

WASHINGTON v. GLUCKSBERG (1997)

Background

The State of Washington has always had a law making it a crime (a felony, punishable by up to 5 years' imprisonment and up to a \$10,000 fine) to help someone commit suicide. In 1994, Harold Glucksberg and three other physicians, along with three terminally ill patients, sued the State in Federal Court, alleging that the assisted-suicide ban violates patients' right to liberty under the DP Clause of the Fourteenth Amendment. Glucksberg won in Federal District Court, and the lower court decision was affirmed by the Ninth Circuit Court of Appeals. The State of Washington appealed the Ninth Circuit's decision to the U.S. Supreme Court, which decided the case in the State's favor in 1997.

Five Justices signed Rehnquist's opinion for the majority (Rehnquist, Scalia, Kennedy, O'Connor, and Thomas). Four Justices (Stevens, Souter, Ginsburg, and Breyer) wrote concurring opinions. There were no dissenting opinions.

Rehnquist's Opinion

Legal History

Rehnquist spends a good chunk of his opinion reviewing the relevant legal history. The point of all this is to emphasize that "in almost every State—indeed, in almost every western democracy—it is a crime to assist a suicide." Rehnquist concludes that assisted-suicide bans, even in the case of terminally ill persons in terrible irremediable pain, are "deeply rooted in this Nation's history and tradition." Rehnquist acknowledges that efforts are now under way in several States to revoke these laws, but notes that they have been rebuffed in all but one State: Oregon.

Why There is no Fundamental Right at Issue in Glucksberg

Rehnquist acknowledges that, in a long string of "right to privacy" cases, the Court has found a fundamental right to privacy that includes the right to marry, to have children, to direct the education and upbringing of one's children, to use contraceptives, and to decide to terminate one's pregnancy. In addition, he acknowledges that the Court's *Cruzan* decision strongly suggests that the DP Clause protects a person's right to refuse unwanted medical treatment.

Whether a right counts as fundamental depends on whether it is "deeply rooted in this Nation's history and tradition" (*Moore* criterion) AND "implicit in the concept of ordered liberty" (*Palko* criterion).

[Notice that Rehnquist has conjoined the *Moore* and *Palko* criteria into a single criterion of fundamentality. The effect of this is to make it much more *difficult* to find that such-and-such a right is fundamental.]

[Notice also that the United States does not, in fact, have a long tradition of respecting the right to marry the person of one's choice (anti-miscegenation laws), to have children (sterilization of "habitual" criminals), to use contraceptives, or to obtain an abortion. The *only* way to uphold these rights against State intrusion is to apply the *Palko* criterion of fundamentality and *not to apply* the *Moore* criterion. So Rehnquist's conjunctive criterion of fundamentality simply does not make sense of prior "right to privacy" cases.]

Given the legal history of assisted-suicide bans, Rehnquist concludes that the right to assistance in committing suicide is not deeply rooted in this Nation's history and tradition, and then infers that the right to this sort of assistance is not fundamental.

Distinguishing Glucksberg from Cruzan

According to Rehnquist, *Cruzan* stands for the principle that people have a right to refuse unwanted medical treatment. But, so he claims, this principle "was not simply deduced from abstract concepts of personal autonomy," but rather from the common law rule that forcing medication on an unwilling patient is a form of battery (intentionally causing harmful or offensive contact), and from the long history of respect for the principle.

Thus, Rehnquist denies that *Cruzan* stands for a more general principle to the effect that people have a fundamental right of autonomy, i.e., a right to make decisions about intimate and personal matters (and carry them out).

[Note: For Rehnquist, the U.S. Constitution is not a constitution of principle, but rather a constitution of detail: the Constitution protects this right and that right, but not on the basis of any overarching principle. This is an unfortunate way of approaching the Constitution. As I have tried to argue, it is the business of the U.S Supreme Court to make the best sense of past judicial decisions in light of moral principle. Surely the most theoretically satisfying way of doing this is to understand all of the rights mentioned in the "right to privacy" line of cases as deriving from a single, overarching moral right to autonomy in crucial intimate matters.]

Rehnquist also insists that the right to assistance in committing suicide cannot be inferred from the right to refuse unwanted medical treatment.

"The two acts [namely, assisting a suicide and refusing artificial nutrition and hydration] are widely and reasonably regarded as quite distinct."

