

DEATH BY VOLUNTARY DEHYDRATION: SUICIDE OR THE RIGHT TO REFUSE A LIFE-PROLONGING MEASURE?

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ABSTRACT

The decision concerning voluntarily stopping eating and drinking (VSED) is increasingly discussed by health care professionals as an appropriate palliative option for decisionally capable, suffering patients who wish to hasten their deaths. Most palliative care clinicians consider VSED an ethical and legally supported choice, and some argue that there is therapeutic value in discussing this option with patients when suffering is intolerable and the desire to control the circumstances of dying is clear and enduring. Others resist informing patients about this option. This article presents a case of a decisionally capable, terminally ill patient who requests hospice support for her decision to hasten her death by VSED.

I. INTRODUCTION

Most terminally ill patients occasionally think about death, and many hope that it will come quickly. Similarly, the desire for a hastened death regularly occurs, but such thoughts are frequently kept secret unless clinicians specifically inquire. Palliative care clinicians observe that it is not uncommon for patients with advanced cancers to ask their caregivers for an assisted or hastened death.¹ There is agreement among such clinicians that a request for an assisted death represents, at a minimum, a plea for help. Understanding the meaning of the request and the nature of the patient's distress requires assessing unmet psychosocial, spiritual, and/or physical concerns, and requires a thoughtful and respectful exploration of the patient's fears, hopes, and needs. When palliative or hospice clinicians respond with intensified symptom management and psychosocial support, the desire for an assisted death often abates. On other occasions, the patient's determination to control the circumstances and timing of death persists and these cases present challenges for clinicians, as being asked by a patient for an assisted death often causes intense and conflicted feelings in clinicians.² The following case study reveals some of the difficulties of perception regarding VSED, but provides a

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1. Janet L. Abrahm, *Patient and Family Requests for Hastened Death*, in HEMATOLOGY 2008: EDUCATION PROGRAM BOOK 475, 475 (Am. Soc'y Hematology ed. 2008). See Judith K. Schwarz, *Responding to Persistent Requests for Assistance in Dying: A Phenomenological Inquiry*, 10 INT'L J. PALLIATIVE NURSING 225 (2004).

2. Susan D. Block & J. Andrew Billings, *Patient Requests to Hasten Death: Evaluation and Management in Terminal Care*, 154 ARCHIVES INTERNAL MED. 2039, 2043 (1994).

good illustration of what may happen when a decisionally capable, terminally ill patient requests VSED to hasten her death.

II. A CASE STUDY

In 2007, when SD was eighty-one years of age, she was told she had a year and a half to live.³ A cancerous pelvic tumor metastasized throughout her abdomen and she was told there was no further treatment following the initial surgery. SD had a history of cancer and was previously treated successfully for both lung and breast cancer. When she was seventy-five she had a hip replacement, and soon resumed her active life in the Southern state where she and her husband had moved after retiring. SD was accustomed to overcoming life's obstacles and sought second opinions about treatment options for this latest cancer. The prognosis was confirmed and hospice care was recommended, an option she rejected at that time. In 2009, her husband died suddenly following a short illness.

She had only one child, a daughter, who insisted that she move back to the Northeast. Even as she grew physically weaker, SD was not eager to move; she and her daughter had never been close, and she was reluctant to leave her friends and independence behind. Her daughter's wishes prevailed. In 2010, SD was moved into a luxurious senior living facility in a large city in the Northeast and began to receive home hospice care. Although her abdominal pain was adequately managed with opiate analgesia, she developed increasing intestinal difficulties. The possibility of having an 'accident' became a growing and humiliating concern. As a consequence of these problems, she ate little, lost a good deal of weight, and rarely left her small apartment. She had to use an electric scooter for her infrequent trips to the dining room when she wished to socialize.

SD began to look forward to the weekly visits by the hospice team's Spiritual Counselor, David. Although she was not a religious person, she enjoyed their wide-ranging discussions. She found him to be a patient and attentive listener. She told him that she had lived a good life and was ready to die—without fear or regret. He was the first person with whom she discussed her interest in hastening her death by stopping eating and drinking. She told David that she heard about this approach from a discussion about another resident's peaceful death following his decision to stop oral intake once his ALS symptoms became intolerable. SD thought this could be the solution to her problems, as she had reached the conclusion that the burdens of living consistently outweighed any associated benefits. She knew she was dying but the pace was too slow; she wanted to speed up the process but did not wish to involve her daughter in her plans. She was accustomed to making her own decisions and wished to die as she had lived—in charge and with dignity.

