OFFICIAL TRANSCRIPT

PROCEEDINGS BEFORE

THE SUPREME COURT

OF THE

UNITED STATES

CAPTION: WASHINGTON, ET AL., Petitioners V HAROLD GLUCKSBERG, ET AL.

CASE NO: No. 96-110

PLACE: Washington, D.C.

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IN THE SUPREME COURT OF THE UNITED STATES

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WASHINGTON, ET AL., :

Petitioners :

V. : No. 96-110

HAROLD GLUCKSBERG, ET AL. :

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Washington, D.C.

Wednesday, January 8, 1997

The above-entitled matter came on for oral argument before the Supreme Court of the United States at 10:02 a.m.

APPEARANCES:

MR. WILLIAM L. WILLIAMS, ESQ., Senior Assistant Attorney General of Washington, Olympia, Washington; on behalf of the Petitioners.

GEN. WALTER DELLINGER, Acting Solicitor General Department of Justice, Washington, D.C.; on behalf of the United States, as amicus curiae.

MS. KATHRYN L. TUCKER, ESQ., Seattle, Washington; on behalf of the Respondents.

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P R O C E E D I N G S

(10:02 a.m.)

CHIEF JUSTICE REHNQUIST: We'll hear argument now in No. 96-110, Washington versus Harold Glucksberg.

Mr. Williams

ORAL ARGUMENT OF WILLIAM C. WILLIAMS

ON BEHALF OF THE PETITIONER

MR. WILLIAMS: Mr. Chief Justice and may it please The Court. We are here today representing the people of the State of Washington to defend their legislative policy judgment to prohibit assisted suicide. The Constitutional concept of ordered liberty requires the drawing of clear lines to delineate that conduct which is permissible from that conduct which is not.

The Washington statute prohibiting assisted suicide was forged at the common law, tempered by centuries of legal traditions and ratified by recent legislative action and by a direct vote of the people of Washington. The same prohibition has been enacted by the legislatures of virtually every state and the line that it draws in the end-of-life context is

supported by the organizations of the health care professionals who care for the sick and dying on a daily basis.

The issue here today is whether the Constitution requires that the social policy developed by Washington voters must be supplanted by a far different social policy, a Constitutionally recognized right to physician-assisted suicide that is contrary to our traditions and overrides the important state interests that are served by the Washington statute.

In contrast to the clear line that is drawn by Washington law, Respondents offer a line that is unstable and inconsistent with the concept of ordered liberty. It is inconsistent with liberty in three respects. First, it is limited to a very few of our citizens. Secondly, those few must justify their exercise of this so-called Constitutional right. Thirdly, if -- even the Respondents and their amici agree that this right, if it is to be exercised at all, if it is to be recognized at all, must be closely regulated. And their equal protection argument demonstrates just how unstable the line is,

because they suggest that flowing from this Court's assumed recognition of a right to refuse treatment in the Cruzan case, there is a seamless web of Constitutional -- excuse me, a seamless -- stream of Constitutional rights that flows from that decision.

QUESTION: Mr. Williams, in the Cruzan case, The Court recognized a liberty interest and yet it upheld restrictive legislation.

MR. WILLIAMS: Yes, ma'am, Justice Ginsburg.

QUESTION: So couldn't one take the same approach here, there is a liberty interest, but because of the risks and dangers involved, considerable state regulation is permissible?

MR. WILLIAMS: Yes, Your Honor, one could take that approach. The problem that that would create by recognizing a liberty interest is that many states are considering whether to move the line by legislation -- in fact, our sister state of Oregon has done just that -- in the beginning of a recognition of a liberty interest may limit their flexibility to deal with this complicated area.

We agree that, even if you find the

existence of a liberty interest, that the same important state interests that were present in Cruzan are present in this case and would justify the statute nonetheless.

QUESTION: And the bottom line of Cruzan was to uphold precisely what the state did.

MR. WILLIAMS: That's exactly right, Your Honor.

QUESTION: What are the state interests you would argue support the law here in the event that a liberty interest is recognized?

MR. WILLIAMS: Your Honor, there are three important state interests that are involved. The first one is life, which includes the state's interest in prevent -- is a subset the interest of preventing suicide. And, in the hierarchy of Constitutional value, certainly the protection of life is the highest. In fact, one could argue that that's why people organize into communities, into civilized societies, is to protect life.

The second one is to prevent abuse and undue influence, and certainly the risk is higher in the physician-assisted suicide context than it

is in the refusal of treatment context.

And thirdly, there is a strong interest in regulating the medical profession. Precisely because physicians have the capacity to injure or perhaps cause the death of their patients, the state has an important interest in maintaining a clear line between physicians as healers and curers and physicians as instruments of death of their patients.

And we believe all three of those interests together or frankly any one of them separately would support the state legislation in this case.

QUESTION: Mr. Williams, taking the second one separately, the fear of abuse, the argument runs in various forms that, if what the -- what the two Courts of Appeals so far have recognized prevails, the risk is that, in fact, the practice of assistance, so-called, is going to sort of gravitate down to those who are not terminally ill, to those, in fact, who have not made a truly voluntary or knowing choice. And ultimately it's going to gravitate out of physician-assisted suicide into euthanasia.

One of the difficulties that I have

with this case and with the one that follows it is I'm not sure how I should weight or value that risk or those risks. What the argument raises is plausible. I mean, it's easy to see. But I don't know how realistic it is. And I don't know how much weight to put on it. What should I do, where should I look, or what methodology should I pursue to try to solve my difficulty?

MR. WILLIAMS: I would make at least two suggestions, Justice Souter. First, look at the Respondents' equal protection argument and contrast that with the doctrinal support that they offer for a liberty interest in this case. The doctrinal support that they offer does not provide the limitations that they suggest should be in play with respect to this liberty interest. Yet their equal protection argument that equates the withdrawal of medical treatment, in effect, which is a time-honored right under our common-law, with the physician-assisted suicide, when assisted suicide itself was contrary to the common law, it was a common-law crime, and yet they equate those two, while these Respondents may say that what they are trying to do is limit this to a narrow class, the next case

will argue much the same as they have, that it should be extended perhaps to the chronically ill, perhaps to those who -- to euthanasia for those who can't administer that. And in fact, some of their amici have acknowledged that.