[Note: Given that the acts are clearly distinct, it can't be that Glucksberg is arguing that they are the same. Rather, Glucksberg's argument is that, when a patient is terminally ill and in great irremediable pain, there is no morally significant difference between (i) allowing him to die as result of his refusal to be intubated and (ii) helping him commit suicide. In both cases, the patient chooses to die, the physician's conduct is aimed at the patient's death for his own good, and the end result is the same. Rehnquist offers us no reason to believe that there is a morally significant difference between these cases (see the Philosophers' Brief, Section IIB).

Note further that the fact that there is no morally significant difference between (i) and (ii) does not entail that there is no morally significant difference between killing and letting die, or, more generally, between doing harm and allowing it to occur. There are cases that clearly establish that, e.g., killing is morally worse than letting die. Thus, as the Philosophers' Brief argues: "When several patients need organ transplants and organs are scarce..., it is morally permissible for a doctor to deny an organ to one patient, even though he will die without it, in order to give it to another. But it is certainly not permissible for a doctor to kill a patient in order to use his organs to save another." But, in these cases, the persons who die do not want to die. Matters are quite different in assisted suicide cases.]

Distinguishing Glucksberg from Casey

Rehnquist acknowledges that *Casey* does include language that suggests that the right to decide to terminate one's pregnancy is grounded in a more basic right "to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life," and that this right to liberty concerns "the most intimate and personal choices a person may make in a lifetime," choices that are "central to personal dignity and autonomy." Parity of reasoning would then appear to suggest that terminally ill patients in great irremediable agony have a right to assistance in committing suicide, a right that clearly concerns an intimate and personal choice that is central to personal dignity and autonomy, a right to define the arc of one's life by directing how it shall end.

But Rehnquist denies this, claiming that the *Casey* Court was not trying to protect "any and all important, intimate, and personal decisions" from State interference.

[Note: What, then, is the point of the Sweet-Mystery-of-Life passages in *Casey*? Do you think that the *Casey* Court was merely interested in using this sweeping language to justify recognition of a limited number of rights to make decisions relating to intimate and personal matters? This doesn't make sense. The *Casey* Court was trying to explain what justifies the right to decide whether to terminate one's pregnancy. The very same explanation also justifies the right to assistance in determining the time and manner of one's own death.]

The Proper Test: Rational Basis

Given that the right to assistance in committing suicide is, at best, non-fundamental, it follows that the Rational Basis test applies to any law that infringes it. According to this test, a law that infringes a non-fundamental right is constitutionally acceptable as long as it is rationally related to a legitimate government interest.

Rehnquist lists six legitimate interests that would be rationally achieved by means of an assisted-suicide ban.

1. Interest in the preservation of human life *per se*.

Rehnquist says that this is not an interest in preserving the quality of human life, nor is it an interest in respecting a person's decision to fight death. It is an interest in protecting human life for its own sake, presumably on the grounds that human life is intrinsically valuable.

But surely an interest in preserving human life *for its own sake, independently of the stable, informed, and considered views of the person to whom life belongs*, is not legitimate. There is nothing legitimate about preserving the life of a terminally ill patient in great irremediable pain who, in full possession of all her mental faculties and with complete mastery of all pertinent facts, judges that she would rather die than eke out a miserable, painful, undignified, and pointless existence in the few weeks or months before her inevitable demise. This is pure cruelty, plain and simple.

2. Interest in protecting depressed or mentally ill persons, or those who are suffering from untreated pain, from suicidal impulses.

But, as the Philosophers' Brief argues, this is a sufficient reason to regulate, not a sufficient reason to ban, assisted suicide. Even if patients have a fundamental right to determine the time and manner of their deaths, the State does have a compelling interest in protecting persons from the results of decisions that they would never have made if sane and mentally sound. This is good enough reason to establish safeguards, even elaborate measures, designed to protect people from their own wrongheaded decisions.

3. Interest in protecting the integrity and ethics of the medical profession.

Rehnquist claims that "physician assisted suicide could...undermine the trust that is essential to the doctor patient relationship by blurring the time honored line between healing and harming."

Rehnquist's point seems to be that widespread knowledge of the availability of physician-assisted suicide will lead people to think that the medical profession does not have the best interests of patients at heart. But this is preposterous. Surely everyone understands, or could easily be brought to understand, the difference between helping to end the life of a terminally ill person in great pain who wants to die, and helping to end the life of a person who is not ill, not in pain, and does not want to die. Only those who can't make distinctions would suppose that a doctor who is ready to help in the first way is also ready to help in the second. Analogy: Does our knowledge that police officers are prepared to shoot armed and dangerous fugitives in self-defense undermine our trust in the police? Surely not. We do not suppose, as we could if we couldn't make distinctions, that a police officer who is ready to shoot armed fugitives in self-defense is also ready to shoot unarmed innocent bystanders for the fun of it.

