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On Hastening Death Without Violating Legal or Moral Prohibitions

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Abstract

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. Some persons are afflicted with chronic degenerative diseases that take a grievous toll. Chronic pain may be severe and intractable, anxiety about a future treatment regimen may be distressing, and helplessness may erode personal dignity and soil the image that the afflicted person wants to leave behind.

A dying patient's interest in hastening death is often said to be in tension with a bedrock social principle that respect for sanctity of life demands suppression of all intentional killing, including suicide (self-killing) and killing motivated by a desire to relieve suffering. Mercy killing has long been anathema in American law. Even though compassion for a dying person may tempt a health care provider or other observer to relieve suffering by any means possible (at least when the patient is requesting such relief), a ban on mercy killing is a symbolic reminder of the preciousness of human life and of the moral worth of every human. Letting die, but not intentional hastening of death, is said to be compatible with the sanctity of life.

This article argues that this pat framework is simplistic and deceptive. Current medical ethics and the jurisprudence of death and dying authorize practices that intentionally hasten death. Lawful forms of hastening death include: a physician who, at a competent patient's behest, pulls the plug on a life-sustaining medical intervention while sharing the patient's wish to end a torturous dying process; a physician who cooperates with a gravely afflicted person's fatal decision to voluntary stop eating and drinking (VSED); a physician who administers deep sedation to a preservable but suffering patient while knowing that the patient has already declined artificial nutrition and hydration (ANH) and hence will soon die;

and a physician who administers pain relief in a known lethal dosage (even with the primary intention to relieve intractable suffering). These ways of hastening death (with concomitant physician participation) are probably legal and probably in widespread use.

Do these modes of hastening death make bans on physician-assisted suicide (PAS) and/or voluntary active euthanasia (VAE) anomalous? Do they obviate any strong need for legalization of PAS or VAE? Do they meet the common objective of providing competent, dying persons with a means of shaping a dying process to assure a modicum of dignity? The currently legal modes of hastening death often entail a period when the dying patient lingers in unconsciousness or semi-consciousness before expiring. A short period of insentience or unawareness as a prelude to death – usually lasting for no more than a few days – does not violate intrinsic human dignity. Therefore, publicizing the current availability of legal modes of hastening death and making them readily accessible might make the legal status quo morally tolerable. But then some dying persons will have to undergo an unwanted period of lingering helplessly (for days). And we will continue to live with the hypocritical pretense that physician-assisted death is lawful only in Oregon.

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Medical management of the dying process has been part of American culture for approximately 150 years.[1] Initially, physicians could do little beside easing the dying process by making the moribund person comfortable, comforting the surrounding loved ones, and perhaps orchestrating any rituals to be performed. The patient could not linger long, as infectious diseases and other lethal conditions generally took their toll fairly quickly. It was well into the 20th century before physicians dealing with fatal afflictions became capable of relieving pain and even prolonging life via medications, transfusions, respirators, dialysis machines, open-heart surgery and the like. From that point on, medical science could wondrously extend life – sometimes 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. 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.

In the last quarter of the 20th century, courts established that a competent dying patient legally controls the extent of life-sustaining medical intervention.[2] That recognition rested on both the common law doctrine of informed consent and constitutional principles of bodily control and self-determination. By 1990, the Supreme Court was willing to "assume" arguendo that a competent patient was constitutionally entitled to refuse life-sustaining medical treatment;

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[1] Shai Lavi, Euthanasia and the Changing Ethics of the Deathbed, 4 Theoretical Inq. L. 729, 743 (July 2003), at bepress.com/til/default/vol4/iss2/art. 10.

[2] Satz v. Perlmutter, 362 So.2d 160 (Fla. App. 1978); Bartling v.Superior Court, 209 Cal. Rptr 220 (Cal. 1984); In re Farrell, 529 A.2d 404, 406 (N.J. 1987).

seven years later the Court acknowledged that a prerogative to reject life support was part of the liberty protected by the Fourteenth Amendment.[3]

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. Yet control over medical intervention does not assure a tranquil demise. Many persons are afflicted with chronic degenerative diseases that take a grievous toll even before the patient becomes dependent on life-preserving medical intervention. 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 seems to be in tension with a bedrock social principle that respect for sanctity of life demands suppression of all intentional killing, including suicide (self-killing) and killing motivated by a desire to relieve suffering.[4] Mercy killing has long been anathema in American law. Even though compassion for a dying person may tempt a

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[3] Glucksberg v. Washington, 521 U.S. 702, 719 (1997).

