
On Hastening Death Without Violating Legal and Moral Prohibitions

Norman L. Cantor

Medical management of the dying process has been part of American culture for approximately 150 years.¹ Initially, physicians could do little besides ease the dying process by making the moribund person comfortable, comforting the surrounding loved ones, and perhaps orchestrating any rituals. The patient could not linger long, as infectious diseases and other lethal conditions generally took their toll fairly quickly. It was well into the twentieth century before physicians dealing with fatal afflictions became capable of relieving pain and prolonging life via medications, transfusions, respirators, dialysis machines, and open-heart surgery.² Medical science could wondrously extend life, even beyond a point that the dying patient would prefer. Physician management of the dying process then took the form of deciding whether to initiate and how long to maintain life-sustaining medical intervention.³ Hastening of death by poison or other lethal intervention was beyond the pale, violative of medical mores and punishable as homicide under the criminal law.⁴

In the last quarter of the twentieth century, courts established that a competent dying patient legally controls the extent of life-sustaining medical intervention.⁵ This recognition rested on both the common law

1. See Shai Lavi, *Euthanasia and the Changing Ethics of the Deathbed*, 4 THEORETICAL INQ. L. 729, 743 (July 2003), available at <https://bepress.com/til/default/vol4/iss2/art10> (discussing the changing role of the physician in the dying process since 1861).

2. See PETER G. FILENE, *IN THE ARMS OF OTHERS: A CULTURAL HISTORY OF THE RIGHT-TO-DIE IN AMERICA* 47–60 (1999) (discussing physicians' increasing role in pain relief).

3. See generally NORMAN L. CANTOR, *LEGAL FRONTIERS OF DEATH AND DYING* (1987) (discussing potential candidates for determining whether to initiate life-sustaining intervention); ROBERT VEATCH, *DEATH, DYING AND THE BIOLOGICAL REVOLUTION: OUR LAST QUEST FOR RESPONSIBILITY* (2d ed. 1989) (discussing doctors' role in initiating life support); ROBERT F. WEIR, *ABATING TREATMENT WITH CRITICALLY ILL PATIENTS* (1989) (exploring the evolution of doctors' roles in pain management).

4. John Keown, *The Legal Revolution: From "Sanctity of Life" to "Quality of Life" and "Autonomy"*, 14 J. CONTEMP. HEALTH L. & POL'Y 253, 264–65 (1998).

5. *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 224 (Cal. Ct. App. 1984); *Satz v. Perlmutter*,

doctrine of informed consent and constitutional principles of bodily control and self-determination.⁶ By 1990, the Supreme Court was willing to assume *arguendo* that a competent patient was constitutionally entitled to refuse life-sustaining medical treatment;⁷ seven years later the Court acknowledged that a medical patient's prerogative to reject life support was part of the liberty protected by the Fourteenth Amendment.⁸

This prerogative to shape medical response to a fatal affliction gives a moribund patient critical control of the dying process once the patient becomes dependent on life-extending treatment. An advanced cancer patient can decide whether to continue chemotherapy, a heart patient can decide whether to undergo open-heart surgery, and a kidney patient can decide whether to utilize a dialysis machine.⁹ Yet, control over medical intervention does not assure a tranquil dying process. Many persons are afflicted with chronic degenerative diseases that take a grievous toll before the patient becomes dependent on life-preserving medical intervention.¹⁰ While the vast majority of fatally afflicted persons have a powerful wish to remain alive, some stricken persons may, for any of a host of reasons, desire to hasten death. Chronic pain may be severe and intractable, anxiety about a future treatment regimen may be devastating, and helplessness and/or dependency may sap dignity and soil the image that the afflicted person wants to leave behind. Or, lingering in a debilitated status may, from the patient's perspective, burden loved ones excessively.

A dying patient's interest in hastening death is in tension with an apparent social principle that respect for sanctity of life demands suppression of all intentional killing, including suicide and killing

362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978); *In re Farrell*, 529 A.2d 404, 406 (N.J. 1987).

6. See, e.g., *Rasmussen v. Fleming*, 741 P.2d 674, 686 (Ariz. 1987) (discussing the notion that incompetents must be afforded all due process rights); *Severns v. Wilmington Med. Ctr.*, 421 A.2d 1334, 1347 (Del. 1980) (recognizing the constitutional right to self-determination); *In re Colyer*, 660 P.2d 738, 746 (Wash. 1983) (refusing to require judicial intervention when the physician and close family members agree on the prognosis).

7. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 279 (1990).

8. *Washington v. Glucksberg*, 521 U.S. 702, 719 (1997).

9. WEIR, *supra* note 3; Norman L. Cantor, *Twenty-five Years After Quinlan: A Review of the Jurisprudence of Death and Dying*, 29 J.L. MED. & ETHICS 182, 183 (2001); see also *supra* note 5 (outlining cases that establish a person's right to control life-sustaining medical treatment).

10. STEPHEN G. POST, *THE MORAL CHALLENGE OF ALZHEIMER DISEASE* 2-4 (2d ed. 2000).

motivated by a desire to relieve suffering.¹¹ Mercy killing has long been anathema in American law.¹²

Traditional criminal law simply does not let the presence of extreme suffering by the victim and a merciful motive or intention by the perpetrator serve as a legal justification for knowingly killing a person. A knowing killing has always been treated as unlawful no matter how severe the victim's suffering, how near his death, how firm his request for death, or how motivated the killer is by a desire to relieve suffering.¹³

A ban on mercy killing is arguably a reminder of social veneration for life, even though compassion for a suffering, dying person may tempt a health care provider or other observer to relieve that suffering by any means possible, especially when the patient is requesting such relief. The ban is a symbolic reminder of the preciousness of human life and of the moral worth of every human.¹⁴ Is a patient's right to precipitate his own death by demanding removal of a life-preserving respirator or artificial nutrition and hydration consistent with this aversion to intentional killing? The common response is that removal of life support merely allows nature to run its course, while hastening of death via independent human intervention, for example by a poison, represents an unnatural killing undermining the sanctity of life in an imprudent way.¹⁵ An unnatural intervention hastening death supposedly offends the sanctity of life more acutely than removal of artificial medical intervention that has obstructed a natural dying process.

This Article argues that this framework is too simplistic. Current medical ethics and the jurisprudence of death and dying authorize practices that make the ostensible ban on hastening death highly deceptive.¹⁶ These practices include some withdrawal of life support,

11. Daniel J. Gilman, *Thou Shalt Not Kill as a Defeasible Heuristic: Law and Economics and the Debate over Physician-Assisted Suicide*, 83 OR. L. REV. 1239, 1287 (2004).

12. GLANVILLE WILLIAMS, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* 319–22 (1957); John Harris, *The Philosophical Case Against the Philosophical Case Against Euthanasia*, in *EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES* 36, 39–40 (John Keown ed., 1995).

13. Norman L. Cantor, *On Kamisar, Killing, and the Future of Physician-Assisted Death*, 102 MICH. L. REV. 1793, 1837–38 (2004).

14. LEON R. KASS, *LIFE, LIBERTY AND THE DEFENSE OF DIGNITY: THE CHALLENGE FOR BIOETHICS* 240–43 (2002).

15. Daniel Callahan, *Killing and Allowing to Die*, in *BIOMEDICAL ETHICS* 390, 390 (Thomas A. Mappes & David DeGrazia eds., 4th ed. 1996); Leon R. Kass, *Death with Dignity and the Sanctity of Life*, 89 COMMENT. 33, 35–36 (Mar. 1990).

16. See Timothy E. Quill, *Risk Taking by Physicians in Legally Gray Areas*, 57 ALB. L. REV. 693, 694 (1994) (discussing the arbitrary exclusion of severely suffering patients from hastening

patients' voluntary stopping of eating and drinking (VSED), terminal sedation (TERSE), and some forms of pain relief.¹⁷ These ways of hastening death are legal in some circumstances and in use to some degree.¹⁸ Does availability of these modes of hastening death make bans on physician assisted suicide (PAS) and/or voluntary active euthanasia (VAE) anomalous? Does their availability obviate any need for legalization of PAS or VAE? These are hard questions in light of the objective of providing competent, dying persons with a means of shaping a dying process that assures a modicum of dignity.

I. KILLING VERSUS LETTING DIE

A physician's withdrawal of life support is unquestionably an *action* precipitating death.¹⁹ Since the 1970's when the notion of a right to reject life-sustaining medical intervention emerged, the common wisdom has been that such withdrawal at the behest of a competent patient is distinct from assisting a patient to die by providing a lethal poison or from causing death by administering a lethal substance.²⁰ According to proponents of this position, withdrawal of life support merely allows nature to take its course, while PAS and VAE unnaturally precipitate death in order to relieve an afflicted patient's suffering or prospective suffering.²¹ For these persons, PAS and VAE constitute independent terminations of life and intentional killing. The Michigan

death based on ethical and legal distinctions); *see also* Cantor, *On Kamisar*, *supra* note 13, at 1831-40 (discussing legal and moral aspects of end of life options).