QUESTION: Let me direct you into a narrower channel. I understand the, let's say, the problem of doctrinal slippage which is what you're talking about here. But there's also a, just, kind of an empirical component. There's is a prediction about what, in fact, would happen even if the doctrine is maintained pure, even if we draw a line and that line is never going to be crossed.

What basis do I have for evaluating the claim that, in fact, apart from doctrine, this slippage is going to occur and that, in effect, the innocent are going to die as a result of this?

MR. WILLIAMS: Again, the second suggestion I was going to make would be to look at the district court decision in the case involving the Oregon statute, where the district court noted that the proponents of the Oregon law which is limited in the same way that these

Respondents suggest it should be, to the terminally ill. But the proponents of that law acknowledged in that district court proceeding that they intend -- that this was a first step and it would be extended by statute.

QUESTION: But that's a variant -- I think that's a variant of the -- sort of the problem of doctrinal slippage. This is step one and they have step two or three or whatever in mind. My question is, let's assume that there isn't going to be doctrinal slippage, let's assume that we're simply evaluating the argument that if you recognize what is being requested now, in fact, what will happen is that people who don't consent, who are not terminally ill, who do not even self-administer, are going to end up dying as a result of this. What empirical basis do I have for evaluating that argument?

MR. WILLIAMS: Well, there's no empirical basis in our country, of course, because we do not have a history of recognizing that.

QUESTION: Is there anything beyond the references to the Dutch experience?

MR. WILLIAMS: Well, there's the

references to the Dutch experience which are I think important and telling in terms of modern history. And, of course, there is the German experience in the early 1930s.

QUESTION: What about the Australian, wasn't there something about Australian law?

MR. WILLIAMS: The northern territory of Australia, Justice Ginsburg, has authorized by statutory action a form of physician-assisted suicide. And I think a state may legitimately create an exception to its homicide laws for physician-assisted suicide. And if it is subject only to rational basis rule -- review, then I think that the line could be maintained at the terminally ill.

QUESTION: The Australian proposal was not as the result of a judicial decision I take it.

MR. WILLIAMS: That's my understanding, Mr. Chief Justice.

QUESTION: Indeed it was -- whatever the legal status of the Netherlands, but what's elsewhere don't have the kind of Constitutional review that we do either. So --

MR. WILLIAMS: I believe that's

correct, Justice Ginsburg.

QUESTION: But has there been a lot in the briefs about the Netherlands experience, there is this limited legislation in Australia. Has there been any evidence about what's going on under that legislation?

MR. WILLIAMS: I think that legislation is so new, my understanding it just became effective in this past year in 1996, that we don't -- I'm not aware of any --

QUESTION: May I ask you a question. You referred to the -- your sister state Oregon's experience. And one of the most powerful arguments in support of your position in this case is legislatures might adopt the remedy rather than the courts. Is it your view that a legislature does have the Constitutional authority to authorize assisted suicide?

MR. WILLIAMS: Yes, Justice Stevens, it is. Legislature under its police powers can define the crime of homicide, and a subcomponent of that is the current physician -- excuse me, the current assisted suicide statute.

QUESTION: The district court in that case disagreed with that, I think, didn't it?

MR. WILLIAMS: My -- Your Honor, the district court said that the statute that they adopted did not have adequate safeguards and, therefore, did not qual -- did not meet rational basis review for equal protection purposes. It did not say that, as a Constitutional concept, they couldn't strengthen those.

QUESTION: Didn't the Ninth Circuit in this case kind of express its disapproval of the district court ruling in Oregon?

MR. WILLIAMS: That's correct, Mr. Chief Justice, Judge Rhinehart.

QUESTION: Of course, you're not endorsing the Ninth Circuit's position, though?

(Laughter.)

MR. WILLIAMS: Let me be perfectly clear on that.

(Laughter.)

QUESTION: You indicated in your response to Justice Ginsburg that, if we assumed a liberty interest but nevertheless found that the very substantial arguments you have made outweighed it, so that the Washington laws would remain in effect, that this would somehow be confining to legislators and regulators? I

wasn't quite sure that I followed that. I understand the doctrinal significance of this suggestion that was made. I wasn't sure of its practical implications that so concerned you. Would you expand on that?

MR. WILLIAMS: What I was trying to suggest, that -- maybe if I could explain it differently. If you accept our position, which is rational basis review would be the appropriate level of review, then states would have the maximum flexibility to look at this complicated and complex issue and decide on a state-by-state basis.

I don't know for certain that assuming a liberty interest in sustaining the statute would complicate it. I am concerned, depending on how that's expressed, that it may complicate it, that's all I was trying to say.

QUESTION: Well, it would be very difficult to assume a liberty interest and rule in your favor in this case, would it not? Because if we assume a liberty interest but nonetheless say that, even assuming a liberty interest, a state can prohibit it entirely, that would be rather a conundrum.

MR. WILLIAMS: Well, Mr. Chief Justice, I disagree to this extent: I believe the state -- the same important state interests that were implicated in the Cruzan case are implicated here but more strongly, because in the context of withdrawing life support and in the physician-assisted suicide there are some different factual --

QUESTION: But in Cruzan what we were dealing with was a state rule that said you had to prove a certain thing by clear and convincing evidence. Here we're not dealing with any sort of an evidentiary rule, we're dealing with an outright prohibition.

MR. WILLIAMS: That's correct, Mr. Chief Justice.

QUESTION: I suppose that proclaiming a liberty interest is cost-free so long as you can proclaim them and then say, however they can be outweighed by various social policies adopted by the states. We can say there's a liberty interest in murdering people, however it's outweighed by the state's interest in preserving the lives of its' citizens. I guess we could do that, couldn't we?

MR. WILLIAMS: That's true, Justice Scalia. We -- the other point I was going to make to Mr. Chief Justice, in response to your question, there is the Oregon Employment Security Division versus Smith case, the peyote case, where the court there, involving a much stronger interest, the First Amendment free exercise of religion, nonetheless upheld an absolute ban on the use of drugs because of the state's important interest in its drug enforcement policies.

QUESTION: The analysis usually is to ask and to determine whether there's a liberty interest at the outset rather than say that your -- that that inquiry is going to be affected by the standard of review that you use. You don't say, oh, well, I'll find liberty interest because it's going to be a rational basis and everything is going to come out all right.

