ACLU Amicus Brief in Vacco v. Quill (12/10/1996)

Nos. 95-1858 and 96-110

In the
Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, et al., Petitioners,

v.

TIMOTHY E. QUILL, M.D., et al., Respondents.

STATE OF WASHINGTON, et al., Petitioners,

v.

HAROLD GLUCKSBERG, M.D., et al., Respondents.

On Writ of *Certiorari* to the United States Court of Appeals for the Second and Ninth Circuit

Brief *Amicus Curiae* Supporting Respondents of the American Civil Liberties Union, American Civil Liberties Union of Washington, National Gray Panthers Project Fund, Gray Panthers of Washington, Japanese Amercan Citizens League, Pacific Northewest District of the Japanese American Citizens League, Humanists of Washington, Hemlock Society USA, Hemlock Society of New York State, Hemlock Society of Washington State, Euthanasia Research Guidance Organization, AIDS Action Council, Northwest AIDS Foundation, Seattle AIDS Support Group, Local 6 of the Service Employees International Union, Temple De Hirsch Sinai Social Action Committee, Seattle/King County Chapter of the Older Women's League.

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INTEREST OF AMICI CURIAE

The interests of amici curiae are set forth in the appendix to this brief.[1]

SUMMARY OF ARGUMENT

At issue in this case is no more and no less than (1) whether a mentally competent, terminally ill person has a liberty interest protected by the Fourteenth Amendment in choosing to end intolerable suffering by hastening the timing of an inevitable death, (2) whether a state's interests can justify a blanket prohibition on physicians providing assistance in the exercise of such a liberty interest, if it so exists, and (3) whether a state can justifiably grant certain persons the opportunity to make the choice to hasten death while denying to other, similarly situated persons the same opportunity.

The right of a competent, terminally ill person to avoid excruciating pain and embrace a timely and dignified death bears the sanction of history and is implicit in the concept of ordered liberty. The exercise of this right is as central to personal autonomy and bodily integrity as rights safeguarded by this Court's decisions relating to marriage, family relationships, procreation, contraception, child rearing and the refusal or termination of life-saving medical treatment. In particular, this Court's recent decisions concerning the right to refuse medical treatment and the right to abortion instruct that a mentally competent, terminally ill person has a protected liberty interest in choosing to end intolerable suffering by bringing about his or her own death.

A state's categorical ban on physician assistance to suicide -- as applied to competent, terminally ill patients who wish to avoid unendurable pain and hasten inevitable death -- substantially interferes with this protected liberty interest and cannot be sustained. Though a state has significant interests in ensuring that the right at issue here is not abused or misused, an absolute ban on physician assistance unduly burdens the proper exercise of the right of the terminally ill to seek freedom from pain through death, especially given the many less restrictive alternatives which are available to a state and that would in fact greater serve its claimed interests.

Indeed, states typically and successfully employ less restrictive alternatives than blanket prohibitions for terminally ill patients depending on life-sustaining treatment who wish to hasten death. States have recognized the right of this class of terminally ill patients to escape pain and hasten death through the termination or refusal of such life support and accompanying administrations of large and lethal doses of pain-suppressing medication. Accordingly, a state denies equal protection of its laws when it provides that one class of persons may exercise this right while others who are similarly situated for all relevant

purposes are wholly denied the opportunity to exercise the same right for the same reason.

ARGUMENT

I. THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT PROTECTS THE PERSONAL CHOICE OF A MENTALLY COMPETENT, TERMINALLY ILL INDIVIDUAL TO TERMINATE UNENDURABLE SUFFERING AND HASTEN INEVITABLE DEATH

The Due Process Clause of the Fourteenth Amendment declares that no State shall "deprive any person of life, liberty, or property, without due process of law." U.S. Const. Amend. XIV. The Due Process Clause has long been held to contain a substantive component forbidding certain government actions regardless of procedural fairness. See Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 846 (1992); Daniels v. Williams, 474 U.S. 327, 331 (1986).

The content of substantive due process -- i.e., the constitutionally protected interests comprehended within the term "liberty" -- cannot be determined by easy reference to any rule, text or historical period. "Neither the Bill of Rights nor the specific practices of States at the time of the adoption of the Fourteenth Amendment marks the outer limits of the substantive sphere of liberty which the Fourteenth Amendment protects." Casey, 505 U.S. at 848. In the words of Justice Harlan,

> the full scope of the liberty guaranteed by the Due Process Clause cannot be found in or limited by the precise terms of the specific guarantees elsewhere provided in the Constitution.... It is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints.

Poe v. Ollman, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting). Accordingly, in determining the reach of the "least specific and most comprehensive protection" that is the Fourteenth Amendment's guarantee of liberty, courts must employ considered reason and remain "duly mindful of reconciling the needs both of continuity and of change in a progressive society." Rochin v. California, 342 U.S. 165, 170, 172 (1952); see also Casey, 505 U.S. at 847-49 (courts must employ "reasoned judgment" to determine the scope of that "realm of personal liberty which the government may not enter").

Although the boundaries of substantive due process "are not susceptible of expression as a simple rule," Casey, 505 U.S. at 849, this Court has articulated two basic lines of inquiry for deciding whether a particular right falls within the liberty provision of the Due Process Clause. First, the Court has looked to whether the asserted right is "deeply rooted in this Nation's history and tradition." Moore v. City of East Cleveland, 431 U.S. 494, 503 (1977). Second, the Court has consulted the present conscience of the people to determine whether the asserted right is "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if [it] were sacrificed." Palko v. Connecticut,

302 U.S. 319, 325-26 (1937).

In this case, either line of inquiry leads to the conclusion that a mentally competent, terminally ill person's decision to escape unendurable suffering by choosing to die is entitled to recognition as a constitutionally protected liberty interest. That is, the right of the terminally ill to find relief from excruciating pain by hastening death bears the sanction of history. It is also entirely consistent with other rights of fundamental personal autonomy that this Court has found "implicit in the concept of ordered liberty" and thus embraced by the Fourteenth Amendment's Due Process Clause.

A. The Right of a Mentally Competent, Terminally Ill Person to Choose an End to Suffering by Hastening an Inevitable Death Is Deeply Rooted in this Nation's History and Tradition.

Petitioners and their supporting amici contend that history and tradition support their position, but in doing so they improperly define the practice at issue here. Although history's view of suicide generally is subject to debate, this case presents only the narrow question of whether a mentally competent, terminally ill person has a right to seek an end to intolerable suffering by hastening an inevitable death.[2] Framed in these terms, the historical analysis appears very different. In fact, there is a strong historical tradition accepting, and often honoring, terminally ill persons who choose a timely and dignified death in the face of unrelenting and unendurable suffering.