17. All of these techniques hasten death in some fashion. VSED is accompanied by rejection of artificial nutrition and hydration so that the rejecting patient dies of dehydration. TERSE takes various forms. Norman L. Cantor & George C. Thomas III, *The Legal Bounds of Physician Conduct Hastening Death*, 48 BUFF. L. REV. 83, 138-51 (2000). One form of TERSE is a decision by a patient who could survive for some period to be sedated to unconsciousness and allowed to die from dehydration sooner than the patient otherwise would have died. *Id.* at 145-51. Some doses of pain relief medication are capable of affecting the respiratory tract and leading to an earlier death than would otherwise be the case. *Id.* at 110-32.

18. *See* ROGER S. MAGNUSSON, ANGELS OF DEATH: EXPLORING THE EUTHANASIA UNDERGROUND 192-94 (2002) (discussing sedating patients into comas); Quill, *supra* note 16 (discussing physicians' role in easing pain).

19. David Orentlicher, *The Legalization of Physician-Assisted Suicide*, 335 NEW ENG. J. MED. 663, 663 (1996).

20. *See, e.g.*, *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 222-26 (Cal. Ct. App. 1984) (holding patients have the right to refuse medical treatment over the objection of their doctors); *Satz v. Perlmutter*, 362 So.2d 160, 162 (Fla. Dist. Ct. App. 1978) (holding that patients have the right to refuse medical treatment based on constitutional right of privacy); *In re Conroy*, 486 A.2d 1209, 1224 (N.J. 1985) (holding that a competent adult has the right to refuse life support treatment).

21. Orentlicher, *supra* note 19, at 663.

Supreme Court commented, in rejecting a challenge to the state's ban on assistance to suicide:

[W]hereas suicide involves an affirmative act to end a life, the refusal or cessation of life-sustaining medical treatment simply permits life to run its course, unencumbered by contrived intervention There is a difference between choosing a natural death summoned by uninvited illness or calamity, and deliberately seeking to terminate one's life by resorting to death-inducing measures unrelated to the natural process of dying.²²

The idea of "letting nature take its course" does not fully explain why "pulling a plug" is different from other acts that hasten a person's death. A doctor's withdrawal of life sustaining medical treatment (LSMT) may constitute an unlawful killing even though the conduct merely allows a natural disease condition to take its fatal course.²³ For example, a physician, even one motivated by compassion, who enters a suffering pulmonary patient's room and without consent pulls the plug from the patient's respirator is guilty of murder if death follows from the physician's action.²⁴ That is so regardless of the patient's short remaining life span, the physician's motive to relieve suffering, or the fact that the immediate cause of death was asphyxiation stemming from the underlying lung disease. The key to making the physician's conduct lawful would be the patient's informed consent to cessation of LSMT. In short, withdrawal of life support can offend the sanctity of life as much as administration of a poison. Each of these lethal actions can constitute the intentional termination of life—mercy killing. It is self-deception if people think they are not killing anyone when they deliberately choose a regimen of treatment which they know will result in the patient's death when there is an alternative which will keep the patient alive.²⁵

22. *People v. Kevorkian*, 527 N.W.2d 714, 728–29 (Mich. 1994). See also *Thor v. Superior Court*, 855 P.2d 375, 385 (Cal. 1993) (holding that a physician is not criminally liable if he allows a patient to forego a life-sustaining procedure); *McKay v. Bergstedt*, 801 P.2d 617, 632 (Nev. 1990) (affirming the right of a competent adult to allow his natural death to take its course, unimpeded by artificial support).

23. Allen Buchanan, *Intending Death: The Structure of the Problem and Proposed Solutions*, in *INTENDING DEATH: THE ETHICS OF ASSISTED SUICIDE AND EUTHANASIA* 28, 30 (Tom L. Beauchamp ed., 1996).

24. The unauthorized withdrawal of life support violates the physician's duty to continue life-sustaining treatment that the patient has sought. Alan Meisel, *Physician-Assisted Suicide: A Common Law Roadmap for State Courts*, 24 *FORDHAM URB. L.J.* 817, 846–48 (1997); David Orentlicher, *The Legalization of Physician-Assisted Suicide: A Very Modest Revolution*, 38 *B.C. L. REV.* 443, 447–48 (1997).

25. John Harris, *The Philosophical Case Against Euthanasia*, in *EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES* 36, 43 (John Keown ed., 1995).

Many distinguish a physician's removal of life support at the request of a patient from administration of a poison at the request of a patient by pointing to the patient's exercise of a right to bodily integrity in the former case. From that perspective, a person has a venerable constitutional prerogative to resist bodily invasions, including medical interventions, but not to introduce dangerous substances such as poisons into the body. Chief Justice Rehnquist used that rationale in upholding Washington State's ban on physician provision of a poison even though the state permitted removal of LSMT.²⁶ Chief Justice Rehnquist's claim to the contrary notwithstanding, the fact that withdrawal of treatment avoids a bodily intrusion does not by itself account for a patient's prerogative to control LSMT. Patient autonomy has had equal stature with bodily integrity in the cases upholding a patient's right to reject life-sustaining medical intervention.²⁷ That is, a medical patient's autonomy in responding to a fatal affliction is an integral part of the prerogative to resist LSMT.

Common sense dictates a similar conclusion. For those who think that control over bodily intrusions is the key to a right to reject LSMT, I urge a thought experiment.

Suppose that a dying patient who has deteriorated to an intolerably undignified state could be kept alive by a medical treatment that involved no bodily intrusion—say by a magic extra-corporeal machine that emitted waves neither penetrating the body nor even noticeable to the patient. Does anyone doubt that the patient would be entitled to reject the magic machine? And wouldn't it be the patient's autonomy interest in choosing how to respond to a fatal affliction that accounted for the patient's prerogative? In other words, the fact that letting nature take its course entails an avoidance of bodily intrusions does not account for the disparate treatment of PAD and withdrawal of LSMT.²⁸

In short, it is doubtful that either the patient's interest in bodily integrity or the attributing of death to a natural disease process supports the judicial insistence that removal of life support constitutes less of an affront to the sanctity of life concept than PAS or VAE.

The societal prohibition of virtually all active killings does underscore the symbolic importance of human life. Yet removal of life-

26. *Washington v. Glucksberg*, 521 U.S. 702, 725 (1997).

27. *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 306 (Cal. Ct. App. 1986) (holding that personal dignity is part of the right to privacy); *Satz v. Perlmutter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978) (holding state interest in preserving life is outweighed by competent adult patient's interest in choosing death if suffering from an incurable disease).

28. Cantor, *On Kamisar*, *supra* note 13, at 1805–06.

sustaining medical intervention is not generally viewed as any less of a symbolic affront to the sanctity of life than more active killing of suffering medical patients. That is, the removal of life support by a physician is often perceived as a killing, just as administration of an injection would be.²⁹

Public perception (which is, after all, the determinant of the success of any symbolic message about sanctity of life) often regards a physician's removal of life support as an intentional killing. In the recent *Schiavo* case, right to life advocates cultivated the image of physicians "making someone die" by removal of artificial nutrition and hydration, branding the conduct "court-ordered euthanasia."³⁰ Since the *Quinlan* case surfaced in New Jersey in 1975,³¹ popular consciousness has often regarded disconnection of life support as causing death. This perspective was supported when the Morris County prosecutor in 1975 threatened to indict for homicide anyone who disconnected Ms. Quinlan's respirator. Even the trial judge regarded removal of a life-preserving respirator as a form of homicide.³² This common perception of physician end-of-life actions also accounted for the frequent reference to removal of life support as "passive euthanasia,"³³ at least where the withdrawal was apparently intended to hasten the afflicted patient's death. Yale Kamisar, always a vigorous opponent of physician-assisted suicide and euthanasia, found removal of life support "troubling" precisely because of the accompanying image of a mercy killing.³⁴ Finally, some recent critics of a proposed living will statute in the United Kingdom expressed strong concern that the withdrawal of treatment would constitute "euthanasia by omission."³⁵

The perception of removal of life support as intentional killing sharpens when the life support consists of artificial nutrition and hydration (ANH). Some people portray withdrawal of ANH as an

29. J. Andrew Billings & Susan D. Block, *Slow Euthanasia*, 12 J. PALLIATIVE CARE 21, 26 (1996).

30. Steven W. Mosher, Statement in Support of the Life of Terri Schiavo (Oct. 13, 2004), <http://www.catholic.org/prwire/headline.php?ID=1155>.