[4] Daniel J. Gilman, *Thou Shall Not Kill as Defeasible Heuristic: Law and Economics and the Debate Over Physician-Assisted Suicide*, U. Md. Leg. Studies Rsch. Paper #2004-25, 59

health care provider or other observer to relieve that suffering by any means possible, at least when the patient is requesting such relief, a ban on mercy killing is a constant reminder of social veneration for life. The ban is a symbolic reminder of the preciousness of human life and of the moral worth of every human. 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 (an underlying disease process) to run its course, while hastening of death via independent human intervention -- such as by a poison -- represents an unnatural killing undermining the sanctity of life in an imprudent way.[5] Letting die is said to be compatible with the sanctity of life, but not intentional killing.

This article argues that this pat framework is too simplistic and deceptive. Current medical ethics and the jurisprudence of death and dying authorize practices that make the ostensible ban on hastening death anomalous.[6] These practices include some patients' withdrawal of life support, patients' voluntary stopping of eating and drinking, terminal sedation, and some forms of pain relief. These ways of hastening death are probably legal and probably in widespread use. Does availability of these modes of hastening death make bans on physician assisted suicide (PAS) and/or voluntary active euthanasia (VAE) anomalous? Does it obviate any strong need for legalization of PAS or VAE? These are hard questions in light of the

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[5] Leon R. Kass, *Death with Dignity and the Sanctity of Life*, 89 COMMENT. 33, 35-36 (March 1990); Daniel Callahan, in M & D at 390.

[6] See also Timothy E. Quill, et al., *Risk Taking by Physicians in Legally Gray Areas*, 57 ALB. L. REV. 693, 694 (1994); Norman L. Cantor, On Kamisar, Killing, and the Future of Physician Assisted Death, 102 Mich. L. Rev. 1793, 1831-40 (2004).

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. 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 making the patient dead by administering a lethal substance. According to this wisdom, while PAS and VAE may precipitate death in order to relieve an afflicted patient's suffering or prospective suffering, withdrawal of life support merely allows nature to take its course. PAS and VAE constitute independent termination of life – i.e., intentional killings. The Michigan Supreme Court commented, in rejecting a challenge to the state's ban on assistance to suicide:

> Whereas 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.[7]

The notion of letting nature take its course does not really explain why pulling a plug is different from other acts hastening a person's death. A doctor's withdrawal of LSMT may constitute an unlawful killing even though the conduct merely allows a natural condition to take

[7] People v. Kevorkian, 527 N.W.2d 714, 728-29 (Mich. 1994). See also Thor v. Superior Court, 855 P.2d 375 (Cal. 1993); McKay v. Bergstedt, 801 P.2d 617, 632 (Nev. 1990).

its fatal course.[8] A physician who, motivated by compassion but without consent, enters a suffering patient's room and pulls the plug from the patient's respirator is guilty of murder if death follows from the physician's action. 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 same action lawful would be the patient's informed consent to cessation of LSMT. In short, sanctity of life can be just as offended by a withdrawal of life support as by administration of a poison. Each can constitute the intentional termination of life, i.e., a 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."[9]

Many would 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.[10] 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 assistance to suicide even though the state

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[8] Allen Buchanan, *Intending Death: The Structure of The Problem and Proposed Solutions, in* INTENDING DEATH, 28, 30 (T. Beauchamp ed., 1996).

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

[10] Berger & Berger book at 137.

permitted removal of LSMT. 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 (in how to respond to a medical affliction) has had equal stature with bodily integrity in the cases upholding a patient's right to reject life-sustaining medical intervention.[11] 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.[12]

In short, I doubt that either the patient's interest in bodily integrity or attributing death to a natural disease process supports the judicial insistence that removal of life support constitutes less affront to the sanctity of life concept than artificial initiation of the immediate cause of death.

The societal prohibition of virtually all active killings does underscore the importance of human life. Yet removing life-sustaining medical intervention is not generally viewed as any less an affront to the sanctity of life than more independent killings. That is, the removal of life

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[11] Satz v. Perlmutter, 362 So. 2d 1160 (Fla. App. 1978); Bouvia v. Superior Court, 225 Cal. Rptr. 297, 306 (Cal. Ct. App. 1986).