This tradition traces back at least as far as the Greek and Roman philosophers, who accepted suicide where necessary to achieve a dignified death and to escape from a terminal and incapacitating disease.[3] For example, Plato's Republic sanctioned a choice to die under such circumstances: "If any man labour of an incurable disease, he may dispatch himself, if it be to his good."[4] Similarly, the Stoics of Rome, who believed that freedom must be based on the dictates of the deliberative will rather than passion or compulsion, embraced suicide as an appropriate response to a terminal illness whose overpowering physical assaults and demands would otherwise superimpose itself on the will and usurp the freedom of the sufferer.[5]

Significantly, neither the Old nor the New Testament prohibits suicide.[6] The notion of suicide as a crime was not introduced until late in Christian doctrine, and then only as a response to the temptation that martyrdom held for the early Christians.[7] Moreover, despite the Church's general prohibition on suicide, certain prominent adherents recognized the appropriateness of choosing death to end intolerable suffering for the terminally ill. Sir Thomas More, who was later canonized by the Roman Catholic Church, strongly supported the right of those with incurable diseases to commit suicide, and in Utopia he depicted the ideal treatment of the terminally ill "full of continual pain and anguish" as allowing the patient to "despatch himself out of that painful life, as out of a prison."[8]

The origin of suicide as an English common law offense was also ecclesiastical; thus, the initial penalty was merely the denial of a Christian burial.[9] During feudal times, the

penalty was expanded to include the forfeiture of goods to the suicide's liege lord; later, the Crown declared suicide a felony, primarily because a felon's goods were then forfeited directly to the King.[10] The common law, however, has never treated all suicides alike. Of greatest significance here, it was more lenient from the outset with those who killed themselves due to an inability to endure the suffering of disease.[11]

The crime of suicide, along with the rest of English common law, migrated to the American colonies, but it never took root even in its more limited form. As the Ninth Circuit explained: "There is no evidence that any court ever imposed a punishment for suicide or attempted suicide under common law in post-revolutionary America. By the time the Fourteenth Amendment was adopted in 1868, suicide was generally not punishable, and in only nine of the 37 states is it clear that there were statutes prohibiting assisting suicide." Compassion In Dying v. Washington, 79 F.3d 790, 809 (9th Cir. 1996).

Today, no American jurisdiction criminalizes suicide or attempted suicide. And while a small majority of states currently criminalize assistance to suicide, there is no reported American case of a physician criminally punished for helping a patient commit suicide notwithstanding the fact that assisting the terminally ill who wish to hasten their deaths has been a time-honored, though hidden, practice of compassionate physicians.[12] For well over the past half century, no person (physician or otherwise) has been meaningfully punished for aiding the terminally ill to end their suffering.[13] This reluctance to prosecute and failure to punish can only be explained by society's abiding judgment that it has no right to insist on the continued suffering of the terminally ill, and no right to punish those who honor the request of the terminally ill by assisting them in ending their agony.[14]

There is nothing new about the desire of terminally ill patients to end their suffering by hastening their death. Developments in modern health care have simply brought into the open a previously private practice that society has long condoned. Until the early part of this century patients suffering from incurable conditions overwhelmingly died at home due to the limitations of the health care system. Their deaths were frequently eased by the ministrations of alcohol and opiates.[15] Indeed, opiates (including morphine), which lead to death in excessive doses, were available without prescription until 1914. Thus, terminally ill patients had at their disposal throughout the Nation's early history the means of hastening death in a certain and gentle manner when their pain became unendurable.

With the regulation of morphine and other opiates during the last century, this gentle quitting of a life ravaged by terminal disease was dependent on the aid of compassionate physicians. The evidence shows that, despite the strictures of the criminal law, many physicians have long been willing to provide such assistance.[16] They do so in response to an undeniable reality. More recent advances in medicine have dramatically increased the life span of the terminally ill; they have also stretched out the "death span," prolonging the agony of the end stages of terminal disease, often accompanied by severe pain, physical deterioration, and unspeakable indignities.

In sum, a review of this nation's history and tradition in fact provides considerable support for recognition of a constitutionally protected liberty interest in the choice of the terminally ill to bring an end to their suffering by hastening an inevitable death.

B. The Right of a Mentally Competent, Terminally Ill Person to Choose to End Suffering by Hastening an Inevitable Death Is Implicit in the Concept of Ordered Liberty.

The right of the terminally ill to hasten their death and escape intolerable pain is not only grounded in history, it is also implicit in the very concept of ordered liberty, as this Court has understood and applied that notion in past decisions. In particular, the combined force of Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992), and Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990), leads to the conclusion that the right of the terminally ill to quit a life burdened by intractable pain in a gentle and dignified manner is at the core of the liberty interests protected by the Constitution.

Cruzan and Casey do not stand alone, however. They represent only the latest examples of an enduring principle that has found expression in numerous cases over the years. This Court has repeatedly protected from state intrusion a set of decisions that go to the very essence of what it means to be an individual in command of a personal history and life course -- decisions relating to marriage, family relationships, conception, procreation, child rearing, education, and the refusal or termination of life-saving medical treatment. See Casey, 505 U.S. at 849 ("It is settled now...that the Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood, as well as bodily integrity.") (citations omitted). Review of this well-settled line of cases reveals the vital presence of three distinct, though interrelated, components of "liberty," each of which strongly supports a finding of constitutional protection for the right of the terminally ill to hasten inevitable death.

The first and perhaps pre-eminent component of "liberty" protects the individual's interest in personal dignity and decisional autonomy. See Moore v. City of East Cleveland, 431 U.S. 494 (1977); Roe v Wade, 410 U.S. 113 (1973); Eisenstadt v. Baird, 405 U.S. 438 (1972); Loving v. Virginia, 388 U.S. 1 (1967); Griswold v. Connecticut, 381 U.S. 479 (1965); Prince v. Massachusetts, 321 U.S. 158 (1944). These cases develop the central notion that liberty only has meaning if an individual is able to make central decisions concerning his or her own life free from significant governmental interference. The decision in Casey stands as the most recent and most cogent articulation of these principles:

These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. 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.

505 U.S. at 851.

It is beyond dispute that the decision to control the end of one's life when confronted with terminal illness and intolerable pain is among the most critical and personal decisions an individual can make. Indeed, given its profound significance to a person's individual, familial, moral, spiritual and religious beliefs, it is difficult to view any other life choice as striking more to the core of personal dignity and autonomy than the decision of a competent and suffering terminally ill patient concerning how and when to die. Both the majority and dissents in Cruzan stressed the fundamental nature of the choice at issue here. See Cruzan, 497 U.S. at 281 ("The choice between life and death is a deeply personal decision of obvious and overwhelming finality."); id. at 310-11 (Brennan, J., dissenting) ("Dying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence."); id. at 343 (Stevens, J., dissenting) ("Choices about death touch the core of liberty. Our duty, and the concomitant freedom, to come to terms with the conditions of our own mortality are undoubtedly "so rooted in the traditions and conscience of our people as to be ranked as fundamental."... [N]ot much may be said with confidence about death unless it is said from faith, and that alone is reason enough to protect the freedom to conform choices about death to individual conscience.") (citations omitted).

The second component of "liberty" to be found in this Court's cases involves bodily integrity. The line of cases supporting this component arose primarily in the context of medical procedures, and a person's right to direct the course of his or her own treatment. See Washington v. Harper, 494 U.S. 210 (1990); Winston v. Lee, 470 U.S. 753 (1985); Schmerber v. California, 384 U.S. 757 (1966); Rochin v. California, 342 U.S. 165 (1952); Jacobson v. Massachusetts, 197 U.S. 11 (1905). Here the Cruzan decision makes the latest and most germane statement about the role of bodily integrity in liberty. The majority in Cruzan explained that this Court's precedents indicate that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment," 497 U.S. at 278, and Justice O'Connor in concurrence stressed that "our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination...." 497 U.S. at 287 (O'Connor, J., concurring).