31. *In re Quinlan*, 355 A.2d 647, 651 (N.J. 1976).

32. *In re Quinlan*, 348 A.2d 801, 820 (N.J. Super. Ct. Ch. Div. 1975).

33. William E. May et al., *Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons*, 3 ISSUES IN L. & MED. 203, 207-09 (1987), quoted in NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN OTHERS MUST CHOOSE 209 n.8 (1992).

34. Yale Kamisar, *The "Right to Die": On Drawing (and Erasing) Lines*, 35 DUQ. L. REV. 481 (1996).

35. Liam Allen, *Living Wills: "My Right to Choose,"* BBC News, Dec. 14, 2004, <http://news.bbc.co.uk/1/hi/uk/4095869.stm>.

action aimed at death, a form of murder or euthanasia.³⁶ That certainly occurred in the recent *Schiavo* case on the part of those trying to keep Ms. Schiavo alive. Nevertheless, the fatal consequences of removal of ANH are no different than the fatal consequences of removal of a critical respirator or any other life-extending medical intervention. The point is that some people consider an affront to the sanctity of life to be present any time a physician terminates artificial life support. The public message accompanying a withdrawal of life support thus seems to mirror the message accompanying physician-assisted suicide or euthanasia.

Efforts are often made to use the physician's state of mind to differentiate physician removal of life support from other ways of hastening death.³⁷ The contention is that a physician withdrawing life support intends only to respect the patient's wishes to be spared further medical intervention rather than to make the patient dead.³⁸ There are, of course, instances when a patient does reject further LSMT to avoid a burdensome medical intervention and has no specific intent to die. In many other instances, however, a dying patient has reached a stage of debilitation that is personally intolerable, so that rejection of LSMT reflects a specific wish to die.³⁹ In such instances, a cooperating physician withholding or withdrawing LSMT may well share the patient's object to hasten death.⁴⁰ "Compassionate critical care clinicians [ending life support] may often wish that death would come quickly . . . for the sake of patients"⁴¹

A fatally stricken patient's intent to hasten death is clearest when the choice to reject LSMT ends a life that could be preserved for a substantial period via unburdensome medical intervention. This occurs, for example, when a debilitated patient whose condition has stabilized nonetheless rejects relatively unburdensome LSMT. On several

36. *Woods v. Commonwealth*, 142 S.W.3d 24, 61–62 (Ky. 2004) (Wintersheimer, J., dissenting).

37. *Vacco v. Quill*, 521 U.S. 793, 802 (1997); Leon R. Kass, "I Will Give No Deadly Drug": *Why Doctors Must Not Kill*, in *THE CASE AGAINST ASSISTED SUICIDE* 17, 37 (Kathleen, Foley & Herbert Hendin eds., 2002).

38. Felicia Cohn & Joanne Lynn, *Vulnerable People: Practical Rejoinders to Claims in Favor of Assisted Suicide*, in *THE CASE AGAINST ASSISTED SUICIDE*, at 238.

39. Alexander Morgan Capron, *Death and the Court*, *HASTINGS CENTER REP.*, Sept.–Oct. 1997, at 27–28; Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 *HARV. L. REV.* 2021, 2030 (1992).

40. Buchanan, *supra* note 23, at 28–30.

41. Capron, *supra* note 39, at 27–28 (stating that a physician's object may well be "to allow death to occur, to end an existence that no longer benefits the patient"); Graeme M. Rucker & J. Randall Curtis, *Caring for the Dying in the Intensive Care Unit*, 290 *J. AM. MED. ASS'N* 820, 821 (2002).

occasions, paraplegics have chosen to reject ANH even though they are certain to die without it.⁴² Cooperating physicians withdrawing ANH *might* only be following the patient's wishes, or *might* somehow mentally focus entirely on relieving suffering rather than ending life, but often those physicians sympathize with and share the patient's desire to end the debilitated existence as quickly as possible.⁴³

As noted, some physician removals of LSMT constitute intentional killings and are perceived as killings by the public for purposes of symbolism even though the physicians' actions allow a natural disease process to run its course. But even if there were some symbolic difference between physician conduct in independently initiating death (as by a lethal injection) and physician conduct precipitating death from an underlying disease (as by removal of LSMT), other legal modes of hastening death exist where the cause of death is not an underlying disease process. The next section addresses those modes.

II. VOLUNTARY STOPPING OF EATING AND DRINKING

One thesis of this article is that existing modes of handling dying medical patients permit some intentional hastening of death. Rejection of LSMT is one example. Voluntary stopping of eating and drinking is another.

Even before a natural pathology or disease process makes a fatally stricken person dependent on artificial life support, the patient may voluntarily stop eating and drinking and decline any ANH.⁴⁴ This course of conduct will prompt death by dehydration within seven to fourteen days. Such a dying process is usually tranquil, the patient slipping into a coma within days from which she never emerges.⁴⁵ In the event any agitation or discomfort occurs, it can be handled by

42. *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 306 (Cal. Ct. App. 1986); *State v. McAfee*, 385 S.E.2d 651, 651 (Ga. 1989); *McKay v. Bergstedt*, 801 P.2d 617, 620 (Nev. 1990).

43. See, e.g., Henk Jochemson, *Life-Prolonging and Life-Terminating Treatment of Severely Handicapped Newborn Babies*, 8 ISSUES IN L. & MED. 167, 167 (1992) (exploring withdrawal of life support by Dutch physicians aimed at hastening death).

44. See Robert M. McCann et al., *Comfort Care for Terminally Ill Patients: The Appropriate Use of Nutrition and Hydration*, 272 J. AM. MED. ASS'N 1263 (1994) (discussing benefits patients receive when they voluntarily cease eating and drinking); Candace Jans Meares, *Terminal Dehydration: A Review*, 11 AM. J. HOSPICE & PALLIATIVE CARE 10 (1994) (discussing the decision to employ artificial means of nutrition); Louise Printz, *Terminal Dehydration, A Compassionate Treatment*, 152 ARCHIVES OF INTERNAL MED. 697, 700 (1992) (discussing patients' decision to stop intravenous or nasogastric fluids); Paul Rousseau, *Hospice and Palliative Care*, DISEASE-A-MONTH, Dec. 1995, at 788, 829-30 (describing palliative care for primary care physicians).

45. Ira Byock, *Patient Refusal of Nutrition and Hydration*, 12 AM. J. HOSPICE & PALLIATIVE CARE 8, 11 (1995).

simple palliative attention including sedation.⁴⁶ For a terminally ill or chronically suffering patient, VSED seems like a simple and effective way to control the timing of death.⁴⁷

VSED has some earmarks of suicide, and a health care provider's cooperation, such as by providing palliative care, smacks of assisted suicide. In contrast to rejection of LSMT, the fasting patient self-initiates the destructive course (dehydration) that brings about death. Most people acknowledge that passive means may accomplish suicide, such as by refusal to eat or drink.⁴⁸ In addition, despair may prompt the fatally stricken patient's course of conduct, so that the patient's specific intent is to bring about her own death.⁴⁹ This conscious and deliberate refusal of ANH is different from the common phenomenon in which a patient imminently dying loses interest in eating and drinking; physicians may then refrain from ANH, but it's because of futility rather than acquiescence in a patient's chosen course of conduct.⁵⁰

The common elements between facilitation of VSED and assisted suicide make the legal status of VSED somewhat uncertain. Many commentators invoke a competent person's bodily integrity and control of medical intervention to maintain that VSED is lawful.⁵¹ Yet, the

46. See JAMES HOEFLER, *MANAGING DEATH* 112–23 (2001) (discussing the status of ANH); see also James Bernat et al., *Patient Refusal of Hydration and Nutrition*, 153 *ARCHIVES OF INTERNAL MED.* 2723 (1993) (examining physician-assisted suicide, voluntary active euthanasia, and patient refusal of hydration and nutrition); McCann et al., *supra* note 44, at 1265–66 (addressing provision of nutrition and hydration to terminally ill or incapacitated patients); Meares, *supra* note 44, at 11 (discussing benefits of terminal dehydration).

47. A recent report from Oregon indicated that more people there end their lives by VSED than by poison as authorized by Oregon law. Joan Arehart-Treichel, *Terminally Ill Choose Fasting Over M.D. Assisted Suicide*, *PSYCHIATRIC NEWS*, Jan. 16, 2004, at 15.