3. The individual's name has been changed to maintain anonymity.

SD asked David what he knew about this approach to dying, whether VSED would be painful, how long it would take, and whether the other members of the hospice team would support her choice. David was quite willing to discuss her wish to die, but told her that he had no experience with patients who had chosen to hasten their deaths in this manner. He suggested she call Compassion and Choices (C&C), a non-profit community resource that provides end of life advocacy and counseling for decisionally capable, terminally ill patients and their families who seek information about controlling the circumstances and timing of death. He knew that the local clinical coordinator of this organization had experience providing information about VSED to patients who wanted to consider controlling the timing of death.⁴ SD called the coordinator and arranged a visit during which all her questions were answered, and she was given additional printed material that described the process of VSED. Arrangements were made for follow-up and conversations.

Although SD was eager to begin to fast, the clinical coordinator recommended that she first discuss her choice with her daughter and the other members of the hospice team so arrangements could be made for palliative over-sight and psychosocial support. She was also encouraged to hire caregivers who would support her choice to fast, and ensure her physical well-being, once she became too weak to care for herself. She was told that the average time from beginning the fast until death was two weeks. SD was assured that a decision to stop eating and drinking is a well-accepted palliative end of life option that is routinely supported by hospice clinicians. The coordinator offered to speak with her daughter about this option and process, and also offered to collaborate with the members of her hospice team.

During the next visit from the hospice nurse and social worker, SD announced her intention to stop eating and drinking, asked for their support, and added that she was being counseled about this option by C&C. This visit did not proceed smoothly. The hospice nurse and social worker informed SD that they were concerned about her wish to hasten her death in this manner; they said they might have to call an ethics committee meeting, and would certainly have to consult their clinical managers before proceeding. After consulting their managers, the nurse and social worker returned to inform SD that the hospice team could not be involved in any way in support of her choice to VSED. They added that if they did provide any assistance, they might lose their jobs. They would not speak with the C&C coordinator.

SD's daughter was upset by the hospice reaction and became concerned about her own legal liability. She informed the C&C coordinator that she feared being involved in any way that might be viewed as supporting her mother's decision to VSED because assisted suicide is illegal in this state, and she was the only beneficiary of her mother's estate. During a subsequent conversation the daughter told the coordinator that she had consulted the

4. See generally Judith K. Schwarz, *Stopping Eating and Drinking*, AM. J. NURSING, Sept. 2009, at 53, 53-54 (describing a similar end-of-life counseling with an individual whose name and identifying characteristics were changed).

family attorney who confirmed that she and her husband would be at great legal risk if they had any involvement at all in her mother's death. The coordinator was unable to calm her fears despite assuring her that her only 'involvement' might be to help hire health care aides and visit her dying mother. The daughter stated she would do neither.

Despite all this, SD continued to actively pursue her end of life goals. She spoke by phone with the C&C coordinator, arranged to hire several residential aides to provide care when she became bedbound, and met regularly with David, the Spiritual Counselor, as she planned for her death. On the day that she had chosen, she began her fast. She remained alert and oriented throughout the first five days and denied experiencing any significant discomfort. The hospice nurse and social worker resumed their visits after the hospice medical director met with the team and assured them of the legality of SD's choice. Her daughter also returned to her mother's bedside once it became clear that she was going forward with her plan, regardless of the concerns of others. On day four of her fast, SD insisted upon taking her red scooter for one last spin outside. With David accompanying her, she successfully navigated around the whole block and triumphantly and safely made it back to her room. She slipped into a coma at the end of the fifth day of her fast and died peacefully three days later.

III. DISCUSSION

There is broad agreement about how clinicians ought to respond to patients who request assistance in dying. Clinicians are taught to systematically explore the reasons behind the request, to identify and intensify efforts to relieve physical pain and other sources of suffering, to consult with specialists in the relief of psychological or spiritual anguish as needed, and to commit to non-abandonment and the identification of a mutually acceptable solution to the patient's suffering.⁵ When unacceptable suffering persists despite all efforts, palliative care clinicians agree that decisionally capable patients who request assistance in dying should be informed about all 'legal' palliative options that permit patients to speed the dying process.⁶ Those legally recognized options include: refusing all potential and actual life-prolonging treatments such as, all medications, surgically implanted cardiac devices, renal dialysis, mechanical

5. *Position Statements: Physician-Assisted Death*, AM. ACAD. OF HOSPICE AND PALLIATIVE MED. (Feb. 14, 2007), <http://www.aahpm.org/positions/default/suicide.html>. See also Timothy E. Quill & Christine K. Cassel, *Nonabandonment: A Central Obligation for Physicians*, 122 ANNALS INTERNAL MED. 368, 369-70 (1995) (detailing the importance of committing to non-abandonment of patients).