MR. WILLIAMS: That's correct, Your Honor.

Mr. Chief Justice, I'd like to reserve the rest of my time for rebuttal.

CHIEF JUSTICE REHNQUIST: Very well, Mr. Williams.

General Dellinger.

ORAL ARGUMENT OF WALTER DELLINGER
ON BEHALF OF THE UNITED STATES, AS AMICUS CURIAE,
SUPPORTING PETITIONERS

MR. DELLINGER: Mr. Chief Justice and may it please the Court:

QUESTION: General Dellinger, these last questions, of course, really should be addressed by you because it's your brief that takes the position that there is a liberty interest, but nonetheless, the law should be upheld.

MR. DELLINGER: That is correct, Justice O'Connor. The liberty interest we would recognize, however, unlike the argument made by Respondents is not a liberty interest in dying. We recognize the existence of a liberty interest because, on a careful reading of the complaints in this case, the Plaintiffs allege that they were undergoing severe pain and suffering. And the state had a rule which prevented them from the means of relieving that pain and suffering.

Narrowly conceived, we believe that that state's -- the kind of liberty interest that, while not fundamental, while not even as strong as the liberty interest in Cruzan,

nonetheless is not the ordinary liberty interest of shifting commercial arrangements, where a state merely need have a plausible --

QUESTION: And what -- what precisely is the liberty interest that you urge us to recognize?

MR. DELLINGER: We urge you to acknowledge, Mr. Chief Justice, that we think it's not critical to the case, but we urge you to acknowledge that a person states a cognizable liberty interest when he or she alleges that the state is imposing severe pain and suffering or has adopted a rule which prevents someone from the only means of relieving that pain and suffering. This is a narrow liberty interest, but it's -- and it's -- and it's --

QUESTION: It certainly wasn't the basis on which the Ninth Circuit decided that.

MR. DELLINGER: That is correct, that is correct. And we do not agree with the Ninth Circuit's conclusion that there is a general liberty interest in dying. But we -- and indeed this does not -- this isn't an acknowledgment on our part that does not advance our conclusion that these state laws are constitutional. But we

felt it important to indicate that --

QUESTION: And how does it differ from the liberty interest recognized or assumed, let's say, by the plurality in Cruzan?

MR. DELLINGER: That is a liberty interest that is sort of a -- deeply a part of the antitotalitarian principle, the state may not compel a person to undergo unwanted medical treatment, recognized very substantially in history. Here I think we're -- we merely look at cases like Ingraham against Wright involving corporal punishment or the prisoner medical cases about not denying prisoners access to pain relief to indicate that there is a liberty interest.

But the critical part here, I think, is that here, as in Cruzan, the critical issue is the state's overwhelming interest. States have long had laws that affirm the value of life by prohibiting anyone from promoting or assisting a suicide and I believe that no one disputes the constitutionality of those laws as a general matter. The actual question before The Court is whether the Constitution compels an exception to those laws here.

In our view it does not. The --

QUESTION: Mr. Dellinger, we've always had such laws and you go back as far as Blackstone and find Blackstone saying that suicide is not excused even when committed, quote, to avoid those ills which persons had not the fortitude to endure.

When is it that you suppose this liberty interest that didn't used to exist sprang into existence? When? 1963? What year do you think it -- it came to be?

MR. DELLINGER: 1790.

QUESTION: 1790?

MR. DELLINGER: I'm saying -- the answer is not -- not in jest. The liberty interest that we suggest unlike the generalized liberty interest in defining the time and manner of one's death, and -- and we would have made our oral argument easier if we had just gone along with the states on this.

But -- but -- but, in fact, we believe that, that if one alleges the kind of severe pain and agony that is being suffered here and that the state is the cause of standing between you and the only method of relieving that, you have stated a constitutionally cognizable liberty

interest to which a merely plausible response is not true.

If the state, for example, Justice Scalia, barred all pain medication for the terminally ill on a theory that we felt was merely plausible, we think that you would need something more substantial, not perhaps a compelling governmental interest but -- but --

QUESTION: But that has nothing to do with -- that has nothing to do with suicide, it has nothing to do with --

MR. DELLINGER: That is correct.

QUESTION: -- with a continuous tradition in our society, if not, indeed, in all western society
against -- against suicide.

MR. DELLINGER: That is correct. I think our difference is that -- is -- is -- is perhaps only one of where the greater analytical clarity comes in. We put this on the side of -- of the state's compelling interest, because here I think what is critical is that, if this -- while the individual stories are heartrending and make the case for unexception one that strikes a resonant chord for many people, it's important

for this Court to recognize that, if you were to affirm the judgments below, lethal medication could be proposed as a treatment, not just to those in severe pain, but to every competent terminally ill person in the country.

QUESTION: General, it could. The problem that I'm having is as my earlier question indicated is I -- I don't know how to weight this probability and this risk. Help me out on that.

MR. DELLINGER: Justice Souter, it is said that the risks that -- that are suggested I think by all of the parties are best weighed by you with the understanding that no American jurisdiction has ever recognized physician-assisted suicide as a lawful practice. So that there's no experiential basis for the conclusion that there could be adequate safeguards to protect those who are suffering from depression and who may request lethal medication because of untreated depression which is --

QUESTION: Of course, that -- that might be a -- a perfectly legitimate argument for saying that, on the -- on the subject of recognizing the -- the -- the -- the ultimate

cognizability of -- of new substantive due process rights, timing is a legitimate factor in what The Court does and maybe, in fact, you might argue The Court should wait until it can know more --

MR. DELLINGER: It would be --

QUESTION: -- before it passes ultimate judgment.

MR. DELLINGER: Yes. Yes, in light of the multiple uncertainties we refer to in our brief, it would be I think a grave mistake for The Court to impose on 50 states such a marked transformation that had never been tried by even a single state.

QUESTION: General Dellinger, now or ever, because this case raises that very basic question of who decides. And is it simply a question of waiting for more experience abroad or in Oregon or is it -- but, what is your position? Is this ever a proper question for courts as opposed to legislatures to decide?

MR. DELLINGER: Justice Ginsburg, we believe that the states have interests that are enduring that would sustain a decision by the state simply not to introduce lethal medication.