Cruzan clearly stands for the proposition that the bodily integrity component of liberty, which encompasses the right to direct one's own medical treatment, is so fundamental that it is to be honored even when the consequence of the choice is hastening an individual's death. Accordingly, this component of liberty must extend to persons like the patient-respondents who, with their lives ending and their bodies wracked with pain, sought the means to preserve their dignity and control over their bodily integrity by obtaining prescribed medication to terminate their suffering.[17]

The third and final component of "liberty" supporting constitutional protection of the ability to choose a peaceful death is the right to avoid intolerable suffering. As the United

States highlights in its brief (Govt. Br. in Glucksberg at 14), a liberty interest is surely implicated if the State itself inflicts severe pain and suffering. See Ingraham v. Wright, 430 U.S. 651, 674 (1977); see also Hudson v. McMillan, 503 U.S. 1, 9-10 (1992). A liberty interest is also implicated when the state interferes with an individual's ability to relieve his or her pain, as the United States again appropriately recognizes. See Govt. Br. in Glucksberg at 14-15; cf. Estelle v. Gamble, 429 U.S. 97, 104 (1976). Casey acknowledges that the ability to seek relief from pain is a component of the "liberty" protected under the Due Process Clause -- especially when the pain at issue is itself integrally bound up with a decision which implicates the dignity and autonomy interests in directing one's own life course that are also the province of the Due Process Clause:

The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear.... Her suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role.... The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society.

505 U.S. at 852.

The same principle applies where a state prohibition relegates competent, terminally ill individuals to continue to suffer acute pain without the option of a gentle, hastened death. Like the pregnant woman's decision, the decision of a terminally ill individual to quit life in the face of unendurable pain and certain death is too intimate, too personal, and too central to the totality and meaning of that person's life for the State to impose its own philosophical and moral imperatives upon that decision. Indeed, the personal stories of the patient-plaintiffs plainly illustrate the extent of the suffering at stake in these cases.[18] The United States properly recognizes this "significant liberty interest" in its brief, noting that "it persists even at the point at which avoiding severe pain and suffering coalesces with ending life." Govt. Br. in Glucksberg at 16. This view resonates fully with the decision in Cruzan, which teaches that a liberty interest persists even to the point where an individual decides to hasten his or her death through the refusal of life-sustaining treatment.[19]

These three components of "liberty," all recognized by this Court as hallmarks of "the concept of ordered liberty," forge a strong base of constitutional support protecting the right of a competent, terminally ill person to choose to end suffering by gently hastening death. To deny constitutional protection for this right would undermine concepts of liberty and autonomy previously recognized as sacrosanct. "Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny."[20] The right to define the limits of one's endurance in the face of terminal illness and to embrace a swifter, more gentle death, should be recognized as an essential component of liberty under the Due Process Clause.

II. A BLANKET PROHIBITION AGAINST AID TO SUICIDE UNDULY BURDENS THE RIGHT OF THE TERMINALLY ILL TO MAKE RATIONAL

END OF LIFE DECISIONS

If this Court determines that the right of the terminally ill to escape intolerable pain and suffering through hastening death is a liberty interest protected by the Fourteenth Amendment, there can be little doubt that the laws at issue here "operate as a substantial obstacle" to the exercise of that constitutionally protected personal liberty interest. Casey, 505 U.S. at 895.

Amici acknowledge that the states have a significant interest in the preservation of life that permits them to regulate, even quite extensively, the exercise of the right of the terminally ill to choose the time and manner of their death. Indeed, such regulation is undoubtedly appropriate to ensure the right at issue here is not misused. This case, however, does not involve regulation, but prohibition. And, in this context, it is undeniable that an absolute ban on obtaining assistance from a physician unduly burdens the right of the terminally ill to escape pain by hastening death. Indeed, for many terminally ill patients, it precludes it entirely. Furthermore, there are less restrictive alternatives available that would in fact better serve the interests claimed by the states in this case.[21]

A. A Blanket Ban on Assistance to Suicide Is a Substantial Obstacle to the Right of the Terminally Ill to End Their Suffering.

A state's blanket prohibition against aid in dying unduly burdens the right of terminally ill individuals to end their suffering and hasten their death, preventing significant numbers of terminally ill from achieving the release from suffering that they desire and relegating still others to unacceptable options. Along with improving and extending life, the advances of modern medicine have transformed radically the social circumstances of death. Whereas only a generation ago the vast majority of persons died at home, now approximately 80% of individuals die in hospitals and long-term care institutions.[22] It is, as a practical matter, impossible for the terminally ill who are institutionalized to obtain release from suffering unassisted; without aid, they are unable to obtain the means for a swifter death. Moreover, a state's blanket prohibition against aid in dying presents an absolute obstacle to those who do not wish to quit their lives until their terminal illnesses progress to the point at which they lack the very strength to accomplish suicide unassisted. One consequence is particularly intolerable. Faced with increasing weakness and loss of autonomy in the final stages of an illness, terminally ill patients who have chosen to avoid lengthy and excruciating deaths are often forced to end their lives prematurely for fear that further loss of strength or intense medical supervision effectively will deprive them of their choice.

Furthermore, such terminally ill patients often are driven to end their lives by violent means and entirely alone. Ironically, such violent means are often legally accessible, whereas the medical means that might allow the patient to quit life gently are now inaccessible in the absence of a physician willing to transgress the law. The fear of implicating one's friends or family in crime, moreover, often induces the terminally ill to carry out their resolve secretly and alone. The trauma is then magnified for friends and

family who must deal not only with the death, but the gruesome means employed and the fact that their loved one was forced to meet death unsupported and alone.[23]

Other terminally ill individuals determined to end their suffering frequently turn for help to friends or family members, who must then choose between love and compassion or the dictates of the law.[24] Thus, another cruelty caused by the ban on assistance is that non-physician assisted suicides are amateurish affairs, always clandestine and often bungled. One Canadian study of "back-alley euthanasia" among the Vancouver AIDS population found that one-half of assisted suicides were botched, perversely increasing -- rather than alleviating -- suffering.[25]

B. The States' Asserted Interests Do Not Justify an Absolute Ban on Physician Aid in Dying for the Terminally Ill.

In opposition to this right, Washington and New York invoke interests in preserving human life, precluding undue influence or mistake, safeguarding the integrity of the medical profession and a concern over the "slippery-slope" -- i.e., that line-drawing in this area will prove impossible. These interests and concerns, however legitimate, do not justify an absolute ban on physician aid in dying for terminally ill persons and should not outweigh the recognized right of a competent, terminally ill individual to end his or her suffering.

1. Interest in Preserving Each Citizen's Life.

First, as this Court has determined, a state's interest in the preservation of every citizen's life, such as that asserted by New York and Washington here, abstracted from the value that a particular person may place on the continuation of that life, cannot outweigh a terminally ill individual's choice to end suffering and quit a life burdened by intractable pain and irreversible disintegration. Casey, 505 U.S. at 857 ("[A] State's interest in the protection of life falls short of justifying any plenary override of individual liberty claims.").[26]

Second, the pitiless process by which many terminally ill die -- the unremitting pain, the erosion of privacy and dignity, the loss of control over basic bodily functions -- leads some to conclude that the burden of their corporeal existence degrades the very humanity it was meant to serve. In choosing to end their suffering, the terminally ill do not repudiate an interest in life but seek to affirm a meaningful life with a dignified death.[27]

In these circumstances, a state may not insist that the terminally ill endure the unendurable in order to promote the state's abstract interest in the preservation of life. To do so is to appropriate an individual's existence, and to prolong cruel and unusual torment, for the purpose of proselytizing the state's preferred philosophical view of life. This a state may not constitutionally do.[28]

2. Preventing Undue Influence or Mistake.

Washington and New York also rely on their interest in protecting vulnerable citizens. They argue that the right at issue, if recognized, would be subject to abuse and mistake -- that requests for aid in dying would be mistakenly granted to those not terminally ill (because incorrectly diagnosed) or to those whose request was not truly voluntary (due to undiagnosed depression, lack of capacity, inadequately treated pain, or undue influence from family or physician).

