Ginsburg and Breyer, JJ., joined in part. Stevens, J., Souter, J., Ginsburg, J., and Breyer, J., filed opinions concurring in the judgment.

U.S. Supreme Court

No. 95-1858

DENNIS C. VACCO, ATTORNEY GENERAL OF NEW YORK, et al., PETITIONERS v. TIMOTHY E. QUILL et al.

on writ of certiorari to the united states court of appeals for the second circuit

[June 26, 1997]

Chief Justice Rehnquist delivered the opinion of the Court.

In New York, as in most States, it is a crime to aid another to commit or attempt suicide, 1 but patients may refuse even lifesaving medical treatment. 2 The question presented by this case is whether New York's prohibition on assisting 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 practice[s]" 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. App. 25-26. 3 Respondents, and three gravely ill patients who have since died, 4 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. Quill v. Koppell, 870 F. Supp. 78, 84-85 (SDNY 1994).

The District Court disagreed: "[I]t 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." Id., at 84. The court noted New York's "obvious legitimate interests in preserving life, and in protecting vulnerable persons,"and concluded that "[u]nder the United States Constitution and the federal system it establishes, the resolution of this issue is left to the normal democratic processes within the State." Id., at 84-85.

The Court of Appeals for the Second Circuit reversed. 80 F. 3d 716 (1996). 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." Id., at 727, 729. In the court's view, "[t]he ending of life by [the withdrawal of life support systems] is nothing more nor less than assisted suicide." Id., at 729 (emphasis added) (citation omitted). The Court of Appeals then examined whether this supposed unequal treatment was rationally related to any legitimate state interests, 5 and concluded that "to the extent that [New York's statutes] prohibit a physician from prescribing medications to be self administered by a mentally competent, terminally ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest." Id., at 731. We granted certiorari, 518 U. S. ___ (1996), 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 nosubstantive rights. San Antonio Independent School Dist. v. Rodriguez, 411 U.S. 1, 33 (1973); id., at 59 (Stewart, J., concurring). Instead, it embodies a general rule that States must treat like cases alike but may treat unlike cases accordingly. Plyler v. Doe, 457 U.S. 202, 216 (1982) (" `[T]he Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same' ") (quoting Tigner v. Texas, 310 U.S. 141, 147 (1940)). 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. Washington v. Glucksberg, ante, at 15-24; see 80 F. 3d, at 726; San Antonio School Dist., 411 U.S., at 28 ("The system of alleged discrimination and the class it defines have none of the traditional indicia of suspectness"); id., at 33-35 (courts must look to the Constitution, not the "importance" of the asserted right, when deciding whether an asserted right is "fundamental"). 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); see Personnel Administrator of Mass. v. Feeney, 442 U.S. 256, 271 -273 (1979) ("[M]any [laws] affect certain groups unevenly, even though the law itself treats them no differently from all other members of the class described by the law").

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. 80 F. 3d, at 729. This conclusion depends on the submission that ending or refusing lifesaving medical treatment "is nothing more nor less than assisted suicide." Ibid. 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 6 and in our legal traditions, is bothimportant and logical; it is certainly rational. See Feeney, supra, at 272 ("When the basic classification is rationally based, uneven effects upon particular groups within a class are ordinarily of no constitutional concern").

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. See, e.g., People v. Kevorkian, 447 Mich. 436, 470-472, 527 N. W. 2d 714, 728 (1994), cert. denied, 514 U.S. 1083 (1995); Matter of Conroy, 98 N. J. 321, 355, 486 A. 2d 1209, 1226 (1985) (when feeding tube is removed, death "result[s] . . . from [the patient's] underlying medical condition"); In re Colyer, 99 Wash. 2d 114, 123, 660 P. 2d 738, 743 (1983) ("[D]eath which occurs after the removal of life sustaining systems is from natural causes"); American Medical Association, Council on Ethical and Judicial Affairs, Physician Assisted Suicide, 10 Issues in Law & Medicine 91, 92 (1994) ("When a life sustaining treatment is declined, the patient dies primarily because of an underlying disease").