48. See, e.g., ROBERT N. WENNBERG, *TERMINAL CHOICES: EUTHANASIA, SUICIDE, AND THE RIGHT TO DIE* 33–34 (1989) (discussing whether refusing food constitutes suicide); Robert M. Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 *FORDHAM L. REV.* 1, 18 (1975) (discussing the difference between passively submitting to death and actively seeking it); Terence M. O'Keefe, *Suicide and Self-Starvation*, in *SUICIDE: RIGHT OR WRONG?* 117, 123 (John Donnelly ed., 1990) (exploring whether refusal of nutrition constitutes suicide). Starving oneself to death is no different from putting a gun to one's temple as far as the common-law definition of suicide is concerned. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 296 (1990) (Scalia, J., concurring).

49. See *Rasmussen v. Fleming*, 741 P.2d 674, 674 (Ariz. 1987) (holding that an individual may refuse medical treatment even if that refusal results in death); *In re Colyer*, 660 P.2d 738, 742 (Wash. 1983) (holding that the right to refuse medical treatment, even if that decision leads to death, is a constitutional right).

50. McCann, *supra* note 44, at 1266; Printz, *supra* note 44, at 700.

51. E.g., Bernat *supra* note 46, at 2725 (justifying patient refusal of hydration and nutrition as consistent with medical, moral, and legal practices); Timothy E. Quill, et al., *Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia*, 278 *J. AM. MED. ASS'N* 2099, 2100 (1997) (explaining patients' reasoning for refusing life-sustaining treatment); Lori

patient's self-initiated fatal course complicates the picture. In cases involving hunger-striking prisoners whose object is to fast until death, most courts see a suicide and reject the notion that a person has a right to die by self-initiated dehydration.⁵² The comment of an intermediate appellate court in New York is fairly typical:

[I]t is self-evident that the right to privacy does not include the right to commit suicide To characterize a person's self-destructive acts [hunger striking] as entitled to Constitutional protection would be ludicrous. On the contrary, the State has a duty to protect the health and welfare of those persons in its custody.⁵³

In dictum in 1990, a Supreme Court majority seemed to assume that a state could constitutionally intervene to prevent an adult from starving herself to death.⁵⁴

The commentators asserting the legality of VSED by a fatally stricken patient are probably right. Although authority on point is sparse, neither courts nor health care providers are inclined to intervene when a fatally stricken, debilitated patient competently decides to stop eating and drinking. Two unpublished cases in New York involve chronically ill women in their mid-eighties engaging in VSED.⁵⁵ When their nursing homes sought judicial intervention authorizing ANH to prevent the patients' deaths, the courts refused to intervene.⁵⁶

Diverse factors may account for the judicial reluctance to intervene to compel nutrition and hydration. Some courts think that a competent person has a right to resist both natural feeding and ANH, as a matter of bodily integrity and self-determination,⁵⁷ even when death is purposefully hastened. A major factor reinforcing that judicial

Montgomery, *Starving is Legal Suicide Method*, DETROIT FREE PRESS, Nov. 20, 1996, at 1A (explaining the use of starvation by individuals to commit suicide).

52. NORMAN L. CANTOR, LEGAL FRONTIERS OF DEATH AND DYING 26–28 (1987); Cantor & Thomas, *supra* note 17, at 98–102.

53. *Von Holden v. Chapman*, 450 N.Y.S.2d 623, 625 (N.Y. App. Div. 1982). *See also In re Caulk*, 480 A.2d 93, 97 (N.H. 1984) (holding the state's interest in life outweighs healthy prison inmate's interest in bringing about his own death); *Laurie v. Senecal*, 666 A.2d 806, 808 (R.I. 1995) (reaching a similar holding to that of *Von Holden*).

54. *Cruzan v. Dir. Mo. Dep't of Health*, 497 U.S. 261, 280 (1990).

55. *In re Brooks* (N.Y. Sup. Ct. 1987) (unpublished opinion on file with author); *A.B. v. C.*, 477 N.Y.S.2d 281 (N.Y. Sup. Ct. 1984).

56. *In re Brooks*; *A.B. v. C.*, 477 S.2d at 284; Rebecca Dresser, *When Patients Resist Feeding*, 33 J. AM. GERIAT. SOC'Y 790, 793 (1985).

57. *See Zant v. Prevatte*, 286 S.E.2d 715, 715 (Ga. 1982) (holding that a prisoner has the constitutional right to refuse food); *In re Brooks* (refusing to intervene to force an elderly nursing home patient to have a feeding tube forced on her against her wishes); Rebecca Dresser, *The Supreme Court and End-of-Life Care: Principled Distinctions or Slippery Slope?*, in LAW AT THE END OF LIFE 83, 87 (Carl Schneider ed., 2000) (highlighting differing perspectives on physician assisted suicide).

inclination may be revulsion at the prospect of physically overcoming and restraining people—all of whom are debilitated and some of whom are enmeshed in an inexorable dying process—against their will. The use of long-term physical or chemical restraints is obviously inhumane and demeaning and therefore repugnant.⁵⁸ Justice O'Connor has noted how forced treatment of a competent patient burdens "liberty, dignity, and freedom to determine the course of her own treatment."⁵⁹

Accordingly, "[t]he likelihood is that solicitude for the competent patient's dignity will impel courts to refrain from interfering when nutrition is declined by fatigued, dying patients."⁶⁰ This provides a moribund patient with a means of hastening death (VSED) within a maximum of seven to fourteen days. This form of self-killing is probably lawful and will probably become more and more common in America as its availability becomes more widely known.⁶¹

III. TERMINAL SEDATION

Another contemporary medical practice that offers a way to hasten death is terminal sedation. There are actually several different versions of TERSE, with the common thread that they all begin with medical administration of deep sedation rendering the patient unconscious or stuporous, and end with the patient's death.⁶² The first form of TERSE is sedation accompanying the cessation of mechanical life support.⁶³ The object is to preclude any discomfort, anxiety, agitation, respiratory distress, or pain and suffering while the patient dies from the underlying disease following the removal of artificial life support. The dosage of sedatives is generally commensurate with relief of suffering without causing respiratory depression, so that the sedation need not hasten

58. Bernard Lo & Laurie Dornbrand, *Guiding the Hand that Feeds*, 311 NEW ENG. J. MED. 402, 403 (1984). For a more detailed description of the restraint process, see Norman L. Cantor, *Two Opinions in Search of a Justice: The Constitution and Physician-Assisted Suicide*, 28 RUTGERS L.J. 435, 447-48 (1997).

59. *Cruzan*, 497 U.S. at 288-89 (O'Connor, J., concurring).

60. Cantor & Thomas, *supra* note 17, at 102. See also Dresser, *supra* note 56, at 793 (predicting that courts will permit some competent, seriously ill individuals to refuse life-sustaining nutritional support).

61. Dresser, *supra* note 56; Printz, *supra* note 44; Arehart-Treichel, *supra* note 47.

62. For a more exhaustive analysis of terminal sedation, see Cantor & Thomas, *supra* note 17, at 138-51.

63. Margaret L. Campbell, *Case Studies in Terminal Weaning from Mechanical Ventilation*, 2 AM. J. CRITICAL CARE 354 (1993); Barbara J. Daly et al., *Withdrawal of Mechanical Ventilation: Ethical Principles and Guidelines for Terminal Weaning*, 2 AM. J. CRITICAL CARE 217 (1993); William C. Wilson et al., *Ordering and Administration of Sedatives and Analgesics During the Withholding and Withdrawal of Life Support from Critically Ill Patients*, 267 J. AM. MED. ASS'N 949, 951 (1992).

death.⁶⁴ Nevertheless, there are anecdotal reports of excessive doses of sedatives probably precipitating death⁶⁵ and in one study, thirty-six percent of surveyed professionals reported that hastening death was at least a secondary object in administering sedatives in tandem with withdrawal of life support.⁶⁶

A second form of TERSE—unassociated with removal of life support—involves deep sedation to unconsciousness or stupor toward the end stage of a dying process.⁶⁷ The object is still preclusion of suffering accompanying diverse intractable symptoms such as pain, nausea, dyspnea, anxiety, or delirium.⁶⁸ While the literature usually describes this second form of TERSE as occurring at the “end stage” in a dying process, the definition of end stage varies from imminent death looming within hours or days, to death unavoidably occurring within weeks or even months.⁶⁹ Since deep sedation is administered to patients who are gravely deteriorated and unavoidably dying, it may be almost impossible to know whether the underlying disease process or the effects of sedation caused death.⁷⁰ Often, the literature by clinicians assigns the underlying ailment as the cause of death rather than sedation.⁷¹ Still, the possibility of the sedative hastening death by

64. Daly, *supra* note 63, at 222; Wilson, *supra* note 63, at 952–53.

65. Billings & Block, *supra* note 29; Carol A. Riddick & Lawrence J. Schneiderman, *Distinguishing Between Effect and Benefit*, 5 J. CLINICAL ETHICS 41, 42 (1994).