[12] Cantor, On Kamisar, supra note 6, at 1805-06.

support is commonly perceived as a killing, just as administration of an injection would be.[13] Certainly, within public perception (which is, after all, the determinant of the success of any symbolic message about sanctity of life) removal of life support by a physician is viewed as an intentional killing. Ever since the *Quinlan* case surfaced in New Jersey in 1975, popular consciousness has regarded disconnection of life support as causing death (i.e, as a killing). This was so 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.[14] This common perception also accounted for the frequent reference to removal of life support as "passive euthanasia,"[15] at least where the withdrawal was apparently intended to hasten the afflicted patient's death. Yale Kamisar always found removal of life support to be "troubling" precisely because of the accompanying image of a mercy killing.[16] Recently, some critics of a proposed living will statute in England expressed strong concern that the withdrawal of treatment would constitute "killing by omission."[17]

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

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

[14] In re Quinlan, 348 A.2d 803, 820 (N.J. Super. Ct. Ch. Div. 1975).

[15] New York State Task Force on Life and the Law, (1992) 209 n.8

[16] Yale Kamisar, The Right to Die: On Drawing and Erasing Lines, 35 Duq. L. Rev. 481, (1996).

[17] Liam Allen, *Living Wills: "My Right to Choose,"* BBC News, Dec. 14, 2004.

ANH as an action aimed at death, a form of murder or euthanasia.[18] In the recent Schiavo case, right to life advocates cultivated the image of physicians "making someone die" by removal of simple nutritive measures, branding the conduct "court-ordered euthanasia."[19] Yet neither the fatal consequences of removal of ANH nor the state of mind of the relevant parties differs from removal of other forms of life support. In other words, some people would consider an affront to the sanctity of life principle to be present any time a physician terminates artificial life support.

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. 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.[20] There are, of course, instances when a patient does reject further LSMT to avoid a burdensome medical intervention (e.g. dialysis) and has no specific intent to die. Yet in many other instances a dying patient has reached a stage of debilitation that is personally intolerable, so that rejection of LSMT reflects a specific wish to die. In such instances, a cooperating physician withholding or withdrawing LSMT may well share the patient's object to hasten death. "Compassionate critical care clinicians [ending life

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[18] Woods v. Kentucky, 142 S.W.3d 24, 26 (Wintersheimer, J, dissenting)

[19] Steven W. Mosher, Population Research Institute, Statement in Support of the Life of Terri Schiavo, http://www.pop.org (10/13/04)

[20] 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 (K. Foley & H. Hendin eds. 2002).

support] may often wish that death would come quickly . . . for the sake of patients . . . ."[21]

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 with relatively light medical treatment. This occurs, for example, when a debilitated patient whose condition has stabilized nonetheless rejects relatively unburdensome LSMT. On several occasions, paraplegics have chosen to reject ANH even though they are certain to die,[22] and patients afflicted by other conditions have also so chosen.[23] 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.[24]

The basic point is that 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 is 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

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[21] Graeme M. Rocker & J. Randall Curtis, Caring for the Dying in the Intensive Care Unit, 290 JAMA 820, 821 (2002); Alexander Morgan Capron, Death and the Court, Hastings Center Rep., Sept.-Oct. 1997, at 27-28 (A physician's object may well be "to allow death to occur, to end an existence that no longer benefits the patient").

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

[23] People v. Velez, 602 P.2d , 760 ; Powell at 55

[24] Cf. Henk Jochemson, Life-Prolonging and Life-Terminating Treatment of Severely Handicapped Newborn Babies, 8 Issues in L. & Med. 167, 168 (1992)(describing withdrawal of life support by Dutch physicians aimed at hastening death).

LSMT), other legal modes of hastening death exist where the cause of death is not an underlying disease process. I turn to those modes.