These concerns, however, are not unique to the present situation. The risk of abuse or mistake exists in many medical contexts, including the end-of-life decisions already condoned by the State. These risks are routinely and appropriately dealt with through regulation. For example, only an informed competent adult may consent to an order not to resuscitate, see, e.g., N.Y. Pub. Health Law §§ 2960 et seq. (McKinney's 1993). Similarly, only a competent principal may appoint a health care agent (who may be a family member) who has the power to decide not to resuscitate or to terminate life support for the principal in the event of incapacity. See, e.g., N.Y. Pub. Health Law §2981 (McKinney 1993). Indeed, under applicable state statutes, a finding of competence is a necessary precondition to the execution of health care directives.[29]

If the law permits life-ending actions to be taken on the basis of competence in other medical contexts, there is no reason to claim that such a determination is impossible in this setting. Moreover, the recognition of the right to physician aid-in-dying would better address some of the state's concerns here. Whereas the current legal regime may lead the terminally ill to hide their wish for suicide from their doctor for fear that needed pain medication may be withheld, recognition of the right to physician assistance in hastening death would encourage frank discussion between the terminally ill considering suicide and their treating physician. Such discussions necessarily would raise the issue of the patient's mental state and the pain being experienced, and lead to the provision of treatment for depression, where warranted, or for pain, where all available methods have not been tried. Furthermore, where family or friends have improperly planted the thought of suicide, involvement of an objective physician would be salutary.

With respect to the concern over mistaken diagnosis (as with the previous concerns), safeguards short of an absolute ban can be crafted to minimize the likelihood of misdiagnosis to a very small order of probability.[30] Furthermore, the risk is equally present in other end-of-life decisions already condoned by the state such as the withdrawal or refusal of life-support by the terminally ill.[31]

Furthermore, the state's concerns regarding mistake in the exercise of the right ignore the consequences of a prophylactic outright ban on the terminally ill who are unquestionably competent and unquestionably in the end-stage of terminal disease.

These terminally ill would be left acutely to suffer -- having been foreclosed, as the United States acknowledges, from the "one humane and certain route of escape from pain and suffering." Govt. Br. in Quill at 15. These individuals, whose lives have already been so horribly compromised, cannot be forced to such a sacrifice.

Moreover, the current unregulated practice of assisted suicide by the terminally ill is clearly more subject to the abuse and mistake that concern petitioners and their amici. Existing back-alley methods provide no safeguards at all and thus no assurance that diagnosis will be accurate, that depression will be identified, and that undue influence has not been exercised. Yet, if the right claimed here is not recognized, certain terminally ill patients who are incapable of enduring further suffering will resort to self-help or the back-alley methods currently available with all of their significant risks.

Accordingly, amici urge recognition of the right claimed by respondents. Amici also support the use of legislative safeguards to ensure that all requests of the terminally ill for aid in dying are the product of thoughtful and informed self-determination.[32] Petitioners have offered no persuasive justification to support the need for a total prohibition.[33]

Indeed, several model statutes for physician assistance to the terminally ill already exist that incorporate procedural safeguards to screen out inappropriate cases, including requirements of: witnesses to ensure voluntariness (neither related to the patient nor involved in his or her treatment); reasonable waiting periods to preclude rash decisions; confirmation by a second physician of the terminal diagnosis and that the patient has been receiving proper palliative care; psychological examination to ensure that the patient is not suffering from a momentary or treatable depression; and reporting procedures.[34]

3. Implicating Doctors in Killing and Slippery-Slope Arguments.

Petitioners and their amici also contend that affirming the decisions below will lead to the erosion of society's confidence in the medical profession by implicating physicians in intentional killings. But, as the Second Circuit correctly noted, the physician assistance sought by patient-plaintiffs in this case, "the writing of a prescription to hasten death ..., involves a far less active role for the physician than is required in bringing about death through" the withdrawal of life support. Quill v. Vacco, 80 F.3d 716, 729 (2d Cir. 1996). Accordingly, the right the patient-plaintiffs wished to exercise in this case implicates doctors in intentionally killing, and risks tarnishing their image, no more than does the currently sanctioned practice of removing life-sustaining medical treatment. See Compassion, 79 F.3d at 828 ("Given the similarity between what doctors are now permitted to do and what the plaintiffs assert they should be permitted to do, we see no risk at all to the integrity of the profession."). Furthermore, since safeguarding of the right at issue here will permit and encourage candid discussions of all available options between the terminally ill and their physicians, instead of "criminaliz[ing] the provision of medical assistance to patients in need," id. at 827, recognizing the right of the terminally ill to obtain the relief they seek from their doctors would foster rather than erode public confidence in the medical profession.

The other argument raised by petitioners and their supporting amici is that recognition of the right to physician aid-in-dying urged here would somehow be uncontainable. These sorts of slippery-slope arguments can be made in opposition to any constitutional right (and have been leveled against many recently recognized, including the right to terminate life-sustaining treatment and the right to abortion). Recognition of any right creates the

possibility of its abuse; but petitioners do not raise any cogent concerns that could not be addressed in ways that still allow the right to be exercised.

Finally, Petitioners point to the difficulty in defining the category of the "terminally ill." In fact, this term has been used (and defined) in "living will" statutes in effect in 40 states. See Compassion, 79 F.3d at 818 & nn.77-78 (listing state statutes). While the term is not free from difficulty, it has proved workable and is not problematically unconstitutionally vague.[35]

III. BECAUSE TERMINALLY ILL PATIENTS ON LIFE SUPPORT HAVE THE RIGHT TO MEDICAL ASSISTANCE IN HASTENING DEATH, DENYING TERMINALLY ILL PATIENTS NOT ON LIFE SUPPORT MEDICAL ASSISTANCE IN HASTENING DEATH VIOLATES THE EQUAL PROTECTION CLAUSE OF THE FOURTEENTH AMENDMENT.

The arguments supporting the right urged here are further buttressed by the fact that New York, Washington and most other states, have recognized the right of a competent, terminally ill patient to choose to end a dehumanizing process of dying by hastening inevitable death. Indeed, they have recognized the right to physician assistance in implementing this choice. Most states, however, have explicitly extended this right only to a limited category of terminally ill patients: those dependent on life-support, including the provision of life-sustaining hydration and nutrition, who are permitted to end their suffering by directing the termination of such treatment even where the express purpose of such action is to hasten death. Physicians who comply with these directives are immune from criminal liability. But other terminally ill patients, also facing imminent death but not undergoing such treatments, are not granted the right to truncate a dehumanizing and agonizing dying process and to embrace a swifter death through medical assistance.

The Equal Protection Clause mandates that "all persons similarly circumstanced shall be treated alike." Royster Guano Co. v. Virginia, 252 U.S. 412, 415 (1920). The Second Circuit recognized that, with respect to the decision to end intolerable suffering by hastening an inevitable death, all terminally ill persons are similarly situated, whether or not on life support. But, by denying only those not on life support access to a medical means to achieve their desired end, "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." Quill v. Vacco, 80 F.3d 716, 727 (2d Cir. 1996). Accordingly, New York's laws (and their Washington equivalents) which prohibit only some terminally ill from obtaining an escape from their pain "are violative of the Equal Protection Clause." Id.