66. Wilson, *supra* note 63, at 951.

67. Howard Brody, *Commentary on Billings & Block's "Slow Euthanasia,"* 12 J. PALLIATIVE CARE 38, 39 (1996); Patrick Norris, *Palliative Care and Killing: Understanding Ethical Distinctions*, 13 BIOETHICS F. 25, 27 (1997).

68. Beth McIver et al., *The Use of Chlorpromazine for Symptom Control in Dying Cancer Patients*, 9 J. PAIN & SYMPTOM MGMT. 341 (1994) (discussing a study indicating need for deep sedation to relieve distressing symptoms in 25% to 50% of dying cancer patients); Balfour Mount, *Morphine Drips, Terminal Sedation, and Slow Euthanasia: Definitions and Facts, Not Anecdotes*, 12 J. PALLIATIVE CARE 31, 35 (1996).

69. Robert E. Enck, *Drug-Induced Terminal Sedation for Symptom Control*, AM. J. HOSPICE & PALLIATIVE CARE Sept.–Oct. 1991, at 3, 4 (1991) (discussing sedation in the last weeks of life); Paul Rousseau, *Terminal Sedation in the Care of Dying Patients*, 156 ARCHIVES OF INTERNAL MED. 1785, 1785 (1996) (discussing the humanity of TERSE in cases of imminent death).

70. Robert Dozor, *Intentionally Hastening Death*, 38 J. FAM. PRAC. 295, 297 (1994); William R. Greene & William H. Davis, *Titrated Intravenous Barbiturates in the Control of Symptoms in Patients with Terminal Cancer*, 84 SO. MED. J. 332, 335, 337 (1991); Russell K. Portenoy, *Morphine Infusions at the End of Life: The Pitfalls in Reasoning from Anecdote*, 12 J. PALLIATIVE CARE 44, 45 (1996).

71. Nessa Coyle, *Pain Management and Sedation in the Terminally Ill*, 5 AACN CLINICAL ISSUES IN CRITICAL CARE NURSING 360, 362–63 (1994); Greene & Davis, *supra* note 70, at 335; Robert D. Truog et al., *Barbiturates in the Care of the Terminally Ill*, 327 NEW ENG. J. MED. 1678, 1679 (1992).

prompting respiratory depression is present even if that causation is unprovable.⁷²

A third form of TERSE is the most problematic. This form resembles the other forms (deep sedation to unconsciousness in order to avoid unnecessary suffering) with the important addition that no ANH is provided once the patient becomes unconscious.⁷³ While the patient is sure to die without ANH, the actual cause of death may still be uncertain. The underlying disease, the sedation, and dehydration accompanying cessation of ANH are all candidates for cause of death. Relief of intractable and intolerable symptoms provides a legal justification for deep sedation even if the sedation poses some risk of hastening death.⁷⁴ The troublesome case is where the sedated patient was previously capable of eating so that the sedation prompts incapacity to orally ingest nutrition and hydration and where the TERSE process is commenced at a point so far in advance of the expected death by natural disease that the actual cause of death will probably be dehydration. Indeed, once relief of suffering has been achieved by deep sedation, the function of withholding ANH appears to be hastening death.

Earlier, this article argued that a suffering, dying patient is entitled to stop eating and drinking (VSED), reject ANH, and then receive sedation as necessary to relieve anxiety, agitation, or distress encountered during the days preceding death by dehydration. The third form of TERSE is a variation on that theme. The fatally stricken patient requests deep sedation and simultaneously declines ANH that might well be necessary for survival in an unconscious, deeply sedated state. Does the sequence here render the course of events, and a physician's participation in it, unlawful? Is this process "slow euthanasia" precipitated by the sedation that incapacitates the patient's normal digestive processes?⁷⁵

One possible distinction is that a patient who initiates VSED and then rejects ANH is seeking to escape experiential suffering while a patient who first initiates deep sedation is already relieved from experiential suffering at the point when ANH is subsequently withheld. That is, one

72. Daly, *supra* note 63, at 222; Wilson, *supra* note 63, at 952–53 (acknowledging the hemodynamic and respiratory depressant qualities of the sedatives used).

73. MAGNUSSON, *supra* note 18, at 194; Cantor & Thomas, *supra* note 17, at 145–51; Quill, *supra* note 51, at 2101.

74. Nathan I. Cherny & Russell K. Portenoy, *Sedation in the Management of Refractory Symptoms, Guidelines for Evaluation and Treatment*, 10 J. PALLIATIVE CARE 31, 36 (1994); Daly, *supra* note 63 at 222.

75. See Billings & Block, *supra* note 29, at 25 (discussing the use of euthanasia); David Orentlicher, *The Supreme Court and Physician-Assisted Suicide: Rejecting Assisted Suicide but Embracing Euthanasia*, 337 NEW ENG. J. MED. 1233, 1237–39 (1997) (discussing terminal sedation as a form of euthanasia and contrasting terminal sedation and assisted suicide).

of the elements that helped justify VSED (relief from experiential suffering) might be absent at the moment when a TERSE patient forgoes ANH, so that the ostensible function of ceasing ANH is the hastening of the patient's death. Nevertheless, at least at the moment when a physician initiates this third form of TERSE by administration of deep sedation, the patient is in fact seeking to avoid experiential suffering.

Another element possibly differentiates the VSED process from this third form of TERSE. The projection of legal acceptance of VSED made earlier in this article was in part grounded on the distasteful specter of forcing a competent, dying patient to receive ANH.⁷⁶ Forcing ANH on a conscious, struggling patient is indeed repugnant, yet that element is absent once the patient has requested and received deep sedation. A judge might therefore be more emotionally willing to treat this third TERSE technique as suicide warranting judicial interference.

Any conclusion about the legality of this third form of TERSE is tentative because of the absence of precedent on point. Some commentators assert legality on the basis that the physician's primary intent is to relieve suffering rather than to cause death when the deep sedation is administered to commence this third form of TERSE.⁷⁷ This explanation is not entirely convincing. First, the actual intention of the cooperating physician is probably not just to relieve suffering. The deep sedation in this scenario already ends the patient's experiential suffering. The likelihood is that the patient goes further—invoking bodily integrity to resist ANH at this stage—because the patient prefers to die rather than linger in an insensate state. The cooperating physician administering deep sedation and withholding ANH may well intend to hasten death for the same reason—avoidance of the patient's protracted lingering in an insensate condition.⁷⁸ Further, as this article will shortly explain, the absence of a specific intent to hasten death would not eliminate the possibility that when a physician initiates this palliative process, knowing that the patient's death will inevitably follow, the physician is performing euthanasia.⁷⁹ If the third form of TERSE is initiated weeks or months before the patient would otherwise die, then the physician is certainly hastening the patient's death rather than letting a disease process follow its natural course.

76. *Supra*, Part I.

77. Rob McStay, *Terminal Sedation: Palliative Care for Intractable Pain*, *Past Glucksberg and Quill*, 29 AM. J. L. & MED. 56, 76 (2003); Mount, *supra* note 68, at 34; Portenoy, *supra* note 70, at 45.

78. Dresser, *supra* note 56, at 791; Quill, *supra* note 51, at 2101.

79. *See infra*, Part IV (discussing the effects of specific intent).

While a physician's state of mind does not seem determinative, this third form of TERSE—deep sedation accompanied by withholding of ANH—is arguably lawful. This article has posited that VSED accompanied by rejection of ANH is lawful.⁸⁰ Assuming, then, that a dying patient has that VSED prerogative, and given that the patient invoking deep sedation retains self-determination and bodily integrity interests in avoiding ANH, judges might well respect those interests and uphold this third form of TERSE.

From one perspective, this third form of TERSE is a legitimate part of a natural dying process. Deep sedation occurs when a natural disease process causes severe, intolerable distress. The sedation, in turn, results in the incapacitation of normal nutritional processes, thus creating dependence on ANH. In a real sense, then, the patient's rejection of ANH as a matter of bodily integrity is part of a personal choice about how to respond to a fatal affliction. While deep sedation until the patient's demise has customarily been employed where dying patients are within days of unavoidable death, close proximity of death does not seem like a necessary element. The bottom line is that TERSE coupled with rejection of ANH may well be an additional mode for a competent, dying patient to significantly hasten death.