It is --

QUESTION: But you say -- you say only if we agree with the states, you say there is a liberty interest which -- which -- which tosses the whole matter into this Court so that it's up to us to decide whether indeed the states are right or wrong that this is a dangerous practice. And, if we think they're wrong, then -- then the liberty interest must prevail.

MR. DELLINGER: Yes.

QUESTION: That's the consequence of recognizing the literate.

MR. DELLINGER: Yes, that is -- that is correct. And I would -- but I would -- I would refer you -- I know one seldom reads but just two sentences of the New York State task force address Justice Souter's question on life and -- and, well, as I say in our briefs and both parties' briefs and many amicus briefs. But after -- after study since 1982 they said that for purposes of public debate --

QUESTION: What page? What page are you reading from.

MR. DELLINGER: Page 120, Justice Kennedy, the third paragraph below the middle of

the page. They -- they note that one can deposit ideal cases in which all recommended safeguards would be satisfied: Patients would be screened for depression and offered treatment, effective pain medication would be available, and all patients would have a supportive, committed family and doctor. Yet the reality of existing medical practice in doctors' offices and hospitals cannot generally meet these expectations, however any guidelines or safeguards might be framed. The systemic dangers are dramatic. The least costly treatment for any illness is lethal medication.

And the medical profession tells you in briefs from the A.M.A., The National Hospice Organization, the American Geriatric Association, the nurses association, that we have a system in which we are struggling to try to provide proper treatment for pain and for depression. Someone who is not treated for pain is not in a position to make the kind of decisions they need to be forced to make here.

QUESTION: So -- so what -- what should I make I thought in these very helpful briefs and there were so many helpful briefs, the

statistics, and I'm quite serious here, they were very helpful, on that worried me the most that says that only between 1 percent or 2 percent of possibly all people need die in pain. But 25 percent or more do die in pain. And I suppose that the first fact isn't of much help to the people in the second category. I'd like to get a -- I'd like to get a reaction from you.

MR. DELLINGER: The fact that 25 percent unnecessarily die in pain shows the task awaiting the medical profession, but it's not a task that calls for the cheap and easy expedient of lethal medication rather than the more expensive pain palliative.

CHIEF JUSTICE REHNQUIST: Thank you, General Dellinger.

Ms. Tucker, we'll hear from you.

ORAL ARGUMENT OF MS. TUCKER

ON BEHALF OF RESPONDENTS

MS. TUCKER: Thank you. Mr. Chief Justice, and may it please the Court:

This case presents the question whether dying citizens in full possession of their mental faculties at the threshold of death due to terminal illness have the liberty to choose to

cross that threshold in a humane and dignified manner. Does our constitution endow government with the power to intrude into --

QUESTION: You say -- you say they have the -- have the liberty to choose. But no -- as I understand it there is not an issue here. Any patients choosing to die or to commit suicide, it's that they want assistance from a physician to do it, that's what we're arguing about.

MS. TUCKER: That's correct, Your Honor. And the reason why we are focused on that is because these dying patients want a peaceful death, they want a humane death and they want a dignified death. And, in order to access that kind of death they need the assistance of their physician. The physician is the gatekeeper for the medications that can bring that peaceful end to the suffering that for these patients is intolerable.

QUESTION: Ms. Tucker, why -- why is it limited to those on the threshold of death? I mean suppose I have, you know, terrible pain and the doctor says you're going to be in terrible pain for ten years.

MS. TUCKER: Your Honor --

QUESTION: Why shouldn't I have the right to suicide.

MS. TUCKER: Justice Scalia, we do draw the line at a patient who is confronting death. That individual has a very different choice than the one you posit. This individual does not have a choice between living and dying. This dying patient whose dying process has begun and is underway, this individual has only the choice of how to die. Will that death be brutal, will that death be peaceful.

QUESTION: I hate to tell you, but the dying process of all of us has begun and is underway. It's just a matter of time. And it seems to me that the patient who has ten years of agony to look forward to has a more appealing case than the patient who is at the threshold of death.

MS. TUCKER: Well, I think not, Justice Scalia, because the patient who is facing this question of how to die -- this is the final decision for this individual. This is a patient who physicians do not have the difficulty that the state would suggest in determining that, in fact, the dying process really is imminent at

this point.

Now, keep in mind in the record in this case it was never disputed that these patients who came forward to bring this case were, in fact, quite close to death and then subsequently all did die. There's no dispute in the record about that. The physicians each testified in both of these cases that it is their regular medical practice to make that diagnosis and of course --

QUESTION: Ms. Tucker, you -- you -- you said on one end of it that it's got to be the terminal point of life, however one defines soon to die. And that's not as clear. But what about the person who is in such agony that that person is not able to assist in her own suicide so she needs the doctor or the nurse to administer the lethal dose. Isn't that person in a more sympathetic situation than the one you're describing?

MS. TUCKER: Your Honor, we don't believe that that class of persons in reality would exist. We believe that any patient who could fully express their wishes with regard to this end of life choice --

QUESTION: Let's take this person. I'm in agony, but I just can't do it myself, please do it for me.

MS. TUCKER: I see your point. I think you are describing someone who just can't bring themself to do it, as opposed to having the --

QUESTION: But wants it and six psychiatrists will swear that that's the mental state of that person.

MS. TUCKER: Your Honor, we would posit that that is not permissible, that self-administration does address an important state concern here, and that's the concern of voluntariness. We agree that this decision should always rest with the individual and that it should be authentic and voluntary. And to require the individual to not only make this choice but then to take the final act, we believe assures voluntariness in an important way.

QUESTION: Now, we believe everything that you said, it seems to me, could go on in a legislative chamber. Where should we draw the line?

MS. TUCKER: Well --

QUESTION: To say that as a matter of

Constitutional due process you include the person who is able to take the pill herself but exclude the one whose mental state is the same? I don't understand how you get that line out of a grand due process clause.

MS. TUCKER: I think again in the constitutional analysis, Your Honor, we are considering the state interests as balanced against the patient's interests. And because voluntariness is so essential here, an additional guarantee of voluntariness tips that balance differently. And I would posit that, when the patient is fully mentally competent, is making a reasoned and deliberative decision and is able then to take final action on that decision, that the balance clearly tips in favor of individual having the right to exercise this choice.