6. See Abrahm, *supra* note 1, at 477-78. In the face of a request for hastened death, physicians should "[r]eiterate [their] commitment to ongoing discussions about [the patient's] concerns" and realize "a discussion of their other options may be needed. Patients have a legal right to stop eating and drinking, or to stop artificial nutrition or hydration." *Id.* at 478 (footnotes omitted).

ventilation, and medically provided nutrition and hydration.⁷ Eating and drinking is categorized as a life-prolonging measure that can be refused by capacitated patients who wish to hasten dying to escape suffering when no other life-sustaining medical interventions exist.⁸ Similarly, within the context of far-advanced disease, when patient suffering is refractory to all standard palliative measures, clinicians can provide palliative sedation to unconsciousness, a palliative measure that generally is accompanied by the discontinuation of all other life prolonging measures including medically provided hydration and nutrition.⁹

Physician-assisted dying (PAD) is a legal option in Oregon, Washington, and Montana where physicians may write prescriptions for a lethal amount of medication for legislatively appropriate terminally ill patients who self-administer the medication at a time of their choosing.¹⁰ However, PAD is currently not a legal option for terminally ill patients in the rest of the country. Alternatively, recent medical discussions of VSED suggest the question of its legality is now settled. Berry describes this option as a legal “means of hastening death . . . supported by both statutory and case law.”¹¹ Other clinicians state,

[f]or those patients for whom the control of the time and place of their death are the core concerns, a discussion of their other options may be needed. Patients have a legal right to stop eating and drinking . . . You can assure them that your care for them and their family would continue should they choose that path.¹²

A decade ago, when palliative care clinicians first began to discuss voluntary refusal of food and fluid as one of the palliative options of last resort, they acknowledged that legal precedents to guide this option were less developed than those supporting the refusal of other interventions like ventilators and feeding tubes.¹³ Similarly, a decade ago when legal scholars explored the

7. Rachel Lampert et al., *HRS Expert Consensus Statement on the Management of Cardiovascular Implantable Electronic Devices (CIEDs) in Patients Nearing end of Life or Requesting Withdrawal of Therapy*, 7 *HEART RHYTHM* 1008, 1011 (2010).

8. See James L. Bernat et al., *Patient Refusal of Hydration and Nutrition: An Alternative to Physician-Assisted Suicide or Voluntary Active Euthanasia*, 153 *ARCHIVES INTERNAL MED.* 2723, 2725 (1993).

9. Timothy E. Quill & Ira R. Byock, *Responding to Intractable Terminal Suffering: The Role of Terminal Sedation and Voluntary Refusal of Food and Fluids*, 132 *ANNALS INTERNAL MED.* 408, 410 (2000).

10. The Oregon Death with Dignity Act, OR. REV. STAT. 127.805 § 2.01, 127.815 § 3.01 (2007); The Washington Death with Dignity Act, WASH. REV. CODE §§ 70.245.020-.040 (2010); *Baxter v. State*, 224 P.3d 1211, 1222 (Mont. 2009) (holding PAD as legally defensible and stating that “nothing in the plain language of Montana statutes indicat[es] that physician aid in dying is against public policy” and “[i]n physician aid in dying, the patient—not the physician—commits the final death-causing act by self-administering a lethal dose of medicine”).

11. Zail S. Berry, *Responding to Suffering: Providing Options and Respecting Choice*, 38 *J. PAIN & SYMPTOM MGMT.* 797, 799 (2009) (footnote omitted).