IV. PAIN RELIEVERS THAT MIGHT HASTEN DEATH

Provision of effective pain relief is a medical duty.⁸¹ In fulfilling that duty, physicians coping with intractable patient suffering sometimes have to use analgesics⁸² that pose some risk of hastening death. In the context of a debilitated, fatally afflicted patient, it is difficult to establish whether the analgesics actually hasten death. That evidentiary difficulty helps explain why very few criminal prosecutions have involved physician administration of analgesics.⁸³ Nonetheless, it is important to understand the legal bounds of risky pain relief in order to accurately inform risk-averse physicians who want to effectively provide pain relief for moribund patients.

80. See *supra*, Part II (discussing the legal impact of VSED).

81. Rima J. Oken, *Curing Healthcare Providers' Failure to Administer Opioids in the Treatment of Severe Pain*, 23 CARDOZO L. REV. 1917 (2002); Ben A. Rich, *A Prescription for the Pain: The Emerging Standard of Care for Pain Management*, 26 WM. MITCHELL L. REV. 1 (2000).

82. The term "analgesics" is employed here as a shorthand for the variety of substances, including opioids and barbiturates, that may be used to ease patients' pain and suffering during a dying process.

83. Phebe Saunders Haugen, *Pain Relief for the Dying: The Unwelcome Intervention of the Criminal Law*, 23 WM. MITCHELL L. REV. 325, 351 (1997).

The conventional wisdom is that medical use of analgesics risking acceleration of death is lawful as long as the physician's primary intent is to reduce suffering rather than to cause death.⁸⁴ Chief Justice Rehnquist asserted in 1997: "[i]t is widely recognized that the provision of pain medication is ethically and professionally acceptable even when the treatment may hasten the patient's death if the medication is intended to alleviate pain and severe discomfort, not to cause death."⁸⁵ This framework tries to transpose the doctrine of double effect from moral philosophy to criminal law.⁸⁶

The attempted transposition fails in the context of providing risky pain relief to fatally afflicted medical patients. The elusiveness of specific intent in this context is one defect.⁸⁷ A natural objective for a physician desiring to relieve intractable suffering is to put the foundering patient out of his misery by hastening death.⁸⁸ Distinguishing intent to relieve suffering from intent to cause death is a mission impossible as long as the analgesic dosage is not extraordinarily large.

In 1983, the President's Commission for the Study of Ethical Problems in Medicine acknowledged the difficulties of focusing on the physician's state of mind in the pain relief context. It noted that the various possible purposes behind administration of risky analgesics entail substantial potential for unclear or contested determinations of mental state to an extent that reliance on specific intent does not help.⁸⁹ Hinging criminal culpability on specific intent also encourages a hypocritical practice of stating an intention to relieve suffering when the real objective is to hasten death.⁹⁰ The result might be to encourage

84. Donald G. Casswell, *Rejecting Criminal Liability for Life-Shortening Palliative Care*, 6 J. CONTEMP. HEALTH L. & POL'Y 127, 129 (1990) (distinguishing between palliative care and euthanasia); Miriam K. Feldman, *Pain Control in Dying Patients: How Much is Too Much?* 73 MINN. MED. 19, 21 (1990); Haugen, *supra* note 83, at 351.

85. *Vacco v. Quill*, 521 U.S. 793, 808 n.11 (1997) (citing NEW YORK TASK FORCE, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 163 (1994)).

86. *See, e.g.*, Thomas A. Cavanaugh, *The Ethics of Death-Hastening or Death-Causing Palliative Analgesic Administration to the Terminally Ill*, 12 J. PAIN & SYMPTOM MGMT. 248 (1996) (arguing double effect doctrine simplifies ethical determinations); Stephen R. Latham, *Aquinas and Morphine: Notes on Double Effect at the End of Life*, 1 DEPAUL J. HEALTH CARE L. 625 (1997) (describing the doctrine of double effect and the methods for its application); Patrick F. Norris, *Palliative Care and Killing: Understanding Ethical Distinctions*, 13 BIOETHICS FORUM 25 (1997) (arguing the double effect doctrine's importance in ethical determinations).

87. Timothy Quill, *The Ambiguity of Clinical Intentions*, 329 NEW ENG. J. MED. 1039 (1993).

88. Cavanaugh, *supra* note 86, at 252; Truog, *supra* note 71, at 1680.

89. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT* 78, 81 (1983).

90. Latham, *supra* note 86, at 643.

some physicians to act aggressively with pain relief, but many other physicians would either be confused or skeptical about whether euthanasia is being administered.⁹¹

A physician's specific intent to relieve suffering cannot resolve the question of criminal culpability for risky pain relief. A purpose to relieve suffering does not exculpate a person for a killing, as the law of euthanasia has long established and Dr. Kevorkian has discovered.⁹² Also, administration of risky analgesics which accelerate death can constitute an unlawful killing even without a showing that the actor's primary intention was to end life.⁹³ A reckless state of mind or reckless disregard for harmful consequences can suffice for criminal liability.⁹⁴

This means that relief of suffering can justify administration of a risky analgesic only as long as the physician's conduct conforms to certain conditions avoiding a taint of recklessness. To justify an analgesic carrying a mortal risk, the patient must be suffering grievously and the analgesic must embody the safest means to relieve the suffering.⁹⁵ "[T]he risk of death is justified not because it is unintended but because there is no alternative approach that makes the risk of death less likely and the alleviation of suffering possible."⁹⁶ Professional practice therefore requires that analgesic dosage start at a safe level and increase only as necessary.⁹⁷ In short, even with a primary intention to relieve suffering, a physician does not have carte blanche to administer pain relief medication that risks hastening death.

91. Paul J. van der Maas et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 THE LANCET 669, 672 (1991).

92. *People v. Kevorkian*, 527 N.W. 2d 714 (Mich. 1994) (stating that justifications for killing are limited to self-defense, defense of others, capital punishment, and war); WILLIAM L. BURDICK, *THE LAW OF CRIME* 422, 447 (1946).

93. Raymond G. Frey, *Intention, Foresight, and Killing*, in *INTENDING DEATH* 66 (Tom L. Beauchamp ed., 1996); Harris, *supra* note 25, at 39–40.

94. Norman L. Cantor & George C. Thomas III, *Pain Relief, Acceleration of Death, and Criminal Law*, 6 KENNEDY INST. ETHICS J. 107, 110–11 (1996); Cantor & Thomas, *supra* note 17, at 115–20.

95. Nathan I. Cherny & Kathleen Foley, *Nonopioid and Opioid Analgesic Pharmacotherapy of Cancer Pain*, 10 HEMATOLOGY/ONCOLOGY CLINICS OF NORTH AMERICA 79, 82, 92, 94 (1996); Greene & Davis, *supra* note 70.

96. Alan R. Fleischman, *Ethical Issues in Pediatric Pain Management and Terminal Sedation*, 15 J. PAIN & SYMPTOM MANAGEMENT 260, 261 (1998).

97. Medical professional norms seem to require these limitations on risky pain relief. See Cantor & Thomas, *supra* note 17, at 117. See also Howard Brody, *Physician-Assisted Suicide in the Courts: Moral Equivalence, Double Effect, and Clinical Practice*, in *LAW AT THE END OF LIFE* 101, 106 (Carl Schneider, ed., 2000) (observing that it is difficult to distinguish the differences in intent between palliative care and assisted dying); Tony Sheldon, *Two Test Cases in Holland Clarify Law on Murder and Palliative Care*, 329 BRITISH MED. J. 1206 (Nov. 20, 2004) (discussing two cases that distinguish between palliative care and euthanasia).

Another part of the legal framework governing physicians' conduct dictates that conduct which the physician-actor *knows* will hasten death is impermissible. Under both the Model Penal Code and state law definitions of homicide, conduct certain or practically certain to hasten death is deemed to be knowing and unlawful, even if the actor's intent is to relieve suffering.⁹⁸ Glanville Williams long ago explained:

There is no legal difference between desiring or intending a consequence as following from your conduct, and persisting in your conduct with a knowledge that the consequence will inevitably flow from it, though not desiring that consequence. When a result is foreseen as certain, it is the same as if it were desired or intended.⁹⁹

In other words, criminal law treats a knowing killing as intrinsically bad conduct even when there is a noble reason, such as relief of suffering, for the conduct.¹⁰⁰ This means that a physician may justifiably use a risky analgesic when necessary to relieve suffering, but not in a dosage that the physician knows will certainly or almost certainly cause death.¹⁰¹

Nevertheless, isolated language from concurring opinions in the Supreme Court's 1997 cases on assisted suicide undermines the thesis that a physician is forbidden from administering an analgesic that she knows will cause death. Justices Souter, O'Connor, and Breyer all commented that state law, while prohibiting physician-assisted suicide, permits physicians to administer necessary analgesics "even when doing so would hasten [dying patients'] deaths."¹⁰² This judicial language, while only dictum in concurring opinions, could be read to endorse use of analgesics even when death is a certain or practically certain result, so long as the analgesics are necessary to provide pain relief (and the actor's intent is to relieve suffering).¹⁰³

98. MODEL PENAL CODE § 2.02 (1962). *See also* Cantor & Thomas, *supra* note 17, at 117–22 (discussing the recklessness standard followed in some state laws for the use of pain medication); Donald Casswell, *Rejecting Criminal Liability for Life-Shortening Palliative Care*, 6 J. CONTEMP. HEALTH L. & POLICY 127 (1990) (discussing legal precedent that palliative care is murder, but argues for specific exceptions).