Petitioners argue that there is a constitutionally significant distinction between the withdrawal of medical treatment (even life-sustaining medical treatment) and the release from suffering sought by the respondents in this case. In fact, as the United States essentially acknowledges, see Govt. Br. in Quill at 10, 13, and as the Second Circuit found, see Quill, 80 F.3d at 729-30, there is no material distinction between the patient's choice in either case or between the physician's involvement in accomplishing that

choice.

In both cases the patient is making the decision to curtail weeks or months of suffering in the face of further devastation and certain death. Terminally ill patients who request the discontinuance of life-sustaining treatment, like the terminally ill patient-plaintiffs who by this action sought to hasten death by consuming drugs prescribed for this purpose, have made a conscious decision to die and seek medical assistance to accomplish their desire.[36] The medical assistance required to implement this choice is far greater (both in terms of quantity of activity and causal nexus to death) than the prescription of medication to be self-administered by the terminally ill. In the case of the withdrawal of life support, the physician must remove the medical machinery sustaining life, monitor the resultant accelerated dying process and administer morphine or barbiturates to ease the pain that would otherwise attend such a death. These medications typically must be administered in doses that in fact precipitate an even earlier death.[37]

Thus the Talmudic distinction petitioners press between the allegedly "natural" death accomplished by withdrawing life-sustaining treatment and the allegedly "unnatural" deaths sought here, is not sustainable. In both cases the motive force is the patient's intention to hasten impending and certain death and in both cases the physician provides the medical assistance to ensure that that desire can be accomplished in a certain, gentle and medically supervised manner. As the Second Circuit rightly concluded in Quill, the withdrawal of life-sustaining treatment by the physician is not "passive" assistance to that desire nor does it allow for a "natural" death. See 80 F.3d at 729.

Petitioner's specious distinction between, and undue emphasis upon, natural and unnatural deaths has warped treatment decisions made by compassionate doctors wishing to respond to requests from terminally ill patients who are not on respirators or receiving artificial nutrition and hydration but who, nonetheless, have reached the limit of their endurance. In such cases, physicians sometimes have aided these patients by contriving a death that mimics those regarded by petitioners as "natural." This practice, sometimes referred to as terminal sedation, involves medicating the patient into a sleep-like state until the patient dies of starvation or dehydration, days or perhaps weeks later. See AMA Br. in Glucksberg at 10; Resp. Br. in Quill at section III.B.

Indeed, as part of palliative care for the terminally ill, doctors routinely have supplied the causal agent of patients' deaths under the doctrine of "double effect." Where the terminally ill suffer from intractable pain in the final stages of disease, doctors sometimes will choose to administer an intravenous morphine drip that eases suffering by inducing a sleep-like state and also hastens death by suppressing respiration; as with terminal sedation, death may be precipitated in a matter of days. Medical ethicists and the Catholic Church justify action such as terminal sedation and morphine drips on the ground of the "double effect," reasoning that the physician's operative intent is to relieve pain, while death is regarded as a foreseen but unintended consequence.

But the patients at issue in these cases also seek a release from suffering, and also believe that such relief can only be accomplished by their deaths. There is no constitutionally

cognizable reason that the prescription of medication to eliminate suffering and achieve a peaceful death can only be legally permissible where death is accomplished gradually (by starvation, dehydration or asphyxiation) while the patient is put into a twilight zone that can last days or weeks. This option, where one is subject to the unknown sensory experiences and state of consciousness that might attend such a drug induced coma, while one's loved ones stand vigil for days or weeks, may appear a monstrous and horrifying prospect to the terminally ill who wish for a certain and gentle death.

Moreover, the practice of terminal sedation and intravenous morphine drip places the decision in the hands of doctors rather than patients.[38] Amici urge that the right pressed here -- which is also meant to relieve suffering by hastening inevitable death -- better serves the needs and autonomy interests of terminally ill patients.

The distinction urged by Petitioners between the competent terminally ill who wish to die and those who wish to terminate life-sustaining treatment (or who are willing to undergo terminal sedation) certainly cannot survive the heightened scrutiny required when fundamental rights are at stake and, as the Second Circuit found, its very rationality is difficult to ascertain.[39] In short, because a complete ban on the prescription of medication to competent terminally ill patients who wish to hasten death does not serve the state's expressed interest as well as would appropriately drawn regulations, it is violative of the Equal Protection Clause.

CONCLUSION

For the foregoing reasons, Amici respectfully request that the judgments of the Courts of Appeals be affirmed and that the New York and Washington statutes prohibiting physician-assisted suicide be declared unconstitutional as applied to competent terminally ill persons requesting such aid to escape unendurable suffering.

Respectfully submitted,

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NOTES

1. Letters of consent to the filing of this brief have been lodged with the Clerk of the Court pursuant to Rule 37.3.

2. The complaint in the case from Washington asserted the issue in terms of whether the "Fourteenth Amendment protects the rights of terminally ill adults with no chance of recovery to make decisions about the end of their lives, including the right to choose to hasten inevitable death with suitable physician-prescribed drugs and thereby avoid pain and suffering." Pet. App. A17 n.7. The first paragraph of the complaint describing the nature of the action brought in New York asserted the issue in the same terms.

As the Ninth Circuit noted, following the approach of this Court's abortion decisions, the liberty interest at stake is not the right to assistance with suicide but, rather, the right of the terminally ill to hasten their death. If such a right exists, then the inquiry is whether a complete ban on assistance in exercising this liberty interest constitutes an undue burden. See Compassion In Dying v. Washington, 79 F.3d 790, 801-02 (9th Cir. 1996).

3. The Court has considered the moral tradition of the Greeks in assessing other liberty interests. See Roe v. Wade, 410 U.S. 113, 130-32 (1973).

4. The Republic of Plato (Book III), 406a-409 (1968) (Alan Bloom ed. 1968). Aristotle, too, endorsed this possibility in his Politics. See Aristotle's Politics III, vi, 1278b15-30.

5. See Patricia A. Unz, Note, Euthanasia: A Constitutionally Protected Peaceful Death, 37 N.Y.L. Sch. L. Rev. 439, 441-42 (1992). Writing in this tradition, Seneca, the great Roman orator, stated:

I will not relinquish old age if it leaves my better part intact. But if it begins to shake my mind, if it destroys its faculties one by one, if it leaves me not life but breath, I will depart from the putrid or tottering edifice. I will not escape by death from disease so long as it may be healed, and leaves my mind unimpaired. I will not raise my hand against myself on account of pain, for so to die is to be conquered. But I know if I must suffer without hope of relief, I will depart, not through fear of the pain itself, but because it prevents all for which I would live.

Quoted in Sherman B. Nuland, How We Die 151 (1993).

6. None of the four suicides recorded in the Old Testament -- Samson, Saul, Abimelech and Achitophel -- is criticized. See Alfred Alvarez, "The Background" 12, in M. Babst Battin & David J. Mayo, Suicide: The Philosophical Issues (1980). The New Testament (Matthew) records the suicide of Judas Iscariot perfunctorily, "instead of being added to his crimes, it seems a measure of his repentance." Id. "In the first years of the Church, suicide was such a neutral subject that even the death of Jesus was regarded by Tertullian, one of the most fiery of the early Fathers, as a kind of suicide." Id.

7. The Christian church taught that the world was a vale of tears, sin and temptation, from which death would release the faithful into eternal glory. Martyrdom afforded certain redemption, and the names of early martyrs were celebrated and their relics worshiped. The temptation to martyrdom culminated in the frenzy of the Donatists who, in the fourth and fifth centuries, actively pursued death. In response, St. Augustine argued in his writings that suicide was a sin.