12. Abrahm, *supra* note 1, at 478 (footnotes omitted).

13. See, e.g., Quill & Byock, *supra* note 9, at 410.

question of whether VSED could or should be distinguished from an act of suicide, they noted that there were few cases of competent persons who chose to voluntarily fast until death.¹⁴ Cantor and Thomas cited two unpublished lower court cases in New York in which nursing homes requested authorization to administer artificial nutrition and hydration to elderly, chronically ill women who had chosen to die via VSED.¹⁵ In both cases, the nursing homes invoked a New York statute authorizing the prevention of suicide, and in both cases the judge refused to intervene.¹⁶ These scholars predicted that “judicial non-intervention is likely to continue in instances of suicidal VSED by competent, dying medical patients.”¹⁷

Even when palliative care clinicians agree that VSED is a legally acceptable option, questions about the morality and professional advisability of this practice may persist for some providers. Clinicians’ concerns about informing patients of VSED, or providing palliative support for those who choose to hasten dying by dehydration, arise from a number of sources.

IV. CLINICIANS’ CONCERNS ABOUT FACILITATING DEATH BY VSED

When a terminally ill patient decides to forgo life-prolonging interventions in order to hasten or cause death, the legal and ethical consensus regarding the patient’s cause of death is clear. In this situation, the cause of death is the underlying disease that necessitated the medical intervention, not the patient’s decision to reject the intervention. Removing the unwanted medical intervention allows the patient to die naturally of his or her disease. Such decisions are routinely made by dying patients and their families, and are supported by hospice and palliative care clinicians. However, when a patient chooses to voluntarily forgo food and fluid, some might argue that “the patient has introduced the fatal cause, dehydration,” thus this choice may seem to have “an element of suicide” that is not present when patients choose to forgo other medical treatments.¹⁸ Many other clinicians, however, view a patient’s valid refusal of food and fluid as a decision that falls within the realm of personal sovereignty over one’s body and the right to be free of unwanted or forced bodily intrusions.¹⁹

Yet clinicians who believe “suicide” is always morally wrong may conclude that when patients intentionally choose to hasten or cause death, even if done to escape intolerable suffering, these patients commit an unacceptable act that

14. Norman L. Cantor & George C. Thomas III, *The Legal Bounds of Physician Conduct Hastening Death*, 48 BUFF. L. REV. 83, 101 (2000).

15. *Id.*

16. *Id.*

17. *Id.*

18. *Id.* at 97.

19. See Franklin G. Miller et al., *Assisted Suicide Compared with Refusal of Treatment: A Valid Distinction?*, 132 ANNALS INTERNAL MED. 470, 473 (2000).

clinicians should not support.²⁰ Some believe that to inform a patient of the option of VSED would also be morally wrong because by doing so, the clinician might influence the patient to choose this immoral option, and thus would be cooperating in wrongdoing.²¹ It is well established professional practice that clinicians are not required to act against their own strongly held moral and/or religious beliefs. Yet, there is also agreement that health care professionals are obligated to inform their patients about all legally available treatment options, and if morally opposed to a particular practice, to refer patients to another clinician who will provide information and support for all legal medical practices.²²

Other clinicians might be concerned that by informing already suffering patients about the option of a VSED death, they might encourage patients to consider a painful and difficult death that has a protracted dying process of such length that might be considered inhumane by patients and family members.²³ Such fears do not seem justified by clinical reality. The results of several small empirical studies and many anecdotal reports suggest that VSED provides most patients with a peaceful and gentle death that is generally well-tolerated and occurs within two weeks of initiating the fast.²⁴ Increasingly, individual patients, family members, and clinicians have been speaking publicly about the nature and experience of VSED deaths.²⁵

Foundational to clinicians' concerns about discussing VSED with patients may be the very reason for the discussion—the patient is seeking advice and support for a hastened death.

V. CLINICIANS' EMOTIONAL REACTIONS TO REQUESTS FOR A HASTENED DEATH

When hospice patients ask their professional caregivers for a hastened death, the clinician often experiences a “storm of feelings” that may include guilt, shock, self-doubt, failure, sadness and self-blame.²⁶ These feelings will “influence the physician’s response to the patient’s request,” and may “adversely influence the patient’s care.”²⁷ Some physicians may simply be

20. Lynn A. Jansen & Daniel P. Sulmasy, *Sedation, Alimentation, Hydration, and Equivocation: Careful Conversation About Care at the End of Life*, 136 ANNALS INTERNAL MED. 845, 848 (2002).

21. *Id.*

22. Farr A. Curlin et al., *Religion, Conscience, and Controversial Clinical Practices*, 356 NEW ENG. J. MED. 593, 597 (2007).