II. Voluntary Stopping of Eating and Drinking

Even before a natural pathology or disease process makes a fatally stricken person dependent on ANH, the patient may voluntarily stop eating and drinking (VSED) and then decline any ANH proferred. This course of conduct will prompt death by dehydration within 7 to 14 days. Such a dying process would usually be tranquil, with the patient within days slipping into a coma from which she never emerges. In the event any agitation or discomfort occurs, it can be handled by simple palliative attention including sedation.[25] For a terminally ill or chronically suffering patient, VSED seems like a simple and effective way to control the timing of death. A recent report from Oregon indicated that more people end their lives there by VSED than by poison as authorized by Oregon law.[26]

VSED has some earmarks of suicide and a health care provider's cooperation – such as by providing palliative care – smacks of assistance to suicide. In contrast to rejection of LSMT, the patient self-initiates the destructive course (dehydration from failure to ingest fluids) that brings about death. Most people acknowledge that suicide can be accomplished by passive

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[25] See James Hoefler, Managing Death (2001); James Bernat, et al., Patient Refusal of Hydration and Nutrition, 153 Archives Internal Med. 2723 (1993); Robert M. McCann, et al., Comfort Care for Terminally Ill Patients: The Appropriate Use of Nutrition, 272 JAMA 1263, 1265-66 (1994); Candace Jans Meares, Terminal Dehydration: A Review, 11 Am. J. Hospice & Palliative Care 10, 11 (1994).

[26] Joan Arehart-Treichel, Terminally Ill Choose Fasting Over M.D. Assisted Suicide, Psychiatric News, Jan.16, 2004, at 15.

means, such as by refusal to eat or drink.[27] And the fatally stricken patient's course of conduct may well be prompted by despair over dismal circumstances, so that the patient's specific intent is to bring about death.[28] (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 parenteral nutrition, but it's because of futility rather than acquiescence in a patient's chosen course of conduct.)[29]

The resemblance between facilitation of VSED and assistance to suicide makes 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.[30] Yet the 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.[31] The comment of an intermediate appellate court

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[27] E.g., Robert N. Wennberg, Terminal Choices: Euthanasia, Suicide, and the Right to Die 33-34 (1989); Terence M. O'Keefe, Suicide and Self-Starvation, in Suicide: Right or Wrong? 117, 123 (J. Donnelly, ed. 1990); Byrn, Compulsory Life-Sustaining Treatment, 44 Fordham L. Rev. 1, 18 (1975). "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. Director, Missouri Dep't Health, 497 U.S. 261, 296-97 (1990)(Scalia, concurring).

[28] See People v. Velez, 602 P.2d at 759.

[29] Louise Printz, Terminal Dehydration, a Compassionate Treatment, 152 Archives Internal Med. 697, 700 (1992); McCann, supra note 23, at 1266.

[30] E.g., Bernat, supra note at 2725; 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 JAMA 2099, 2100 (1997); Lori Montgomery, Starving is Legal Suicide Method, Detroit Free Press, Nov. 20, 1996, at 1A.

[31] Norman L. Cantor, Legal Frontiers of Death and Dying 26-28 (1987).

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.[32]

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.[33]

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. When their nursing homes sought judicial intervention authorizing ANH to prevent the patients' deaths, the courts refused to intervene.[34]

Diverse factors may account for the judicial reluctance to intervene. 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,[35] even when death is purposefully hastened. A major factor reinforcing that judicial inclination may be revulsion at the prospect of physically overcoming

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[32] 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); Laurie v. Senecal, 666 A.2d 806, 808 (R.I. 1995).

[33] Cruzan v. Dir. Mo. Dep't of Health, 497 U.S. 261, 280 (1990).

[34] In re Brooks (N.Y. Sup. Ct. 1987); A.B. v. C., 477 N.Y.S.2d 281, 284 (Sup. Ct. 1984); Rebecca Dresser, When Patients Resist Feeding, 33 J. Am. Geriat. Soc'y 790, 793 (1985).

[35] See Zant v. Pravatte, S.E.2d (Ga.); In re Brooks, supra; see Rebecca Dresser, The Supreme Court and End-of-Life Care: Principled Distinctions or Slippery Slope?, in Law at the End of Life (Carl Schneider ed. 2000) 83, 87.

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. 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."[36]

Accordingly, "the 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."[37] This provides a moribund patient with a means of hastening death within a maximum of 7 to 14 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.

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[36] Cruzan, 497 U.S. at 288-89.

[37] Norman L. Cantor & George C. Thomas III, The Legal Bounds of Physician Conduct Hastening Death, 48 Buff. L. Rev. 83, 102 (2000). See also Dresser, supra note 34, at 793.