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 maybe, 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. See, e.g., Matter of Conroy, supra, at 351, 486 A. 2d, at 1224 (patients who refuse life sustaining treatment "may not harbor a specific intent to die" and may instead "fervently wish to live, but to do so free of unwanted medical technology, surgery, or drugs"); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 743, n. 11, 370 N. E. 2d 417, 426, n. 11 (1977) ("[I]n refusing treatment the patient may not have the specific intent to die").

The law has long used actors' intent or purpose to distinguish between two acts that may have the same result. See, e.g., United States v. Bailey, 444 U.S. 394, 403 -406 (1980) ("[T]he . . . common law of homicide often distinguishes . . . between a person who knows that another person will be killed as the result of his conduct and a person who acts with the specific purpose of taking another's life"); Morissette v. United States, 342 U.S. 246, 250 (1952) (distinctions based on intent are "universal and persistent in mature systems of law"); M. Hale, 1 Pleas of the Crown 412 (1847) ("If A., with an intent to prevent gangrene beginning in his hand doth without any advice cut off his hand, by which he dies, he is not thereby felo de se for tho it was a voluntary act, yet it was not with an intent to kill himself"). Put differently, the law distinguishes actions taken "because of" a given end from actions taken "in spite of" their unintended but foreseen consequences. Feeney, 442 U.S., at 279 ; Compassion in Dying v. Washington, 79 F. 3d 790, 858 (CA9 1996) (Kleinfeld, J., dissenting) (%When General Eisenhower ordered American soldiers onto the beaches of Normandy, he knew that he wassending many American soldiers to certain death . . . . His purpose, though, was to . . . liberate Europe from the Nazis").

Given these general principles, it is not surprising that many courts, including New York courts, have carefully distinguished refusing life sustaining treatment from suicide. See, e.g., Fosmire v. Nicoleau, 75 N. Y. 2d 218, 227, and n. 2, 551 N. E. 2d 77, 82, and n. 2 (1990) ("[M]erely declining medical . . . care is not considered a suicidal act"). 7 In fact, the first state court decision explicitly to authorize withdrawing lifesaving treatment noted the "real distinction between the self infliction of deadly harm and a self determination against artificial life support." In re Quinlan, 70 N. J. 10, 43, 52, and n. 9, 355 A. 2d 647, 665, 670, and n. 9, cert. denied sub nom. Garger v. New Jersey, 429 U.S. 922 (1976). And recently, the Michigan Supreme Court also rejected the argument that the distinction "between acts that artificially sustain life and acts that artificially curtail life" is merely a "distinction without constitutional significance--a meaningless exercise in semantic gymnastics," insisting that "the Cruzan majority disagreed and so do we." Kevorkian, 447 Mich., at 471, 527 N. W. 2d, at 728. 8

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. Glucksberg, ante, at 4-6, 11-15. And "nearly all states expressly disapprove ofsuicide and assisted suicide either in statutes dealing with durable powers of attorney in health care situations, or in `living will' statutes." Kevorkian, 447 Mich., at 478-479, and nn. 53-54, 527 N. W. 2d, at 731-732, and nn. 53-54. 9 Thus, even as the States move toprotect and promote patients' dignity at the end of life, they remain opposed to physician assisted suicide.