23. See Berry, *supra* note 11, at 799.

24. Linda Ganzini et al., *Nurses' Experiences with Hospice Patients who Refuse Food and Fluids to Hasten Death*, 349 NEW ENG. J. MED. 359, 363 (2003); Schwarz, *supra* note 4, at 55.

25. Schwarz, *supra* note 4, at 59; Sandra Jacobs, *Death by Voluntary Dehydration—What the Caregivers Say*, 349 NEW ENG. J. MED. 325 (2003) (explaining the increase in published accounts of VSED deaths); Berry, *supra* note 11, at 797-98; David M. Eddy, *A Conversation with my Mother*, 272 JAMA 179 (1994); DYING WISH (DYING WISH MEDIA 2008) (for more information on the film, visit <http://74.220.215.84/~goipeac/dyingwishmedia/>).

26. Abrahm, *supra* note 1, at 477.

27. Block & Billings, *supra* note 2, at 2043.

unable to hear the request—either because the request causes such distress that they cannot acknowledge hearing the request, or because they fail to recognize the patient’s expression of despair and the extent of their suffering.²⁸ Other clinicians may not understand that ambivalence is a very common aspect of a patient’s request for a hastened death. Block and Billings note that “[w]hen the clinician takes a request to hasten death simply at face value . . . he or she runs the risk of colluding with the patient’s feelings of hopelessness and helplessness.”²⁹ When requests for a hastened death persist, palliative care physicians note the importance of obtaining a psychiatric consultation in order to explore whether a mental illness, such as major depression, is compromising decision making.³⁰ Block and Billings wisely add that “[p]atients should be reassured that psychiatric evaluation does not carry the risk of involuntary hospitalization for suicidal ideation.”³¹

When patients ask their hospice nurses and social workers for a hastened death, these clinicians may feel they have ‘failed’ by not adequately managing symptoms of suffering in their dying patient. Hospice professionals view themselves as ‘experts’ in symptom management, and when patients request a hastened death, hearing the request may cause them to feel they have not adequately done their job—which is to provide sufficiently good symptom relief in order for patients to experience a ‘good’ and ‘natural’ death.³² Many hospice clinicians remain unaware of the Oregon data that has consistently shown, over twelve years of legal access to PAD, that the primary reasons terminally ill Oregonians give for using the law is not poor symptom management, but concerns about loss of autonomy and personal dignity, and the inability to do things that make life worth living.³³

Other hospice nurses may respond to requests for information about hastening death by reciting the hospice mantra: hospice neither hastens nor prolongs dying.³⁴ Others simply say, “I can’t help you with that.” This type of

28. Abraham, *supra* note 1, at 477.

29. Block & Billings, *supra* note 2, at 2044 (footnotes omitted).

30. *Id.* at 2045.

31. *Id.* The author has personal experience of hospice patients being threatened with or actually forced into an institutional setting for seventy-two hours so that suicidal ideation could be explored following a request for assistance in hastening death. Such patients quickly learn what *not* to say to their hospice providers.

32. See generally Theresa A. Harvath et al., *Dilemmas Encountered by Hospice Workers When Patients Wish to Hasten Death*, 8 J. HOSPICE & PALLIATIVE NURSING 200 (2006). But see *id.* at 207 (noting that among Oregon hospice nurses and social workers in the study, VSED was perceived as a more natural process of “letting go of life” with “less emotional baggage” and distinct from MD-assisted dying with medication, which was considered “hastening death in a much more active way”) (internal quotation marks omitted).

33. OREGON PUBLIC HEALTH DIVISION, OREGON’S DEATH WITH DIGNITY ACT—2010, at 2 (2010), available at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year13.pdf>.

34. Courtney S. Campbell et al., *Conflicts of Conscience: Hospice and Assisted Suicide*, HASTINGS CTR. REP., May-June 1995, at 36, 36 (1995).

response effectively ceases all further communication and closes an important opportunity for the nurse to acknowledge the patient's distress, explore the meaning of the desire for a hastened death, and re-focus efforts on relieving their suffering.³⁵ The reluctance to explore the request for a hastened death may also be caused by misunderstandings about whether clinicians assume any legal and ethical liability when discussing options that permit patients to hasten death.