QUESTION: Why should that decision, if it's competent, reasoned, and deliberated, why should it be limited to physical pain? What -- what about the patient who has terrible emotional suffering in life and just says life is not worth it anymore?

MS. TUCKER: That --

QUESTION: You would not allow assisted

suicide in that case, I take it?

MS. TUCKER: No, Your Honor.

QUESTION: Why is that? Because we make some -- the government makes the judgment that physical pain is worse than emotional suffering?

MS. TUCKER: Your Honor, mental competency and freedom from a mental disability or instability including such as a condition --

QUESTION: You don't have to be --

MS. TUCKER: -- like depression.

QUESTION: You don't have to be unstable to think that your life is not worth living, do you? Or is the government going to make that judgment?

MS. TUCKER: I think that mental competency here is a bright line and that the -- that decision as to whether the patient is mentally competent, of course, is a clinician's judgment.

QUESTION: Assume mental competence and assume a patient who is thoroughly mentally competent, is not at the threshold of death, is not in physical pain, but does not want to live anymore.

MS. TUCKER: Well, and again that patient is not confronted with the choice that we address in this lawsuit.

QUESTION: What I'm asking, why you -- how can you limit the choice you're presenting to us to the physical pain situation?

MS. TUCKER: That individual, if intervention occurs and is not allowed to make this choice, may one day rejoice in that. It is an individual who has an expectation of life that could then be a fruitful and fulfilling life which is not the case with a patient whose life is ending due to the progress of terminal illness. That patient has an entirely different character of interest. And I do want to address --

QUESTION: And you're willing to have the government impose that judgement, even though the patient says these emotional scars will never heal.

MS. TUCKER: I believe that the constitutional --

QUESTION: And I've tried it for ten years, I want out; you're willing to let the government make that judgment for the person, but

not willing to make the judgment that your -- your physical pain is -- is not as harmful as a few more years of life would be. You're not willing to let the state make that judgment, but you will let the state make the judgment, your emotional pain is not important enough.

MS. TUCKER: I believe that's an entirely different case, Your Honor. And I did want to respond to what the Solicitor General is suggesting --

QUESTION: Well, but it is -- it is different. But it means that there is a limit to this autonomy that you are supposing.

MS. TUCKER: Yes, Your Honor.

QUESTION: And you are saying that the state can tell individuals that they may not take their own life.

MS. TUCKER: Yes, Your Honor, absolutely.

QUESTION: But I -- I still -- I -- I confess I don't understand what the limit is. You, for example, a moment ago said the -- the person with a longer life span may indeed someday rejoice that -- that -- that he was prevented from making the kind of decision effectively

which you would allow here. I mean, you can argue that of the -- of the terminally ill patient. I mean, we -- if we want to be anecdotal, we've heard anecdotes about those who suffer and at the moment of death say I have fought the good fight. I mean, you can make exactly the same argument, it seems to me, in each case.

MS. TUCKER: Well, the -- the terminally ill patient does not have the expectation of a continued life beyond this very short interim before death. Certainly the patient that you described that would choose to endure that period of suffering before death and find it ennobling and find it fulfilling should be permitted to make that choice, and many will make that choice, Justice Souter. But for some patients, based on their values and beliefs formed over a lifetime, that additional quantum of suffering is intolerable to their personhood. The notion --

QUESTION: Your -- your argument basically is an autonomy argument, then.

MS. TUCKER: Well, this -- this I think will enable me to respond to the Solicitor

General's comment that what we're dealing with here is simply a liberty interest in avoiding pain and suffering. That absolutely trivializes the claim. We have a constellation of interest, each of great Constitutional dimension. Yes, there is the interest in avoiding pain and suffering. And that, of course, was recognized as recently as in Casey as being an important feature.

QUESTION: Well, it is -- it is not only important, but it's essential --

MS. TUCKER: It is --

QUESTION: -- to your -- to your definition of the liberty interest. And we don't understand how that squares, A, with the reasoning of the Ninth Circuit which ruled in your favor and, B, with this definition of autonomy which you are asserting.

MS. TUCKER: The -- the second in the constellation of interest is decisional autonomy, and the third in the constellation that has bearing here is the interest in bodily integrity. Each of those separate interests is of constitutional dimension and each has bearing here. Going --

QUESTION: Ms. Tucker, may I ask you just to qualify one thing. You said formed over a lifetime. That's surely not part of your calculus, it could be someone who never thought a moment about this but is in terrible agony and would fit your terminal illness category. And I thought that the question Justice Souter was asking you was isn't it possible that such a person could at one time, even for a period of days, say I want to die, I want to die, and didn't get the assistance, lives on, and says I'm glad that I didn't do that, just like mistakes are made about people who commit crimes, isn't there the possibility of a person saying, gee, I really thought I wanted it yesterday, but today I don't?

MS. TUCKER: I think that's possible, Justice Ginsburg. I do think that it would be permissible for the state in an abundance of concern in that regard to impose a waiting period. It would be appropriate to ensure that this decision is reflective and that it is enduring. And that is a kind of regulation that certainly --

QUESTION: That's another thing too,

you're talking about all these regulations, very tight regulations for most liberty interests, we think of them as being free, not -- and then, if you're asking a court to declare the interests, who is then to make all these regulations? The waiting period and what else?

MS. TUCKER: Justice Ginsburg, we are asking simply that this Court recognize the vital liberty interest at stake and that it is a protected choice but not asking this Court to engage in legislation, we are not asking this Court to promulgate a code for regulation of the practice. We do think it should be left to the states.

QUESTION: You're not asking that now. But surely that's what the next couple of generations are going to have to deal with, what regulations are permissible and whatnot if we uphold your position here.

MS. TUCKER: I think not, Chief Justice Rehnquist, for this reason, we do think it's appropriate for that experimentation to occur in the states. There is substantial consensus as to what form of regulation would be appropriate. And what I can direct you to in that regard is

the amicus briefing by the state legislators --

QUESTION: But you're going to find the same thing I suspect that perhaps has happened with the abortion cases, there are people who are just totally opposed and people who are totally in favor of them. So you're going to have those factions fighting it out in every session of the legislature, how far can we go in regulating this. And that will be a Constitutional decision in every case.