III. Terminal Sedation

Another contemporary medical practice that offers a way to hasten death is called terminal sedation. There are actually several different versions of terminal sedation (hereinafter "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.[38] The first form of TERSE is sedation accompanying the cessation of mechanical life support.[39] The object is to preclude any discomfort, anxiety, agitation, respiratory distress, or pain – i.e., any suffering – while the patient dies from the underlying disease following the removal of life support. Dosage of sedatives is supposed to be commensurate with relief of suffering. In theory, the sedation does not hasten death,[40] though there are anecdotal reports of excessive doses of sedatives probably precipitating death.[41] And in one study, 36% of surveyed professionals reported that hastening death was at least a secondary object in administering sedatives in tandem with withdrawal of life support.[42]

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[38] For a more exhaustive analysis of terminal sedation, see Cantor & Thomas, supra note at 138-51.

[39] 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 JAMA 949, 951 (1992); 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).

[40] Wilson, supra note 39, at 952-53; Daly, supra note 39, at 222.

[41] J. Andrew Billings & Susan D. Block, Slow Euthanasia, 12 J. Palliative Care 21, 22 (1996); see Susan M. Wolf, Pragmatism in the Face of Death: The Role of Facts in the Assisted Suicide Debate, 82 Minn. L. Rev. 1063, 1088 (1998).

[42] Wilson, supra note 39, at 951.

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. The object is still preclusion of suffering accompanying diverse intractable symptoms such as pain, nausea, dyspnea, anxiety or delirium.[43] 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 in the literature from imminent death[44] (looming within hours or days) to death unavoidably occurring within "weeks" or even "months." Since the 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.[45] Often, the literature assigns the underlying ailment as the cause of death rather than sedation.[46] Yet the possibility of the sedative hastening death by prompting respiratory depression is present even if that causation is

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[43] Beth McIver, et al, *The Use of Chlorpromazine for Symptom Control in Dying Cancer Patients*, 9 J. PAIN & SYMPTOM MANAGEMENT 341 (1994) (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).

[44] Paul Rousseau, Terminal Sedation in the Care of Dying Patients, 156 Archives Internal Med. 1785, 1785 (1996); Robert E. Enck, Drug-induced Terminal Sedation for Symptom Control, Am. J. Hospice & Palliative Care 3, 4-4 (1991).

[45] Greene & Davis, supra note at 335, 337; Robert Dozor, Intentionally Hastening Death, 38 J. Fam. Practice 295, 297 (1994); Russell K. Portenoy, Morphine Infusions at the End of Life: The Pitfalls in Reasoning from Ancecdote, 12 J. Palliative Care 44, 45 (1996).

[46] Nessa Coyle, Pain Management and Sedation in the Terminally Ill, AACN, 5 Clinical Issues in Critical Care Nursing 360, 362-63 (199); Robert D. Truog et al., Barbiturates in the Care of the Terminally Ill, 327 N. Eng. J. Med. 1678, 1679 (1992); Greene & Davis, supra note at 335.

unprovable.[47]

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. 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. 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 is probably dehydration. Indeed, once relief of suffering has been achieved by deep sedation, the very function of withholding ANH seems to be to hasten death.

Earlier, I 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

[47] Wilson, supra note 39, at 952-53 (acknowledging the "hemodynamic and respiratory depressant qualities" of the sedatives used).

the patient's normal digestive processes?[48]

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 (rendering herself unconscious) is already relieved from experiential suffering when ANH is subsequently withheld. That is, one of the elements that helped justify VSED – relief from experiential suffering – might be absent at the moment when a TERSE patient forgoes ANH. Once deep sedation administered by a physician renders the dying patient unconscious, the only function of ceasing ANH seems to be to hasten the patient's death. Nonetheless, when a physician initiates this third form of TERSE (by administration of deep sedation), the patient is in fact seeking to hasten death in order to avoid experiential suffering.

Another element possibly differentiates the VSED process from this third form of TERSE. My projection of legal acceptance of VSED was in part grounded on the distasteful specter of forcing a competent, dying patient to receive ANH. 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 has to be 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

[48] See Billings & Block, supra note 13, at 25; David Orentlicher, The Supreme Court and Physician-Assisted Suicide, 337 N. Eng. J. Med. 1236, 1237-39 (1997).

sedation is administered to commence this third form of TERSE.[49] 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 has already ended the patient's experiential suffering. The likelihood is that the patient has gone further -- invoked bodily integrity to resist ANH at this stage -- because the patient wants to die. And the cooperating physician administering deep sedation (which incapacitates the nutrition process) and withholding ANH may well intend to hasten death.[50] Further, as I will shortly explain, the absence of specific intent to hasten death does not eliminate the possibility that when a physician initiates a palliative process (deep sedation) knowing that the patient's death will inevitably follow, the physician is performing euthanasia. 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.