New York is a case in point. The State enacted its current assisted suicide statutes in 1965. 10 Since then, New York has acted several times to protect patients' common law right to refuse treatment. Act of Aug. 7, 1987, ch. 818, §1, 1987 N. Y. Laws 3140 ("Do Not Resuscitate Orders") (codified as amended at N. Y. Pub. Health Law §§2960-2979 (McKinney 1994 and Supp. 1997)); Act of July 22, 1990, ch. 752, §2, 1990 N. Y. Laws 3547 ("Health Care Agents and Proxies") (codified as amended at N. Y. Pub. Health Law §§2980-2994 (McKinney 1994 and Supp. 1997)). In so doing, however, the State has neither endorsed a general right to "hasten death" nor approved physician assisted suicide. Quite the opposite: The State has reaffirmed the line between "killing" and "letting die." See N. Y. Pub. Health Law §2989(3) (McKinney 1994) ("This article is not intended to permit or promote suicide, assisted suicide, or euthanasia"); New York State Task Force on Life and the Law, Life Sustaining Treatment: Making Decisions and Appointing a Health Care Agent 36-42 (July 1987); Do Not Resuscitate Orders: The Proposed Legislation and Report of the New York State Task Force on Life and the Law 15 (Apr. 1986). More recently, the New York State Task Force on Life and the Law studied assisted suicide and euthanasia and, in1994, unanimously recommended against legalization. When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context vii (1994). In the Task Force's view, "allowing decisions to forego life sustaining treatment and allowing assisted suicide or euthanasia have radically different consequences and meanings for public policy." Id., at 146.

This Court has also recognized, at least implicitly, the distinction between letting a patient die and making that patient die. In Cruzan v. Director, Mo. Dept. of Health, 497 U.S. 261, 278 (1990), we concluded that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions," and we assumed the existence of such a right for purposes of that case, id., at 279. But our assumption of a right to refuse treatment was grounded not, as the Court of Appeals supposed, on the proposition that patients have a general and abstract "right to hasten death," 80 F. 3d, at 727-728, but on well established, traditional rights to bodily integrity and freedom from unwanted touching, Cruzan, 497 U.S., at 278 -279; id., at 287-288 (O'Connor, J., concurring). In fact, we observed that "the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." Id., at 280. Cruzan therefore provides no support for the notion that refusing life sustaining medical treatment is "nothing more nor less than suicide."

For all these reasons, we disagree with respondents' claim that the distinction between refusing lifesaving medical treatment and assisted suicide is "arbitrary" and "irrational." Brief for Respondents 44. 11 Granted, insome cases, the line between the two may not be clear, but certainty is not required, even were it possible. 12 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; maintainingphysicians' 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, ante. These valid and important public interests easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end. 13

The judgment of the Court of Appeals is reversed.

It is so ordered.

U.S. Supreme Court

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

95-1858v.

TIMOTHY E. QUILL et al.

on writ of certiorari to the united states court of appeals for the second circuit

[June 26, 1997]

Justice O'Connor, 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," ante, at 18, 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. See ante, at 18 ("The Washington statute at issue in this case prohibits `aid[ing] another person to attempt suicide,'. . . and, thus, the question before us is whether the `liberty' specially protected by the Due Process Clause includes a right to commit suicide which itself includes a right to assistance in doing so"). 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. See Wash. Rev. Code §70.122.010 (1994); Brief for Petitioners in No. 95-1858, p. 15, n. 9; Brief for Respondents in No. 95-1858, p. 15. 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. Ante, at 27-30; post, at 11 (Stevens, J., concurring in judgments); post, at 33-39 (Souter, J., concurring in judgment).

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 terminallyill, 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. Ante, at 11, 12-13; see post, at 36-39 (Souter, J., concurring in judgment). 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, Mo. Dept. 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)).

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.

U.S. Supreme Court

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

95-1858v.

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.

The morality, legality, and practicality of capital punishment have been the subject of debate for many years. In 1976, this Court upheld the constitutionality ofthe 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. 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 the Court doesnot 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 has an interest in preserving andfostering 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.

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 Courtcorrectly 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 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 beclear 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 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 tradition. The character of the Court's language inthese 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.

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. Allowingthe 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.

Relatedly, the State and amici express the concern that patients whose physical pain is inadequately treatedwill 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 DecisionMaking, 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 suicideis 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.

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 constitutionallysufficient 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 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 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.