MS. TUCKER: Well, I think that what we see when we look at the quite extensive proposed models that are both in the medical and legal literature and have been presented to The Court and discussed in some of the amicus briefs is that there is substantial agreement from all factions that have joined --

QUESTION: Well, I think that there is no doubt that it would result if we upheld your position, it would result in a flow of cases through The Court system for heaven knows how long. I wanted to ask you whether it should enter the balance of state interests versus the interests of the patient here, that this is an issue that every one of us faces, young or old,

male or female, whatever it might be. And all of us who are citizens and authorized to vote can certainly participate through that process in the development of state laws in this area.

Does that cause the balance in any way to shift do you think? We are not dealing perhaps with an unrepresented group, a group of children or a group of women who have no other means to protect themselves, some specific confined group. This is something that affects all of us.

MS. TUCKER: I take your point, Justice O'Connor, but I do think that we are dealing with an issue, the literature is extensive on this, that ours is a culture of denial of death. And that people in our society do not deal with their own mortality until confronted with their death and because of that I think we do have some concerns that the political process would not be expected to work in a usual fashion. We also have the reality.

QUESTION: Presumably the majority disagrees with you about that? I mean, if you're right about that scientific analysis, it's contrary to what the majority feels. And why

shouldn't we follow the majority?

MS. TUCKER: We also have the problem, Your Honor, of the quite well-established and understood underground practice of physician aid in dying and that that is available primarily to the educated and the affluent who can access a physician to provide in that assistance.

QUESTION: May I go back to the reference in your answer to Justice O'Connor to the political process not working. It seems to me that in the prior cases in which we have spoken of the political process being imperfect, it has been imperfect for exactly the reasons suggested by her question. And that is, there were certain groups who simply did not get a representative fair shake for whatever reason.

That's not what we've got here. The premise of her question I thought was, in any case I'll make it the premise of mine, is that everybody is in the same boat. And, if, in fact, you are right about the pervasiveness of the denial of death, that denial simply reflects the way we are. And it seems to me that it's a perfectly legitimate reflection when it finds its way into the legislative process. Is there a

flaw in that reasoning?

MS. TUCKER: Well, I think what I was getting at, Justice Souter, is that because there's the denial and people do not confront mortality until faced up against it, you do not have an activist component that is able to address that in the legislative process. When a patient is on their death bed, they don't have the ability to become politically active. And that is part of the problem --

QUESTION: I think your argument there is somewhat inconsistent with the filings in this case. There are also sorts of active filings of amicus briefs that indicate there is very strong political support for the contrary view.

QUESTION: And, Ms. Tucker, isn't it true that maybe the individual hasn't thought about it, but most of us have parents or other loved ones and we've lived through a dying experience that forces us to think about these things. And so the large question of -- why isn't age considered the same kind of suspect classification as race. Well, because we were all once young, we hope we will be old, it's universal.

MS. TUCKER: I think the final point that I will address to the court on why we should not simply leave this to the legislative process is perhaps the most important point, and that is that this Court has never left to the legislative process the protection of vital liberties, and the liberty at issue in this case is certainly of a vital and substantial nature.

QUESTION: Well, but it's a matter of defining the liberty. And this is a question of ethics and of morals and of allocation of resources and of our commitment to treat the elderly and the infirm. And surely legislators have much more flexibility and a much greater capacity to absorb those kind of arguments and make those decisions than we do. You're asking us in effect to declare unconstitutional the law of fifty states.

MS. TUCKER: We're asking this Court to simply recognize the vital nature of this liberty and to leave to state experimentation the regulatory process and the state --

QUESTION: Ms. Tucker, may I challenge your premise. Your premise is all we are being asked to do is to recognize the vital nature of

the liberty interest. But the issue that comes before us in a substantive due process case like this is an issue of the sort that has described in the question compared to what.

And it's the -- compared among other things, the -- compared to what, which is very, very difficult for us to assess. And it may be impossible for a court to assess that sensibly for a long time until there is more experience out in the world with what you claim ought to be the case than there is now. Why isn't that a reason for saying we are not in a position either to weight the liberty interest, although we may recognize that there is one, or to weight the countervailing claim of the state.

And, therefore, for substantive due process purposes, as an institution, we are not in a position to make the judgment now that you want us to make. It would just be guesswork.

MS. TUCKER: I think, Justice Souter, there is a tremendous amount of guidance on how to weight this liberty interest in this Court's precedence. I think, if one looks to the Cruzan case, where the patient there had lost permanently all cognition and the question was

whether her feeding tube could be withdrawn so that she might die as a result, The Court there found that to be a very significant liberty interest, because the idea.

QUESTION: I disagree with that characterization. I think The Court was very, very careful to assume a liberty interest.

MS. TUCKER: Yes. Yes. Thank you, Justice Kennedy.

QUESTION: That's a rather critical point, is it not?

MS. TUCKER: Yes, it is correct.

QUESTION: And you're talking about all of these precedents, so this first precedent you site Cruzan and that was just an assumption contrary to your description?

MS. TUCKER: I went straight to Cruzan because it's most factually similar and I appreciate the correction that, of course, it was just an assumption by The Court. And that assumption was that that individual had a liberty interest in being --

QUESTION: On the way to upholding the choice that the state made about how it wished to regulate this particular matter --

MS. TUCKER: Yes.

QUESTION: -- and that's what makes this case worlds different from Cruzan. The Court was explaining what the legislature had done and why it was reasonable.

MS. TUCKER: In Cruzan that is correct, absolutely, Your Honor, however, the focus was very much on preserving to the individual the choice.

QUESTION: That was the focus of the legislature. And this Court said, yes, the legislature did right, they recognized a liberty interest or whatever you want to call it, but they put conditions on it. And we say that what the legislature did was all right. I don't see how that is at all helpful when you are asking The Court not to approve what the legislature did and explain what the legislature did to the public, maybe better than the public might have known without The Court's decision. Instead you are asking to overturn the laws of, now, all states but one.