99. GLANVILLE L. WILLIAMS, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* 322 (1957).

100. HARRIS, *supra* note 25, at 39–40; Frey, *supra* note 93, at 66.

101. The Model Penal Code section 2.02(2)(b)(ii) states that a person acts "knowingly with respect to a result of his conduct when he is aware that it is practically certain that his conduct will cause such a result." MODEL PENAL CODE § 2.02(2)(B)(ii) (1962).

102. *Vacco v. Quill*, 521 U.S. 702, 736–38 (1997) (O'Connor, J., concurring). Justice O'Connor also made approving reference to palliative medication "even to the point of causing unconsciousness and hastening death." *Id.* at 736; *see also* Cantor & Thomas, *supra* note 17, at 122–24 (parsing out the relevant language in the opinions of Justices O'Connor, Souter, and Breyer).

103. David J. Garrow, *The Right to Die: Death with Dignity in America*, 68 MISS. L. J. 407,

This notion that physicians may legally use analgesics to relieve suffering even when death is a certain result seems mistaken—“a misconception of the state of the law derived from a too ready acceptance of what some parties and amici curiae [in the assisted suicide cases] . . . declared in the litigation.”¹⁰⁴ This kind of distorted reasoning was recently (mis)used by lawyers instructing military interrogators in Iraq that courts would not find them guilty of torture even if they knowingly inflicted severe pain, so long as causing such harm was not the interrogator’s objective.¹⁰⁵ This same kind of reasoning would allow a person to engage in self-killing by having a healthy, vital organ removed so long as the person had an intention to save another person’s life.¹⁰⁶ Such reasoning might even permit a dying person to engage in self-killing by freezing because the person’s intention was to use cryonic preservation of life rather than to bring about death. In sum, a praiseworthy motive such as relieving suffering does not, under prevailing criminal law doctrine, justify conduct that the actor knows is going to cause death.¹⁰⁷

This issue—whether use of knowingly lethal analgesics is defensible under current law—is not definitively resolved by resort either to medico-legal commentators or to medical norms. Commentators disagree on whether a knowingly lethal dosage of analgesics is lawful.¹⁰⁸ Medical professional standards are largely ambiguous as to whether a knowingly lethal dosage is permissible. Some professional guidelines authorize risky analgesics that “may” hasten death or carry a

417–19 (1998).

104. Cantor & Thomas, *supra* note 17, at 123.

105. Philip Allen Lacovara, *Whom Do Government Lawyers Serve?*, HUMAN RIGHTS FIRST, July 2004, http://www.humanrightsfirst.org/us_law/commentary/lacovara_0704.htm.

106. See Jonathan Herring, *Giving, Selling, and Sharing Bodies*, in BODY LORE AND LAWS 52, 152 (Andrew Bainham et al. eds., 2002) (discussing the legal ramifications of organ donation).

107. See *supra* note 100 and accompanying text (discussing the application of criminal laws despite the irrelevance of the reason for hastening death).

108. Compare Robert Barry & James E. Maher, *Indirectly Intended Life-Shortening Analgesia: Clarifying the Principles*, 6 ISSUES IN L. & MED. 117, 140 (1990) (discussing the limited circumstances when life-shortening analgesia should be administered), and Donald B. Marquis, *Four Versions of Double Effect*, 16 J. MED. & PHIL. 515, 523, 529 (1991) (discussing the arguments for not preserving life unnecessarily), with John Finnis, *Euthanasia, Morality, and Law*, 31 LOY. L.A. L. REV. 1123, 1129 (1998) (arguing that existing doctrines allow individuals to circumvent the law of murder), and John Keown, *The Legal Revolution: From ‘Sanctity of Life’ to ‘Quality of Life’ and ‘Autonomy.’* 14 J. CONTEMP. HEALTH L. & POL’Y 253, 258 (1998) (discussing the arguments supporting the preservation of life). See also Dresser, *supra* note 56, at 83 (discussing the steps that should be followed when patients resist feeding); Yale Kamisar, *The Rise and Fall of the Right to Assisted Suicide*, in THE CASE AGAINST ASSISTED SUICIDE 69, 78–79 (Kathleen Foley & Herbert Hendin eds., 2002) (discussing the justification for preventing assisted suicide).

“possibility” of hastening death.¹⁰⁹ Other guidelines authorize pain medication in “whatever dose” is necessary for relief.¹¹⁰ In other words, palliative care guidelines tend to call for effective pain medication without specifying whether there is an upper boundary, such as a dosage that will surely hasten death.

Possibly, the dicta in the assisted suicide cases’ concurrences will spur acceptance of the principle that a physician can use necessary means of pain relief, including analgesics that the physician knows will precipitate death.¹¹¹ This would be a humane development in avoiding end-of-life suffering and it might even be good public policy. It would certainly expand the palliative care armamentarium. If, as claimed by some commentators,¹¹² the concurring opinions in the assisted suicide cases really signal judicial tolerance of pain relief “as needed,” including a knowingly fatal dose, then physicians have a new way to hasten death without violating legal proscriptions.

Note, though, that acceptance of such a principle tacitly accepts a mode of hastening death that would formerly have been considered a form of euthanasia. “Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient’s intolerable and incurable suffering.”¹¹³ Under that definition, use of an analgesic that is certain or practically certain to cause death is a form of

109. Howard Brody observes that the current ethical roadmap permits analgesic administration for terminally ill patients even if the dosages required approach levels that *might* hasten death. Brody, *supra* note 97, at 110–11. See also American Academy of Neurology Position Statement, *Certain Aspects of the Care and Management of Profoundly and Irreversibly Paralyzed Patients with Retained Consciousness and Cognition*, 43 NEUROLOGY 222 (1993) (arguing the right of autonomy allows individuals to choose a natural and peaceful death); James L. Bernat et al., *Competent Patients with Advanced States of Permanent Paralysis Have the Right to Forgo Life-Sustaining Therapy*, 43 NEUROLOGY 224, 225 (1993) (arguing for the rights of patients to decline life support); Cherny & Portenoy, *supra* note 74, at 34, 36 (arguing relief provides a justification for the use of risky analgesics).

110. American College of Physicians Ethics Manual, 117 ANNALS INT. MED. 947, 955 (1992); Melissa L. Buchan & Susan W. Tolle, *Pain Relief for Dying Persons: Dealing with Physicians’ Fears and Concerns*, 6 J. CLINICAL ETHICS 53, 55 (1995); Sidney H. Wanzer et al., *The Physician’s Responsibility Toward Hopelessly Ill Patients*, 320 NEW ENG. J. MED. 844, 847 (1989).

111. Justice Breyer intimated that pain relief “as needed” should be a licit part of end-of-life palliative care. *Washington v. Glucksberg*, 521 U.S. 702, 791 (1997) (Breyer, J., concurring).

112. Robert A. Burt, *The Supreme Court Speaks: Not Assisted Suicide but a Constitutional Right to Palliative Care*, 337 NEW ENG. J. MED. 1234 (1997); Garrow, *supra* note 103, at 417–19; David A. Pratt, *Too Many Physicians: Physician-Assisted Suicide after Glucksberg/Quill*, 9 ALB. L.J. SCI. & TECH. 161, 223 (1999).

113. AMA Council on Ethical and Judicial Affairs, Opinion 2.21, <http://www.ama-assn.org/> (search “2.21 Euthanasia”; then follow “Policy Finder-American Medical Association” hyperlink).

euthanasia and would ostensibly be unlawful under the Model Penal Code.¹¹⁴

It could be argued that euthanasia is still distinguishable from a knowingly fatal dose of pain medication because the latter requires a specific intent to relieve suffering rather than to make a person dead. Yet, any pretense that a physician's primary specific intent in administering pain relief in dosage certain to cause death is to relieve suffering seems hollow. Often, if not always, that charade masks an actual intention to cause death.¹¹⁵

Moreover, as noted, conduct involving a knowingly fatal dose of analgesics meets the most common definitions of unlawful homicide even if the actor's intent is to relieve suffering.¹¹⁶

V. WHY LEGALIZE PHYSICIAN-ASSISTED DEATH IF IT IS ALREADY LEGAL?

This article has argued that certain methods of hastening the death of a fatally stricken person (such as VSED and TERSE) are probably legal.¹¹⁷ Those options potentially assure that a competent patient can escape suffering via deep sedation and limit the period of remaining life to a maximum of fourteen days (before death by dehydration). From one perspective, these modes of hastening death seem to provide a modicum of dignity in a dying process.¹¹⁸ Do they suffice to meet present social demands for a dignified dying process?