These arguments, coupled with the example of the Donatists, convinced the Church to legislate against suicide. See id. at 25-28.

8. Quoted in O.R. Russell, Freedom to Die 55-56 (1975).

9. See Maria T. CeloCruz, Note, Aid-In-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?, 18 Am. J.L. & Med. 369, 373 (1992).

10. Id. at 373-74.

11. See Compassion, 79 F.3d at 808-09 (quoting 2 H. de Bracton (c. 1250) reprinted in On the Laws and Customs of England, 423 (S. Thorne trans., 1968)).

12. See id. at 811 & nn. 56-59; see also Note, Physician-Assisted Suicide and the Right to Die with Assistance, 105 Harv. L. Rev. 2021, 2021 n.7 (1992).

13. "[F]rom 1930 to 1985, not one state court decision on an actual prosecution for suicide assistance appears in an official state reporter." Catherine D. Shaffer, Note, Criminal Liability for Assisted Suicide, 86 Colum. L. Rev. 348, 358 (1986). Based on newspaper and wire service accounts, it appears that such cases either have not been prosecuted or have resulted in acquittal or sentences of probation. See id. In the last decade, of course, there have been several well-publicized prosecutions. All, so far, have resulted in jury acquittals. See Jeff Stryker, A Bedside Manner for Death and Dying, N.Y. Times, May 19, 1996, § 4, at 3.

14. Indeed, to argue that suicide by persons suffering from terminal illness is ethically wrong, philosophers and theologians have had to resort to the concept of God's proprietary claim over his creations. John Locke argued that suicide was a crime because

man does not have absolute dominion over himself; his being belongs to God and he thus has no right to destroy it. "[M]en being the workmanship of one omnipotent ... makes all servants of one sovereign master, sent into the world by his order and about his business -- they are his property, whose workmanship they are, made to last during his, not another's pleasure." John Locke, The Second Treatise of Government, (C.B. Macpherson, ed.) 9, 17, 21 (1980). The theologian, Dietrich Bonhoeffer, has similarly stated: "It becomes quite clear that a purely moral judgment on suicide is impossible, and indeed that suicide has nothing to fear from an atheistic ethic. The right to suicide is nullified only by the living God." Quoted in P. Baelz, "Suicide: Some Theological Reflections," in Battin & Mayo, supra, at 75.

However deeply held such religious views may be, they cannot (without more) be the basis for government regulation. See Casey, 505 U.S. at 850 (explaining that religious views concerning a liberty "cannot control our decision. Our obligation is to define the liberty of all, not to mandate our own moral code."); id. at 914 (Stevens, J., concurring in part and dissenting in part) ("[I]n order to be legitimate, the State's interest must be secular; consistent with the First Amendment the State may not promote a theological or sectarian interest.")

15. Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261, 339 n.11 (1990) (Stevens, J., dissenting).

16. See generally Julia Pugliese, Note, Don't Ask-Don't Tell: The Secret Practice of Physician-Assisted Suicide, 44 Hastings L. J. 1290, 1297-99 (1993); Timothy E. Quill, Death and Dignity: A Case of Individualized Decision Making, 324 New Eng. J. Med. 691, 694 (1991).

17. Though the United States finds that "Cruzan supports the conclusion that a liberty interest is at stake in this case," Govt. Br. in Glucksberg at 15, it also suggests that this case does not involve Cruzan's interest in "avoiding invasions of bodily integrity." Id. at 16. Such a view misses the reality of those who seek to exercise the right at issue here. Like the patient-plaintiffs in these cases, dying patients seeking to hasten death are typically in excruciating pain and often physically incapacitated; frequently their entire bodily existence is conscripted by the demands and relentless assaults of an incurable disease. To suggest that such persons' "bodily integrity" is unaffected if they are denied the opportunity to seek medication to bring their suffering to an end -- and are thereby forced to continue an existence which they view as a torment -- evinces a remarkably hollow conception of the right to bodily integrity. Of course, this Court's precedents encompass a much fuller conception of bodily integrity. As Casey made clear when it held that denial of access to the medical procedure of abortion touches "upon the very bodily integrity of the pregnant woman," 505 U.S. at 896, this Court has recognized an interference with a liberty interest whenever persons have particular courses of medical treatment thrust upon them or denied to them contrary to their interests or consent. See, e.g., Washington, 494 U.S. at 229; Jacobson, 197 U.S. at 24-30; see also Vitek v. Jones, 455 U.S. 480, 494 (1980); Parham v. J.R., 442 U.S. 584, 600 (1979).

18. Washington notes that respondents and their supporting amici placed before the Courts of Appeals numerous "anecdotes" of the terminally ill who wished to hasten their death and avoid painful, undignified and inhumane endings to their lives. The State of Washington urges that this Court not make constitutional decisions based on "anecdotes." See Washington Br. at 18. But these personal stories, though brief and obviously inadequate to portray essentially indescribable human suffering, are meant to help the Court to conjure the unimaginable pain and suffering experienced by those who might avail themselves of the right urged here. As the United States acknowledges (Govt. Br. in Glucksberg at 18 & n.1), an irreducible core of terminally ill patients (including an estimated 10% of all cancer patients) cannot obtain relief through palliative treatment but are trapped in physical agony. In some cases, pain cannot be controlled even with full and appropriately timed doses of narcotics; in other cases, the toxic effects of the palliative agents may be intolerable. See Howard Brody, Assisted Death -- A Compassionate Response to Medical Failure, 327 New Eng. J. Med. 1385 (1992). Moreover, the invocation of the capabilities of modern palliative medicine ignores the subjective nature of suffering; the diminished fortitude in the face of suffering when all hope of recovery is gone; the practical reality that pain can often only be allayed, if at all, at the cost of mental alertness; and the loss of dignity that accompanies physical deterioration. In these circumstances (the "anecdotes" that respondents and their amici place before the Court), compassion and the Constitution dictate that these terminally ill patients not be denied their wish for a hastened and gentle death.

19. In Cruzan, this Court noted that the "logic of [prior] cases" would extend the liberty interest in refusing medical treatment to refusing "the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life." 497 U.S. at 279.

20. R. Dworkin Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom at 217 (1993).

21. This Court has not always employed a single test when weighing the strength of the state's asserted justification for abridging a fundamental liberty interest. In Casey, the Court adopted an "undue burden" test that focussed on whether the challenged regulation placed a "substantial obstacle" in the path of a woman seeking a pre-viability abortion. In other contexts, this Court has emphasized the need for narrow tailoring. See, e.g., City of East Cleveland, 431 U.S. at 499. Under either formulation, a total ban on physician-assisted suicide cannot be upheld. As explained below, it clearly represents a "substantial obstacle" to terminally ill individuals who wish to end their suffering and it is not narrowly tailored to achieve the state's asserted interests.

22. See Cruzan, 497 U.S. at 302 (Brennan, J., dissenting); id. at 339-40 (Stevens, J., dissenting) ("People are less likely to die at home, and more likely to die in relatively public places, such as hospitals or nursing homes. Ultimate questions that might once have been dealt with in intimacy by a family and its physician have now become the concern of institutions.").

23. The ban on physician assistance may not only cause terminally ill individuals to commit suicide prematurely or preclude a gentle death or one in the company of friends and family, but it also may frustrate the very desire for certain death when self-inflicted attempts fail, thereby causing additional and gratuitous suffering to the tormented patient. See Quill, supra note 16 at 117-20.