MS. TUCKER: The point that -- of Cruzan that I wish to suggest has important bearing here is the point that in reviewing the

state legislation that did impose that very high evidentiary standard, the point was that that was permissible to do so because it did then safeguard the personal element of the individual's choice that --

QUESTION: I don't think Cruzan was primarily about choice in the sense you're -- it was -- the liberty interest it recognized was the right to be refused medical treatment, which was based on the common-law idea that -- imposition of a medical treatment was a battery of common law.

MS. TUCKER: It also, Your Honor, was based on broader concepts than just being free of unwanted bodily invasion. It includes within it the ability to make decisions, and the right decisions.

QUESTION: Are you now drawing language -- I don't think there was language like that in the Cruzan opinion.

MS. TUCKER: I understand the Cruzan assumption of a liberty interest to be something in addition to a recognition that the common law had protected against bodily invasion.

QUESTION: But your remark just now,

that was not a quotation from anything in Cruzan.

MS. TUCKER: Correct. And I think that moving into this subject of withdrawal of treatment and what bearing it has here, I'd like to direct some comments there. In Washington an individual can direct the withdrawal of treatment and have the medical assistance in doing so. And Washington's legislature has described that as a fundamental right and to protect the dignity and autonomy of the patient. And here, where a patient does not happen to be on a removable form of life support but has, of course, had extensive medical treatment, that has very much changed their way of dying.

QUESTION: Declining medical treatment is something quite different from suicide. In saying you have a right not to have your body invaded, if you choose not to receive it, you're following a common-law tradition that goes all the way back. You're opposing a common-law tradition when you say there is a right to kill yourself. Why can't a society simply determine as a matter of public morality that it is wrong to kill yourself just as it is wrong to kill someone else. What in the Constitution prevents

that moral judgment from being made in this society's laws?

MS. TUCKER: Because I think, Your Honor, that this decision is so profoundly personal, so intimate to the individual, so much based on their own values and beliefs and perhaps religious beliefs included among those that the for the state to --

QUESTION: Every religious decision which tells you to do all sorts of unlawful acts by reason of your religious conviction, those are intensely personal as well. We don't change the law on that ground.

MS. TUCKER: This, however, Your Honor, has to do with one's own body, one's own medical care, and suffering in the face of death. And that brings it within -- if any decision falls within the private realm of decision-making, which this Court has indicated the government may not enter, it would be this decision.

QUESTION: May I ask you before you finish to tell us as best you can how you would define the liberty interest on which you rely?

MS. TUCKER: That this is a liberty, Your Honor, that involves bodily integrity,

decisional autonomy, and the right to be free of unwanted pain and suffering, and that that constellation of interests gives rise to a vital liberty, at least of the level of Cruzan.

QUESTION: But only for this narrow class. Because if you describe those as a lot of people would fit the category, but you say there are these interests but we are going to draw the line at which we recognize these interests for this terminally ill group.

MS. TUCKER: Yes.

QUESTION: So how do you get -- leave out the rest of the world who would fit the same standards?

MS. TUCKER: Yes, Your Honor, and again that gets back to the fact that these individuals that are in the process of dying are confronted only with the choice of how to die, they are not confronted with the choice of should I live or should I die.

QUESTION: But that describes something, but I don't understand why that is a disposit -- I don't understand what that justifies.

MS. TUCKER: It is as if, Your Honor,

the right that we claim here only ripens or matures when that patient is at that stage.

QUESTION: By why? That's what you're saying, but why?

MS. TUCKER: I don't think that the interest is as weighty at that point, I think that the state's interests are greater perhaps at a prior point where that individual may go on to lead a fulfilling life and contribute to society. This is not the case for someone who is right about to die.

And I would also like to say that the State of Washington has recognized that the state's interest should ordinarily give way when a patient is in that phase, because the state does permit the individual to make the choice to direct the withdrawal of treatment and thereby bring about death as a result.

QUESTION: At any time?

MS. TUCKER: No.

QUESTION: Someone can withdraw treatment or refuse treatment at age 16 as well as at age 96, isn't that true?

MS. TUCKER: Actually, Justice Ginsburg, in the State of Washington, both by

statute and by case law, the right to direct the withdrawal of treatment is specifically limited to two situations. And that is terminal illness or permanent unconsciousness. And so we have the statutory and judicial --

QUESTION: Do you mean I can't refuse treatment in the State of Washington? I don't want a blood transfusion. I have to get it?

MS. TUCKER: I think that on those kinds of situations you may implicate different rights to refuse the treatment, First Amendment rights perhaps.

QUESTION: No, but what is the law in the State of Washington? I have a toothache, I have to go get it fixed?

MS. TUCKER: I don't think so much that you are compelled to pursue medical treatment. But I think that if you are --

QUESTION: But you're telling us what the law of the State of Washington is. And I thought you told Justice Ginsburg and us that in Washington there is no right to refuse medical treatment except under some very narrow conditions. This may be true with comatose people or people in temporary shock. But I

assume that Justice Ginsburg meant -- and we're interested here, our whole discussion -- is about those who are competent and have a voluntary choice.

MS. TUCKER: I was pointing out that in the State of Washington the right to direct the withdrawal of treatment is limited, tightly, to those who are terminally ill.

QUESTION: You mean as a result of death, you mean withdrawal that will result in death?

MS. TUCKER: Yes. The withdrawal of life-sustaining treatment is limited to terminally ill patients and those that are permanently unconscious. And because the state has recognized --

QUESTION: You mean someone who is permanently -- aren't you talking about substituted judgment? Someone who is permanently unconscious obviously cannot direct the withdrawal of anything.

MS. TUCKER: Well, we do that in the State of Washington, as many states do, through the advanced directive, so that -- this is the law that I'm referring to, is that advanced

directive law.

But for patients who are competent, presently competent, it is limited to patients who are terminally ill. And it's the state's recognition that when the --

QUESTION: Well, I think you would have a pretty good case if you had some kind of kidney disease and said, I'm not going to take dialysis: Or somebody offers surgery to remedy something that's going to be a serious life-threatening problem and you say, thanks but no thanks. Now somebody has that treatment forced on them, maybe they ought to bring a case.

MS. TUCKER: I think in that context, Your Honor, the doctrine of informed consent would arise and the question could the -- would the patient consent to the treatment. And if the patient refused to consent, I do think it's possible that if that patient was appearing to refuse for suicidal reasons, that the state has the power to intervene in what would seem to be a suicidal act.