While a physician's state of mind does not seem determinative, this form of TERSE – a request for deep sedation accompanied by a simultaneous choice to forgo ANH – may in fact be lawful. I have posited that VSED accompanied by rejection of ANH is lawful. Assuming as I do 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. Severe distress warranting

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[49] Mount supra note 43, at 34; Russell K. Portenoy, Morphine Infusions at the End of Life, 12 J. Palliative Care 44, 45 (1996); Rob McStay, Terminal . . . 29 Pall. Care, at 56, 76 (2003).

[50] Dresser, supra note 35, at 89. Quill et al., Palliative Options of Last Resort, 278 JAMA 2099, 2101 (1997)

deep sedation occurs when a natural disease process necessitates 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 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, then, 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. In fulfilling that duty, physicians coping with intractable patient suffering sometimes have to use analgesics[51] 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. 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.

The conventional wisdom is that medical use of analgesics risking acceleration of death is lawful so long as the physician's primary intent is to reduce suffering rather than to cause death.[52] Chief Justice Rehnquist asserted in 1997: "It 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."[53] This framework tries to transpose the doctrine of double effect from moral philosophy

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[51] 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.

[52] Miriam K. Feldman, Pain Control in Dying Patients: How Much is Too Much? 73 Minn. Med. 19,21 (1990); Phebe Saunders Haugen, Pain Relief for the Dying: The Unwelcome Intervention of the Criminal Law, 23 Wm. Mitchell L. Rev. 325, 351 (1997); Donald G. Casswell, Rejecting Criminal Liability for Life-Shortening Palliative Care, 6 J. Contemp. Health L. & Policy 127, 129 (1990).

[53] 521 U.S. 793, 808 n.11 (1997).

to criminal law.[54]

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. A natural object for a physician desiring to relieve intractable suffering is to put the foundering patient out of his misery by hastening death. 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 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."[55] Hinging criminal culpability on specific intent encourages a hypocritical practice of stating an intention to relieve suffering when the real objective is to hasten death. The result might be to encourage some physicians to act aggressively with pain relief, but many other physicians are either confused, or skeptical about whether euthanasia is being administered.

The question of criminal liability for risky pain relief cannot be resolved on the basis of a physician's specific intention to relieve suffering. A purpose to relieve suffering does not exculpate a person for a killing, as the law of euthanasia has long established. Also,

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[54] See, e.g., Stephen R. Latham, Acquinas and Morphine: Notes on Double Effect at the End of Life, 1 DePaul J. Health Care Law 625 (1997); Patrick F. Norris, Palliative Care and Killing: Understanding Ethical Distinctions, 13 Bioethics Forum 25 (1997); 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).

[55] President's Commission, Deciding to Forego Life-Sustaining Treatment 78, 81-82 (1983).

administration of risky analgesics which end up accelerating death can constitute an unlawful killing even without a showing that the actor's primary intention was to end life. As George Thomas and I have explained elsewhere,[56] a reckless state of mind – reckless disregard for harmful consequences – can suffice for criminal liability.

This means that relief of suffering can justify administration of a risky analgesic only so 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 be the safest means to relieve the suffering. Professional practice therefore requires that analgesic dosage start at a safe level and be increased only as necessary.[57] In short, even with a primary intention to relieve suffering, a physician does not have carte blanche to administer a pain relief substance which risks hastening death.

This legal framework of recklessness dictates that conduct which the actor *knows* will cause death (as opposed to merely risks death) is impermissible. Under both the Model Penal Code and state law definitions of homicide, conduct certain or practically certain to hasten death is unlawful, even if the actor's intent is to relieve suffering. Glanville Williams long ago explained:

There is no legal difference between desiring or intending a consequence as following

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[56] 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 37, 48 Buff. L. Rev. at 115-20.

[57] Medical professional norms seem to require these limitations on risky pain relief. See sources cited Id. at 117 nn. 124-26. 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); Tony Sheldon, Two Test Cases in Holland Clarify Law on Murder and Palliative Care, 329 BMJ 1206 (11/20/2004).