24. See, e.g., K. Frederickson, Torn Mother: I Helped Her Pass On, Oregon Bulletin, May 16, 1994, at A1 (giving account of mother's explanation, after expiration of statute of limitations, how she finally acceded to daughter's plea to assist her suicide after months of watching daughter's wasting from bone cancer in too much pain to endure even her mother's touch).

25. See Clyde H. Farnsworth, Vancouver AIDS Suicides Botched, N.Y. Times, June 14, 1994, at C12. For example,

In five cases, victims were unsuccessfully suffocated. In one case, the people who assisted in the suicide resorted to slitting the victim's wrists with a razor blade and in another case to shooting him. Two were injected with pure heroin. Many of the acts of euthanasia took several hours or longer to be completed. In one case it took four days.

Id.; see also Gina Kolata, AIDS Patients Seek Solace in Suicide But Many Risk Added Pain in Failure, N.Y. Times, June 14, 1994, at C1 (reporting on man who in trying to bring on a gentle death by smothering his lover with pillow, asphyxiated him only enough to destroy most of his brain function).

26. In Cruzan, the majority stated

we think a State may properly decline to make judgments about the "quality" of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.

497 U.S. at 282. Indeed, a state has no other choice. More specifically, a state cannot make determinations about the worth or quality of an individual's life and then rely on that determination as a basis for making life or death decisions. For the terminally ill, the meaning of life and the impact of physical and psychological agony represent the most personal of judgments that the state may not usurp.

27. As Justice Stevens noted, an interest in life "includes an interest in how [one] will be thought of after ... death by those whose opinions mattered" during life. "How [one] dies will affect how that life is remembered." Cruzan, 497 U.S. at 344 (Stevens, J., dissenting). Those enduring a life racked with pain and utter helplessness may reasonably reject the prospect of a long vigil where family and friends loyally and lovingly witness their disintegration. The terminally ill reasonably may assert an interest in being remembered for how they lived rather than the excruciating, relentless and lengthy

process by which they died.

28. A state may not even use a person's car as a moving billboard to proselytize its views on life's meaning by insisting that the state's motto appear on citizens' license plates. See Wooley v. Maynard, 430 U.S. 705 (1977). In the abortion context, a state may not insist that a woman carry a not-yet-viable life to term to affirm the state's view of women's role or its philosophic view of when life begins. Casey, 505 U.S. at 851. Equally, a state may not promote its view of the sanctity of life by insisting that a terminally ill individual bear unrelieved suffering rather than hasten death.

29. See generally Compassion, 79 F.3d at 818 (citing numerous statutes).

30. Model regulations have provided that a patient seeking physician assistance in hastening death receive confirmation by at least two physicians (or an entire committee of physicians) that they are in the terminal phase of their illness before such a request will be honored. See infra p. 22 & n.34.

31. The United States argues that an incorrect diagnosis in the case of the withdrawal of life support does not, as it would here, result in death. See Govt. Br. in Quill at 14. In support, the United States points to Karen Ann Quinlan, who lived for years after her life support was disconnected. Id. But the Government's argument conflates two possibilities of misdiagnosis at stake in a terminally ill patient's decision to withdraw life-support and hasten death; dependence on life-support (not at issue in this case) and the terminal phase of an irreversible disease (which is at issue in this case). Withdrawing life-support does not lead to death where there has been a misdiagnosis of dependence on life support. On the other hand, where the misdiagnosis involves the reversibility of the disease (i.e., whether it is terminal) -- the only diagnosis at issue here -- a misdiagnosis leading to withdrawal of life support will lead to a death. In such cases, a person whose condition might have improved if retained on life support, is removed from life support and allowed to die. Despite such risks (which can be and are minimized through requirements of diagnostic confirmation), the right to hasten death through directing the discontinuation of life support has been vouchsafed to the terminally ill.

32. The recommendation of the New York State Task Force, relied on heavily by petitioners and their amici, is instructive in this context. In its 1994 report, When Death Is Sought; Assisted Suicide and Euthanasia in the Medical Context, the New York State Task Force on Life and the Law unanimously recommended that New York's statutory ban on assisting suicide be retained due to the risk of abuse and mistake if physician-assisted suicide for the terminally ill was allowed. In support of its recommendation, the New York State Task Force, like New York and Washington herein, focused on requests that were or might be made due to untreated pain or depression or undue influence. But when confronted with the specific issue raised by these cases -- voluntary requests from the competent and suffering terminally ill -- some Task Force members endorsed assisted suicide as a means of showing respect for the autonomy, and compassion for the suffering, of these patients. They preferred, however, that such patients obtain medical help clandestinely from courageous doctors willing to violate the law. See id. at 141.

Thus, in circumstances directly and solely at issue here, some members of the Task Force urged that the New York laws be disobeyed.

33. The briefs of petitioners and their supporting amici rely on anecdotes (and selective studies -- which are not uncontradicted -- about experiences in another nation) to argue that regulation could not effectively safeguard the right claimed here. Notably, these anecdotes do not involve the exercise of the right to the refusal or withdrawal of life-sustaining treatment which has been effectively regulated. Instead, petitioners and their amici rely largely on hypothesized scenarios and anecdotes relating to the clandestine exercise of physician aid in dying, which at present is illegal and entirely unregulated. Neither these, nor the disputed experience of another nation, provide a sufficient basis to argue against the right urged here.

34. See Oregon's Death with Dignity Act, Oregon Rev. Stat. §§ 127.800-127.995 (1995); Michigan's Model Statue Supporting Aid-in Dying, appended to the Final Report of the Michigan Commission on Death and Dying (1994); New York, Senate Bill No. 7986 (May 3, 1994) entitled "Death With Dignity," sponsored by New York State Senators Galiber, Leichter, Markowitz, Smith and Waldon; Washington Senate Bill 5596 (Jan. 27, 1995) entitled "Terminally Ill Patient Act of 1995." Of course, the constitutionality of particular restrictions is not before the Court since the two state statutes in this case are both total bans.

35. Petitioners point further to the difficulty in distinguishing between a physician's prescription of lethal medication to be self-administered by a terminally ill patient and a physician's administration of that medication where the terminally ill individual is unable to do so. Amici acknowledge that some terminally ill patients who voluntarily request a hastened and gentle death may, due to the devastating progress of their disease, be unable physically to ingest medication without assistance. The question whether the physician's administration of the medication could be constitutionally prohibited in such a case is not presently before the Court. Amici, however, agree with the Ninth Circuit that the crucial question is whether the request is thoughtful and voluntary and, if so, the terminally ill patient who is physically unable to administer the medication that would release him from his agonies cannot, consistent with the Constitution, be prevented from obtaining the necessary aid. See Compassion, 79 F.3d at 831-32. The fact that the right urged here may one day properly be expanded to include such a case is no cause for alarm. It bears no relation to the entirely speculative, nightmare scenarios painted by certain amici supporting petitioners: that the right urged here -- a right of the individual against the state for release from the unendurable ravages of terminal disease -- somehow will metamorphosize into the ability of society to act against the individual and do away with those whose lives are no longer valued. Such dark fantasies should be disregarded.