And that's what I'm trying to suggest, is that it's not a completely unlimited and unfettered right to reject treatment. A patient

who has a temporary condition that can be resolved through a short period of life-sustaining treatment and then go on to a healthy life is not a patient in the State of Washington.

QUESTION: That's not an intensely personal decision? I don't know how it becomes an intensely personal decision, you know, within a short time of death and it's not an intensely personal decision elsewhere.

MS. TUCKER: I don't think that it becomes less intensely personal, but I do think, as I have indicated in earlier responses, that it's a different choice for that patient. It is the choice of how to die when confronted by death that distinguishes it and does, in fact, place it in a separate category.

QUESTION: I don't see -- I don't see how you can separate out the two situations and say the state is entitled to impose its will despite the preferences of the individual at one stage and with respect to some pain and suffering, namely physical, but is not entitled to do it then, but is entitled to do it in other situations, when the person has emotional trauma

or when the person is further away from death.

It seems to me in both cases it is an intensely personal decision and if you want to leave it to the individual, your argument should be much broader than what it is.

QUESTION: You may consider that a question, if you wish, and answer.

(Laughter.)

QUESTION: Yes or no?

(Laughter.)

CHIEF JUSTICE REHNQUIST: Thank you, Ms. Tucker.

Mr. Williams, you have five minutes remaining

REBUTTAL ARGUMENT OF WILLIAM L. WILLIAMS

ON BEHALF OF THE PETITIONERS

MR. WILLIAMS: Thank you, Mr. Chief Justice. There's no question that death and dying are difficult issues around which to formulate public policy. And there's also no question that the line that currently exists, although bright and understandable by all, may be exceedingly fine in its application.

QUESTION: The legal line is bright and understandable. Is the real practice as clear a

line as you define?

MR. WILLIAMS: Your Honor, we have to go only by the data that we have. And there is only one study in Washington state, and for that matter it's the only study I know of nationally, in which doctors were asked whether they had been requested to provide assistance in suicide to terminally ill patients and, if so, to what extent they had complied with those requests and whether they had then been carried out. And in that study there were about 200 requests, 30 --

QUESTION: I'm not thinking so much of studies of data that's not in the public domain generally, but the one historical thing that I can't get totally out of mind is I'm not aware of any doctor ever being convicted of committing this particular offense; is that correct?

MR. WILLIAMS: I'm not aware of any either.

QUESTION: And it's hard to believe it has never been committed.

MR. WILLIAMS: I don't disagree with that, Justice Stevens. But I would remind The Court that there are other regulations as well, the licensing regulations, the heavy regulation

of these very dangerous drugs, the regulation of the health care facilities, there are other constraints. And I guess the other thing I would observe --

QUESTION: Are you aware of anybody ever having been prosecuted for attempted suicide, which is unlawful in some states? I mean, assuming suicide, you know, early in life, not later. I know it's unlawful, I don't know anybody who has ever been prosecuted for it.

MR. WILLIAMS: Most of the -- I believe all of the statutes making that a crime have been repealed because of the recognition or the heavy influence that mental disease, most likely depression, plays in the request for suicide. And that -- by the way, there are studies showing that that's true with respect to people suffering a serious illness as well. So it's the -- the suggestion that somehow the terminally ill and dying are different in that regard is again not substantiated by the studies.

But the other observation I was going to make is that if one assumes that there is some covert practice in the current law with the line as clear as it is, if the line becomes unstable

or gets muddied and the very private nature of the physician-assisted suicide transaction, if you will, between the physical and the patient, one must conclude that the abuses, if they exist at all, will be much worse. At least the potential for abuse will be much worse in that setting as well.

QUESTION: Does the literature tell us that there have been significant advances in palliative care to reduce pain for the terminally ill over the last five years, or the last ten years?

MR. WILLIAMS: Absolutely, Justice Kennedy. If you read the brief of the American Medical Association and the American Nurses Association and the other health care groups who filed a consolidated brief, that that information is in there, as well as the American Geriatric Society brief.

And one of policy arguments against allowing physician-assisted suicide is that it might be -- become the alternative to improvements in palliative care. Whether that's not -- known or not, who knows, but that's one of considerations that anyone making this policy

decision should take into account.

Justice Souter, I have had an opportunity to think a little bit more about your question about what -- experience. And I would point out that, in the Netherlands, one of the problems is that, because it's now permitted, it's become institutionalized. And there is -- although there is some disagreement about how the data is interpreted, that it appears to be pretty clear that a significant number of the deaths occur involuntarily without any consultation with the patient. The physicians over time believe they know what the patients will want and go ahead at what they think is the appropriate time and administer that.

And I would also point out that the Supreme Court of Canada has rejected the notion that there is a Constitutional right under their Article of Freedoms, which is very similar to our Due Process Clause. And that the British Government, with the assistance of the British Medical Society, considered this, they rejected the notion on policy grounds.

And of course, the New York State Task Force, which is the most comprehensive report on

this subject. So while we can't foretell the future for sure, that's one of the things that a legislature should take into account and we're asking The Court to give the legislature that opportunity.

QUESTION: Do you know of the -- any of the international human rights documents or regional human rights documents, there is recognition of what has been called the right to die or, as described today, for the terminally ill?

MR. WILLIAMS: I'm sorry, Justice Ginsburg. I don't know of any such thing, but I don't want to represent that I have a comprehensive knowledge on that. The other point I would make is in the withdrawal and refusal of treatment, the advocates for the handicapped would suggest that that's become institutionalized, and that -- there was an article in The Post on Sunday suggesting that handicapped persons who are admitted to hospitals are routinely -- not routinely, but upon occasion at least, sort of coerced --

CHIEF JUSTICE REHNQUIST: Mr. Williams, your time has expired. The case is submitted.

(Whereupon, at 11:04 a.m., the case in the above-entitled matter was submitted.)

CERTIFICATION

Alderson Reporting Company, Inc., hereby certifies that the attached pages represents an accurate transcription of electronic sound recording of the oral argument before the Supreme Court of The United States in the Matter of:

WASHINGTON, ET AL., Petitioners V HAROLD GLUCKSBERG, ET AL.

CASE NO: 96-110

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BY Ann Marie Federico

(REPORTER)