After all, one ideal version of a dignified death (with a tranquil patient passing into oblivion at a comfortable moment chosen by the patient after gently taking leave from loved ones) is often unobtainable. Sometimes, medical uncertainty creates a faint hope of recovery that impels the dying patient to endure beyond an originally fixed point of tolerable deterioration. Sometimes, the will to live proves so strong that the patient decides to struggle tenaciously despite indignities of debilitation previously thought intolerable. A powerful life force impels the waning patient to adjust to deterioration.

114. MODEL PENAL CODE § 210.2 (1962).

115. MAGNUSSON, *supra* note 18, at 192; Robert Barry & James E. Maher, *Indirectly Intended Life-Shortening Analgesia: Clarifying the Principles*, 6 ISSUES IN L. & MED. 117, 148 (1990); Frey, *supra* note 93, at 69; Thomas A. Preston, *Killing Pain, Ending Life*, N.Y. TIMES, Nov. 1, 1994, at A27.

116. *See supra* note 98 and accompanying text (discussing the legality of administering analgesics).

117. *See supra* Part II–III (arguing the legality of methods to hasten death).

118. George P. Smith II, *Terminal Sedation as Palliative Care: Revalidating a Right to a Good Death*, 7 CAMBRIDGE Q. HEALTHCARE ETHICS 382, 383 (1998).

A further possibility is that advances in palliative care (effective pain control coupled with reassuring support services) will ease the dying process enough to diminish any demand to hasten death. Indeed, good palliative care often succeeds in dispelling anxieties or apprehensions that might otherwise have prompted a patient's determination to hasten death.

While good palliative care is a great boon, it is not a panacea. Good palliative care cannot alter some small number of dying patients' will to hasten their own deaths.¹¹⁹ For these patients, an unacceptable quality of life, meaning indignity associated with helplessness, frustration, dependence, fatigue, or sense of posing a burden to others constitutes the determinative factor.¹²⁰ "[T]he prospect of losing control and independence and of dying in an undignified, unaesthetic, . . . and existentially unacceptable condition"¹²¹ will inevitably move some well cared for patients to seek hastened death. These patients retain an important "interest in dignity, and in determining the character of the memories that will survive long after [their] death."¹²²

For the limited number of patients who persist in a desire to hasten death, do VSED and/or TERSE provide a reasonably comfortable and expeditious dying process? These techniques assure a painless death within fourteen days and sedation or other palliative intervention assures relief from any accompanying emotional suffering.¹²³ For some fatally afflicted persons, however, the possibility of even a few days of lingering in stupor or unconsciousness makes these processes unacceptably demeaning. These persons do not wish to linger at all "in a state that may profoundly compromise their dignity and further distort the memory they leave behind."¹²⁴

Still, a few days of insensate lingering does not seem nearly as inhumane or demeaning as protracted unconsciousness for months or even years. During a natural dying process, a few days of coma may

119. William Breitbart et al., *Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients With Cancer*, 284 J. AM. MED. ASS'N 2907, 2910 (2000); Arthur L. Caplan et al., *The Role of Guidelines in the Practice of Physician-Assisted Suicide*, 132 ANNALS INTERNAL MED. 476, 480 (2000) Ezekiel J. Emanuel et al., *The Practice of Euthanasia and Physician-Assisted Suicide in the United States*, 280 J. AM. MED. ASS'N 507, 512 (1998).

120. Research indicates that indignity, dependency, and lack of control are more important than pain in motivating the desire to die. HOEFLER, *supra* note 46, at 156–57; MAGNUSSON, *supra* note 18, at 90;

121. Timothy E. Quill et al., *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 NEW ENG. J. MED. 1380, 1383 (1992).

122. *Washington v. Glucksberg*, 521 U.S. 702, 743 (1997) (Stevens, J. concurring).

123. See *supra* Part II (describing methods of hastening death).

124. Dresser, *supra* note 56, at 90.

occur as a form of anesthesia making the last days of existence peaceful, devoid of pain, anxiety, or suffering.¹²⁵ A similar terminal period, even if induced by sedation, does not seem intrinsically inhumane. Some people view TERSE as assuring “a modicum of dignity at death.”¹²⁶ Some people might view this limited insensate period as an opportunity for a family ritual or vigil expressing the “ambivalence and distress of death.”¹²⁷ The lingering period of days might serve as an adjustment period for family and surrounding loved ones.¹²⁸

In short, maintenance of the legal status quo toward the dying process might be quite tolerable if it were widely recognized that VSED and TERSE are lawful options for competent, fatally afflicted patients. Nonetheless, these options would not fully satisfy the people who deem even a few days of lingering helplessly and insensately to be repulsive. Those individuals would prefer an option of physician-assisted access to a poison that would provide a possibility of an immediate demise once an intolerable level of indignity is reached.¹²⁹ Just having a poison at hand serves to calm an anxious dying patient and even offers a reason to stay alive until the conclusion of a natural dying process.¹³⁰ Under the status quo, those who prefer access to the immediacy of a poison *might* find a doctor who will accommodate them,¹³¹ but finding such a

125. Brief of Amicus Curiae Choice in Dying, Inc., *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110).

126. Smith, *supra* note 118.

127. Rich, *supra* note 81, at 233–35 (discussing Robert Burt’s interest in terminal sedation as creating a salutary period of vigil); *see also* Norman L. Cantor, *Glucksberg, the Putative Right to Adequate Pain Relief, and Death with Dignity*, 34 J. HEALTH L. 301, 324 (2001) (arguing terminal sedation will provide dignity to the dying process). It seems highly debatable whether a healthy ritual function is better served by a pre-death vigil or by customary ceremonies such as a wake, viewing, memorial service, burial, or shiva following death. Presence of the live but waning and insensate patient might well have a dampening effect on the celebratory element often accompanying the customary rituals at the end of a life well lived.

128. *Cf.* Lewis M. Cohen et al., *Practical Considerations in Dialysis Withdrawal*, 289 JAMA 2113, 2116–17 (2003) (articulating principles to follow when making a decision to cease using life sustaining treatment).

129. MAGNUSSON, *supra* note 18, at 87.

130. Both in Oregon and the Netherlands, some dying people who obtain a lethal poison choose not to use it.

131. Some compassionate physicians have been willing to end lives with overdoses of morphine or other pain killers or by provision of a poison. *See* MAGNUSSON, *supra* note 18, at 88 (discussing the legality of using compassionate methods to ease pain during the dying process); Billings & Block, *supra* note 29 (discussing the practice of ending lives to ease pain); Marcia Angell, *No One Trusts the Dying*, WASH. POST, July 7, 1997, at A19 (arguing that the state should not control the method of dying); Preston, *supra*, note 115 at A27 (arguing that euthanasia is commonplace and that the real issue is creating guidelines for who qualifies for aid in dying).

physician can be a highly fortuitous and capricious matter.¹³² From this perspective, Oregon has found a better way.¹³³

VI. CONCLUSION

This article contends that existing legal and moral structures authorize a variety of ways for a fatally stricken patient to advance the moment of death. Lawful forms of hastening death include: the physician who, at a competent patient's behest, pulls the plug on a respirator while sharing the patient's wish to end a torturous dying process; the physician who cooperates with a fatally afflicted person's choice of VSED; the physician who administers deep sedation (TERSE) knowing that the patient has already declined ANH; and the physician who administers pain relief in a known lethal dosage. Wide dissemination of information about VSED and TERSE might provide sufficient access to hastened death to make the legal status quo tolerable, though not ideal. At the same time, wide access to VSED and TERSE would also underscore the hypocrisy of pretending that physician-assisted death is only lawful in Oregon.

132. Death-hastening practice tends to be secret and unpredictable, depending more on doctors' courage and compassion than on patients' needs and wishes. Angell, *supra* note 131 at A19; Preston, *supra* note 115 at A27.

133. See, e.g., Charles A. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. ON LEGIS. 1 (1996) (discussing state laws in Oregon which legalize physician assisted death); Arthur E. Chin et al., *Legalized Physician-Assisted Suicide in Oregon—The First Year's Experience*, 340 NEW ENG. J. MED. 577 (1999) (finding that the decision to request and use a prescription for lethal medication was associated with loss of autonomy and not with intractable pain or financial loss).