VI. THERAPEUTIC VALUE TO PATIENTS FROM DISCUSSING THE VSED OPTION

Many patients who live with incurable and progressive diseases have had to sacrifice a great deal; they have had to settle for lives filled with chronic pain, physical limitations, sensory decline, and an inability to further pursue activities that were previous sources of joy and satisfaction. Some individuals are able to accept such deprivations with grace and good will, but for many others, the inability to have a voice that is heard or make a choice that is respected by others is an intolerable affront to their personal dignity. Most of these people want to know that there are still choices they can make about important issues in their lives, and planning for the end of life is one such issue. Only the person living that life can decide when the burdens of living consistently outweigh any benefits associated with prolonging life. Only they can decide when their suffering has become unbearable, and when the time has arrived to explore whether and how to hasten their dying.

It is important to note that many more people will seek accurate information about VSED than will ever pursue this option. Nonetheless, many who learn about VSED will feel empowered by the knowledge that they have a choice, which they can implement without a physician's written order or anyone else's permission or approval. Furthermore, VSED is an end of life decision that can be openly discussed with loved ones and caregivers because it is a legal option that does not need to be kept secret. It also furthers patient autonomy. Control over the use of VSED remains with the patient throughout the process because he or she gets to decide whether to initiate the fast, when to begin, and whether to continue.

In the case of SD, additional factors complicated the traditionally supportive role of hospice. The hospice that was providing her care had recently changed its medical director. The previous medical director, who had been with the hospice for almost ten years, had strong moral and religious beliefs that precluded any support for a patient's desire to intentionally hasten death. His values became the dominant values that were applied within the organization. He provided regular in-service presentations so that staff would be familiar with the steps he wanted them to follow to actively intervene if patients requested a hastened death. This previous medical director did not

35. See Judith Schwarz, *I Can't Help You with That*, AM. J. NURSING, Aug. 2008, at 11, 11 (2008).

support the end of life counseling and advocacy provided by C&C—an organization he deemed to be “pro-suicide.”

A new medical director had recently been hired, but she had not yet been able to establish her own palliative care goals within the hospice. This new medical director supported the exploration of a patient’s desire for a hastened death and, when clinically appropriate, believed that hospice staff ought to inform patients about all legal palliative options that permit patient control of dying. Once the new director became aware of the team’s concerns and fears regarding SD’s wish to hasten her death by VSED, the director promptly met with all members of the team and assured them of her support for the VSED option. The director also confirmed the responsibility to provide on-going support and complete information for all patients, regardless of what legal options the patient chose. She acknowledged that patient requests for a hastened death can cause distress among members of the care-giving team and facilitated an open, non-judgmental discussion of their fears and concerns. The new director also confirmed that clinicians have the right to withdraw from a case and transfer that responsibility to a willing colleague if providing support for patient’s choice would offend their strongly held personal values or beliefs. A new series of in-service workshops has been planned for this hospice, including written guidelines for how the organization will respond to patient requests for hastened death going forward.

VI. CONCLUSION

The decision to choose death by voluntary dehydration is increasingly occurring nationwide. Articles are available online that include personal stories from family members of those who have chosen to hasten their deaths in this manner.³⁶ Most responsible clinicians believe that, for the ‘right’ candidates, VSED can be a good choice for those who are decisionally capable, receiving hospice or palliative care, and have an enduring desire to control the circumstances and timing of death without subjecting their loved ones to legal risk for supporting that choice. Yet, VSED is a process that unfolds over time and requires thoughtful planning and support if the patient is to achieve a successful outcome—which is a peaceful death that occurs within days to three weeks after beginning the fast. Patients and families who wish to consider this option must understand what is involved and the importance of having palliative or hospice oversight available to manage any unforeseen physical problems.

Given the opportunity to learn about VSED and to discuss this option with their health care providers, increasing numbers of persons suffering from incurable and progressive diseases will feel empowered by the choice implicit

36. See, e.g., Wendy Underhill, *Choosing to Die*, NEXUS (July/Aug. 2008), http://www.nexuspub.com/articles_2008/feature_ja2008_assist_suicide.php.

in those conversations to decide whether this is an appropriate option for them. In the present case, SD was able to proceed with her plans, despite the initial reservations expressed by members of her hospice team and her family. Once her caregivers recognized that she had made a well-informed and determined decision to proceed, and they understood they would assume no legal risk in supporting her choice, her achievement of a peaceful and dignified death was instructive to all.