36. See Quill, 80 F.3d at 729 (citing Cruzan, 497 U.S. at 296-97 (Scalia, J., concurring)).

37. The Second Circuit's discussion on this point bears repeating:

[T]he writing of a prescription to hasten death, after consultation with a patient, involves

a far less active role for the physician than is required in bringing about death through asphyxiation, starvation and/or dehydration. Withdrawal of life support requires physicians or those acting at their direction physically to remove equipment and, often, to administer palliative drugs which may themselves contribute to death. The ending of life by these means is nothing more nor less than assisted suicide.

Quill, 80 F.3d at 729.

38. Where a patient requests aid in dying quickly, the patient endangers the delicate excuse of the "double effect" and a doctor who otherwise might have employed a morphine drip may demur, afraid of running afoul of the criminal law. See Thomas A. Preston, Killing Pain, Ending Life, N.Y. Times, Nov. 1, 1994, at A27.

39. Interestingly, the United States suggests that this Court need not be especially vigilant in reviewing the state's line drawing here because "[t]erminal illness does not single out any discrete or insular minority; it potentially affects all Americans." Govt. Br. in Glucksberg at 31-32. On this basis, the United States asserts that "there is every reason to believe that the state legislatures will address the competing interests in an impartial and unbiased way," and also contends that "there is no indication that the political processes are malfunctioning." Id. at 31 & n.3. This argument fails, of course, if a fundamental liberty interest is at stake because, in that circumstance, heightened scrutiny is required regardless of whether a discrete and insular majority is involved.

Furthermore, as a matter of practice, it is difficult to put faith in the political processes which have traditionally not acted to safeguard the right of the terminally ill to escape pain through a gentle, hastened death while prosecutors, courts and juries have never meaningfully punished anyone for helping the terminally ill exercise this right. See supra p. 7 & nn.12-13. This disjunction between the law on the books and the law in enforcement bespeaks a malfunctioning of the political process.

APPENDIX

INTERESTS OF AMICI CURIAE

The **American Civil Liberties Union ("ACLU")** is a nationwide, nonprofit, nonpartisan organization with nearly 300,000 members dedicated to preserving the principles of liberty and equality embodied in the Constitution. Since its founding in 1920, the ACLU has participated in numerous cases before this Court. Of particular note here, the ACLU appeared as counsel in both Planned Parenthood of Southeastern Pennsylvania v. Casey, 112 S. Ct. 2790 (1992), and Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990). The ACLU of Washington is a state affiliate of the ACLU and appeared as amicus curiae before the Ninth Circuit in Compassion In Dying v. Washington.

The **National Gray Panthers Project Fund** is a civil liberties advocacy project

concerned with social justice for the aging. As advocates for the aging, the Gray Panthers and their state affiliates of Washington and New York join in this case, as a friend of the court, to highlight the right of individuals to make choices about the quality of their lives.

The Japanese American Citizens League ("JACL") is a national civil rights organization founded in 1930, committed to strive to secure justice and equal opportunities for all Americans of Japanese ancestry as well as for all Americans, regardless of race, creed, color, national origin, religion, sex, sexual orientation, or disability. The JACL supports legislative initiatives that provide for the welfare of the broader community. The Pacific Northwest District of JACL also joins in this amicus brief as a advocate for the health care needs, as well as the death with dignity needs of its membership and of the total community, upholding the individual's right to freedom of choice on those matters that are essential to basic human dignity.

The **Humanists of Washington** is a free thought association dedicated to the principles of secular humanism. The group supports intellectual freedom, free inquiry, critical thinking, and civil liberties. Humanists of Washington's defense of civil liberties is unconditional; it works for the right of individuals to make personal decisions about their bodies free from unnecessary government intrusion. Accordingly, the group defends, among other things, the right of terminally ill persons to choose the time and manner of their death.

The **Hemlock Society USA** was formed in 1980 to achieve the legalization of physician aid in dying for terminally ill, mentally competent adults. It has 25,000 members in 80 chapters and community groups throughout the country. The New York State and Washington State affiliates joining the national organization in supporting the right of dying persons to work with their physicians so that the voluntary request for a hastened death may be part of the continuum of care available to the terminally ill.

The **Euthanasia Research & Guidance Organization ("ERGO!")**, a non-profit educational corporation organized under the laws of the State or Oregon, was founded in 1993 to lay the groundwork for the compassionate and just implementation of a mentally competent terminally ill adult's decision to hasten death when the law permits it in America. ERGO promotes safeguards and guidelines on legal, medical, and ethical issues so that physician aid in dying will be put into careful practice. Its goal is to educate and prepare individuals and institutions, ensuring a smooth transition when the change in law occurs. ERGO supports the respondents' position that a mentally competent terminally ill adult has the right to hasten inevitable death with the assistance of a physician.

AIDS Action Council is the Washington, D.C. representative of over 1,000 community-based organizations and the people living with HIV/AIDS they serve across the nation. As the only national organization devoted entirely to federal advocacy on behalf of people living with HIV/AIDS, AIDS Action works to ensure that effective national initiatives for prevention, care, and research are developed and implemented which are responsive to and respectful of the needs of all people living with or at risk of HIV/AIDS. In that regard, AIDS Action supports policies that empower people living with AIDS to

exercise their fundamental right to make individual decisions about how they live with this disease, including their right to choose in a dignified and humane way the manner and time of their death with the assistance of their physicians.

The Northwest AIDS Foundation is the largest private, non-profit HIV/AIDS service and education organization in Washington state. The Foundation is dedicated to ensuring and maintaining the highest quality of life for persons living with HIV/AIDS, preventing the spread of HIV and advocating for all those whose lives have been affected by HIV/AIDS. Knowing the pain their clients experience as their illness becomes terminal, incapacitating, and untreatable, the Foundation supports the right of all persons with a terminal illness to decide for themselves when to end their own lives and for those individuals to seek assistance in doing so if they so wish.

The Seattle AIDS Supports Groups ("S.A.S.G.") mission is to provide emotional support in a group setting (via support groups and a drop-in center) to persons living with HIV/AIDS and to their families, friends, and loved ones. The group's commitment is to create a safe and supportive environment fostering dignity, fullness of life and personal empowerment for persons with AIDS. By fostering dignity and personal empowerment, S.A.S.G. seeks to validate each individual's own choices about living and dying with this disease. The group believes that the option to hasten inevitable death should be a right for all terminally ill persons who elect to make that choice.

Local 6 of the Service Employees International Union ("Local 6") is a labor union representing 10,000 workers in Washington. As almost every improvement in the condition of working people has been accomplished by the efforts of organized labor and as the welfare of workers in Washington can best be protected and advanced by united action, the mission of Local 6 is to gather and expend its resources and to unite and empower its members for the advancement of working people. As a organization, Local 6 believes that people should exercise control over their lives and take responsibility for their decisions.

The mission of **Temple De Hirsch Sinai ("Temple")** is to serve the spiritual needs of its congregation through the observation, celebration, and study of reformed Judaism. It affirms the principles of reformed Judaism through its religious services, life cycle ceremonies, religion school, social action, and outreach to individuals and families. The Temple promotes Jewish ideals in personal conduct, dedication, family and community life, and in its partnership with other institutions. Its interest comes under the tenets of the Old Testament, where all Jews are admonished to assist and share with the provision of food, clothing, and shelter for those less fortunate. The Temple's specific interest in this case is equal treatment of all citizens of this country.

The Older Women's League ("OWL") is a national organization working to better the lives of all midlife and older women. One of its agenda items is "Staying in Control Through All of Life." OWL works to improve policies and legal means to protect each individual's decision-making capability affecting quality of life until its ending. The Seattle/King County Chapter of OWL joins as amicus to support the right of the

terminally ill to decide to end their suffering.