4. Interest in protecting vulnerable groups (particularly, the poor, the elderly, and the disabled) from coercion.

Rehnquist worries that the friends and family of those who are terminally ill and in great pain will engage in subtle coercion designed to hasten their deaths. He also worries that, even in the absence of coercion, “many [terminally ill patients] might resort to [physician assisted suicide] to spare their families the substantial financial burden of end of life health care costs.”

In the Philosophers’ Brief, we find two responses to this worry. The first is that there are ways to regulate physician assisted suicide to minimize the chances of coercion. For example, there might be evidence that strongly suggests that a patient’s decision to commit suicide is the product of a stable and long-standing commitment to end his life on his own terms, regardless of the views of those around him. The second is that the basis of a rational person’s choice to end his own life rather than face a miserable death is none of the State’s business. It is not up to the State to decide for me whether sparing my family the crushing burden of end of life health care costs is an inappropriate reason to hasten my death by a few weeks or months. That is for me to decide.

In *Cruzan*, the Court required clear and convincing evidence of a patient’s considered refusal of life-sustaining treatment before granting his wish to pull the plug. Why not, at the very least, require the same sort of evidence in assisted suicide cases? As the Philosophers’ Brief notes, there is as much of a risk of subtle coercion in treatment-refusal cases as there is in assisted-suicide cases. Surely a State that finds certain safeguards sufficient to guard against subtle coercion in the former cases will also find these safeguards sufficient to guard against subtle coercion in the latter cases.

5. Interest in protecting vulnerable groups from negative stereotypes and societal indifference.

Rehnquist claims that “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.”

I see. And I presume that forcing a terminally ill, disabled, elderly person to die in unrelievable agony when his carefully considered and strongly held belief is that his life will be irreparably marred if he cannot choose to die in peace reflects the policy that his life has value. What rot! What it reflects, more than anything, is profound disrespect for a choice that is his to make.

Rehnquist is worried that assisted suicide will perpetuate the stereotype that the lives of the terminally ill, the disabled, and the elderly are not worth saving. But this is just silly. Our entire health care system is built to err on the side of life. There is no reason to think that ER nurses and doctors will stop resuscitating

elderly, disabled, or terminally ill patients once the ban on assisted suicide is lifted. If anything, as the Philosophers' Brief points out, the existence of a ban on assisted suicide represents more of a risk to the lives of these patients. For doctors who know that resuscitating a terminally ill and elderly patient who does not have the option of ending his life on his own terms will result in his slow, lingering, painful death may choose not to work as hard to resuscitate him as they would work to resuscitate a young and healthy patient.

6. Interest in avoiding a slippery slope from the legalization of assisted suicide to the legalization of voluntary, and perhaps even involuntary, euthanasia.

This is probably the concern that most worries Rehnquist and his fellow Justices. Once you allow physician assisted suicide for terminally ill patients in irremediable pain who choose to die, doesn't this open the door to allowing physician assisted suicide for

- (a) terminally ill patients who choose to die, but who are not in irremediable pain
- (b) patients who are in irremediable pain and choose to die, but who are not terminally ill
- (c) terminally ill patients who are in irremediable pain, but who have not made the choice to die
- (d) terminally ill patients who are in irremediable pain, but who have made the choice not to die
- (e) patients who are in irremediable pain, but who are not terminally ill and who have not made the choice to die (or who have made the choice not to die)
- (f) patients who are in pain that can be alleviated, but who are not terminally ill and who have not made the choice to die (or who have made the choice not to die)?

Worse, in allowing these sorts of physician assisted suicide, wouldn't the Court's reasoning also force it to allow active *voluntary* euthanasia (killing a terminally ill patient in irremediable pain who chooses to die), and then active *non-voluntary* euthanasia (killing a terminally ill patient in irremediable pain who does not choose to die), and then active *involuntary* euthanasia (killing a terminally ill patient in irremediable pain who chooses not to die). And won't the legalization of active involuntary euthanasia then lead us down the slippery slope towards legalizing the killing of patients in category (f)?

This slippery slope worry is not significant. Surely the State is capable of putting in place elaborate safeguards designed to protect against allowing non-voluntary and involuntary assisted suicide and euthanasia. Similar sorts of safeguards can protect against voluntary assisted suicide and voluntary euthanasia when the patient is incompetent, poorly informed, or depressed.