> 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.[58]

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.[59] 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.[60]

Isolated language from concurring opinions in the Supreme Court's 1997 cases on assisted suicide appears to undermine the thesis that a physician is forbidden from administering an analgesic that she knows will cause death. Justices Souter, O'Connor, and Breyer all comment that state law, while prohibiting physician-assisted suicide, permits physicians to administer necessary analgesics "even when doing so would hasten [dying patients'] deaths."[61] 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 "intention" is to relieve suffering).

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[58] The Sanctity of Life and the Criminal Law 322 (1957).

[59] John Harris, The Philosophical Case against The Philosophical Case against Euthanasia, in Euthanasia Examined: Ethical, Clinical, and Legal Perspectives 36, 39-40 (J. Keown, ed. 1995); Raymond G. Frey, Intention, Foresight, and Killing, in Intending Death 66 (T. Beauchamp ed. 1996).

[60] The Model Penal Code 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."

[61] Vacco v. Quill, 521 U.S. 702, 736-38 (1997)(O'Connor concurring). For parsing of the relevant language in the opinions of Justices O'Connor, Souter, and Breyer, see Cantor & Thomas, supra note , at 122-24.

This notion that analgesics can licitly be used (to relieve suffering) even when death is a certain result seems mistaken to me – "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."[62] This kind of reasoning was recently (mis)used by lawyers instructing military interrogators in Iraq that they would not be guilty of torture even if they knowingly inflicted severe pain, so long as causing such harm was not the interrogator's objective.[63] 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.[64] Or to engage in self-killing by freezing because the dying person's intention was to use cryonic preservation (a worthy, life-affirming goal) rather than to bring about death. Yet 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.

This issue – whether use of knowingly lethal analgesics can be defensible under current law – cannot be definitively resolved by resort either to medico-legal commentators or to medical norms. Commentators disagree on whether a knowingly lethal dosage of analgesics can be lawful.[65] And medical professional standards are largely ambiguous as to whether a knowingly

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[62] Cantor & Thomas, supra note 37, at 123.

[63] Philip Lacovara [in human rights report] 2005

[64] See Jonathan Herring, Giving, Selling, and Sharing Bodies, in 52 (A. Bainham ed. 2002).

[65] Compare Donald B. Marquis, Four Versions of Double Effect, 16 J. Med. & Phil. 515, 523, 529 (1991); Robert Barry & James E. Maher, Indirectly Intended Life-Shortening Analgesia: Clarifying the Principles, 6 Issues in L. & Med. 117, 140 (1990) with John Finnis, Euthanasia, Morality, and Law, 31 Loy. L. A. L Rev. 1123, 1129 (1998); John Keown, The Legal Revolution:

lethal dosage can be permissible. Some professional guidelines authorize risky analgesics that "may" hasten death or carry a "possibility" of hastening death.[66] Other guidelines authorize pain medication in "whatever dose" is necessary for relief.[67] 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 dictum 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. This would be a humane approach and might well be good public policy. Note, however, 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."[68] Under that definition, use of an analgesic that is

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From Sanctity of Life to Quality of Life and Autonomy, 14 J. Contemp. Health L. & Pol'y 253, 258 (1998). See also Dresser, supra note 35, at 83; Yale Kamisar, The Rise and Fall of the Right to Assisted Suicide, in the Case Against Assisted Suicide 69, 78-79 (Foley & Hendin eds. 2002).

[66] 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. *See* Brody, *supra* note at 949; Cherny & Portenoy, *supra* note at 34, 36. *See* also American Academy of Neurology Position Statement, *Certain Aspects of the Care and Management of Profoundly and Irreversibly Paralysed Patients with Retained Cognition,* 43 NEUROLOGY 222 (1993); 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).

[67] Sidney Wanzer et al., The Physician's Responsibility Toward Hopelessly Ill Patients, 320 N. Eng. J. Med. 844, 847 (1989); Melissa L. Buchan & Susan W. Tolle, Pain Relief for Dying Persons: Dealing with Physicians' Fears & Concerns, 6 J. Clin. Ethics 53, 55 (1995); American College of Physicians Ethics Manual, 117 Annals Int. Med. 947, 955 (1992).

[68] AMA Council on Scientific and Judicial Affairs, Opinion 2.21.

certain or practically certain to cause death is a form of euthanasia and would ostensibly be unlawful under the Model Penal Code. If the hints in the concurring opinions in the assisted suicide cases are accurate, as claimed by some commentators, then physicians have a new way to hasten death without violating legal proscriptions.

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

> 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.[69]

IV. Why Legalize Physician-Assisted Death if It's Already Legal?

I have argued that certain methods of hastening the death of a fatally stricken person – such as VSED and TERSE – are probably legal. 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 14 days. From one perspective, these modes of hastening death seem to provide a modicum of dignity in a dying process. Don't they suffice to meet present social

[69] Cantor, supra note 6, 102 Mich. L. Rev. at 1837.

needs?

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. This can be so for any of several reasons. 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 to be intolerable. I.e., a powerful life force impels the waning patient to adjust to deterioration.

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 for death to be hastened. Indeed, good palliative care often does succeed 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.[70] For these patients, an unacceptable quality of life, meaning indignity associated with helplessness, frustration, dependence, fatigue, or sense of being a burden proves to be the determinative factor.[71] "[T]he

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[70] William Breitbart et al., Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients with Cancer, 284 JAMA 2907, 2910 (2000); Ezekiel J. Emanuel et al., The Practice of Euthanasia and Physician-Assisted Suicide in the United States, 280 JAMA 507, 512 (1998); Arthur L. Caplan et al., The Role of Guidelines in the Practice of Physician-Assisted Suicide, 132 Annals Internal Med. 476, 480 (2000).

[71] Glucksberg, 117 S.Ct. at 2289 (Souter concurring). "Research indicates that indignity, dependency, and lack of control are more important than pain in motivating the desire to die." Roger S. Magnusson, Angels of Death: Exploring the Euthanasia Underground 90 (2002); Emanuel, supra note at 509.

prospect of losing control and independence and of dying in an undignified, unaesthetic, . . . and existentially unacceptable condition"[72] will inevitably move some well cared for patients to seek hastened death.

For this limited number of patients, do VSED and TERSE provide a reasonably comfortable and expeditious dying process? These techniques assure a painless death within 14 days and sedation (or other palliative intervention) assures relief from any accompanying emotional suffering. Of course, for some fatally afflicted persons, even a few days of lingering in stupor or unconsciousness makes these processes unacceptably demeaning. They do not wish to linger "in a state that may profoundly compromise their dignity and further distort the memory they leave behind."[73] Nonetheless, 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 occur as a form of anesthesia making the last days of existence peaceful – devoid of pain, anxiety, or suffering. 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."[74] Some people might view this limited insensate period as an opportunity for a family ritual or vigil expressing the "ambivalence and distress of

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[72] Timothy E. Quill et al., Care of the Hopelessly Ill; Proposed Clinical Criteria for Physician-Assisted Suicide, 327 N. Eng. J. Med. 1380, 1383 (1992).

[73] David Orentlicher, as quoted in Dresser, supra note at 90. (Chapter)

[74] George P. Smith II, Terminal Sedation as Palliative Care: Revalidating a Right to a Good Death, 7 Cambridge Q. Healthcare Ethics 382, 383 (1998).

death."[75] The lingering period of days might serve as an adjustment period for family and surrounding loved ones (though it doesn't do much for the insensate patient).

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. This would not fully satisfy those, like myself, who deem even days of lingering helplessly and insensately as repulsive. We 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. 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.[76] Under the status quo, we who prefer access to the immediacy of a poison, *might* find a doctor who will accommodate us,[77] but finding such a physician can be a highly fortuitous and capricious matter.[78] From our perspective, Oregon has found a better way.

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[75] Ben Rich, 24 at 233-35 (discussing Robert Burt's interest in terminal sedation as creating a salutary period of vigil); see also 34 J. Health L. at 324. To me, 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.

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

[77] 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 at 88-89, 192-94, 197; Billings & Block, supra note ; Marcia Angell, No One Trusts the Dying, Wash. Post, July 7, 1997, at A-19; Thomas A. Preston, Killing Pain, Ending Life, N.Y. Times, Nov. 1, 1994, at 27.

[78] Death-hastening practice tends to be "secret and unpredictable, depending more on doctors' courage and compassion than on patients' needs and wishes." Angell, supra.

Conclusion

Widely publicized information about VSED and TERSE might provide sufficient access to hastened death to make the legal status quo tolerable, though not ideal. We can live with the status quo, you should pardon the pun. But then we also have to live with the hypocrisy of pretending that physician-assisted death is only lawful in Oregon. 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 knowing that the patient has already declined ANH, and a physician who administers pain relief in a known lethal dosage.