VOLUNTARILY STOPPING EATING AND DRINKING: A LEGAL TREATMENT OPTION AT THE END OF LIFE

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ABSTRACT

Despite the growing sophistication of palliative medicine, many individuals continue to suffer at the end of life. It is well settled that patients, suffering or not, have the right to refuse life-sustaining medical treatment (such as dialysis or a ventilator) through contemporaneous instructions, through an advance directive, or through a substitute decision maker. But many ill patients, including a large and growing population with advanced dementia who are not dependent upon life-sustaining medical treatment, do not have this option. They have the same rights, but there is simply no life-sustaining medical treatment to refuse.

Nevertheless, these patients have another right, another option by which to avoid suffering at the end of life. Patients with decision-making capacity may choose (through contemporaneous instructions) to voluntarily stop oral eating and drinking in order to accelerate the dying process. Moreover, patients without capacity often have the same option. Voluntarily stopping eating and drinking (VSED) is a clinically validated "exit option" that enables a good quality death. Significant and growing evidence supports VSED as a means of accelerating the dying process. Nevertheless, VSED is widely resisted by healthcare practitioners either because they think that it is illegal or because they are uncertain of its legality.

There has been little legal analysis of a right to VSED. In this Article, we aim to fill this gap and to clarify the legal status of VSED. Specifically, we argue that both contemporaneous and (most) non-contemporaneous decisions for VSED are legally permissible. Individuals may refuse nutrition and hydration just as they may refuse other intrusions on their personal autonomy. This right is grounded in the common law of battery, statutes, state constitutions, and even the United States Constitution. Moreover, VSED does not, as many believe, constitute abuse, neglect, or assisted suicide. Even *ex ante* decisions for VSED (exercised through an advance directive or a surrogate decision maker) are legal in most United States jurisdictions.

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I. INTRODUCTION

Jane is a seventy-four-year-old woman who resides in a long-term care facility in South Australia.[1] She contracted polio as a child in the 1930s, and now suffers from post polio syndrome and Type 1 diabetes.[2] About ten years ago, Jane noticed a right side weakness which has deteriorated to the point where she now has no use of the limbs on the right side of her body.[3] While she has some use of her left-sided limbs, movement is both extremely limited and painful.[4] Jane spends all of her waking hours in a wheelchair, and when she is in bed she is unable to move or change positions.[5] Because of these

1. H Ltd v J & Anor [2010] SASC 176 ¶ 1-2 (Austl.). The patient-defendant's name was abbreviated by the court to protect her privacy. To improve readability, we call the patient "Jane" instead of "J."

2. *Id.* ¶¶ 2-3.

3. *Id.* ¶ 3.

4. *Id.*

5. *Id.*

physical limitations, Jane requires assistance for all of her basic hygiene needs.[6] There is no prospect for any improvement in her condition.[7]

By January 2010, Jane found her existence unbearable. She determined that she had crossed the boundary of what, for her, was a meaningful life.[8] She was suffering not only physically but existentially, wracked with anguish, fear, apprehension, helplessness, despondency, dependency, and a sense of meaninglessness.[9] So Jane chose a treatment option to hasten her death on her own terms.[10] She "asserted a right to lawfully embark upon a course which will shorten her life free from any interference" from her long-term care provider.[11]

Jane was examined by both geriatric and palliative care specialists who determined that she was competent and not depressed.[12] Indeed, Jane showed significant insight into her condition and explained rationally and dispassionately why she no longer wished to live.[13] She made the decision to hasten her death with a "full understanding of the consequences of her decision," after "long reflection," and based on "the importance to her of an independent and dignified life."[14]

Jane was not the paradigmatic patient seeking the right to die. She was not in an intensive care unit, dependent upon a ventilator, clinically assisted nutrition and hydration, dialysis, a pacemaker, or on any other technology that could simply be turned off.[15] So to escape "a despair which she could no longer endure," on January 19, 2010, Jane informed her long-term care facility of her intention to end her life by ceasing to take any food or water.[16] To supplement these instructions, on March 4, 2010, Jane completed an advance directive instructing healthcare providers not to provide nutrition or hydration should she be in the terminal phase of an illness or in a persistent vegetative state.[17] In May 2010, Jane appointed her children to be her enduring guardians, with instructions to refuse nutrition and hydration.[18]

Jane's request was unusual. And her long-term care facility was unsure whether it legally could, should, or was required to comply with her contemporaneous decision or with her advance instructions.[19] Consequently,

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6. *Id.*

7. H Ltd v. J & Anor [2010] SASC 176, ¶ 3 (Austl.).

8. *See* BOUDEWIJN CHABOT, A HASTENED DEATH BY SELF-DENIAL OF FOOD AND DRINK 11 (2008).

9. *See* JAMES L. BERNAT, ETHICAL ISSUES IN NEUROLOGY 156-57 (3rd ed. 2008) (describing how patients in the end stages of a terminal illness share these similar feelings).

10. H Ltd v J & Anor [2010] SASC 176 ¶ 4 (Austl.).

11. *Id.* ¶ 21.

12. *Id.* ¶ 45.

13. *Id.* ¶ 45.

14. *Id.* ¶ 46.

15. Jane also informed her long-term care facility of her intention to cease taking insulin for her diabetic condition. *Id.* ¶¶ 7, 18.

16. H Ltd v J & Anor [2010] SASC 176 ¶ 4 (Austl.).

17. *Id.* ¶ 4.

18. *Id.* ¶ 5.

19. *Id.* ¶ 7.

the facility filed an action for declaratory relief in the Supreme Court of South Australia.[20] In June 2010, that court ruled that the long-term care facility not only had no duty to feed or to hydrate Jane, but not even a right to do so against her wishes.[21] The court held this was required even if not feeding or hydrating Jane would result in her death.[22] If Jane wanted to die from dehydration, then her healthcare provider was not only permitted to let her do so, but was also prohibited from interfering.

With the publication of this judicial opinion, the legality of Voluntarily Stopping Eating and Drinking (VSED) has been clarified and confirmed in South Australia.[23] But the legality of VSED remains uncertain in the United States. Consequently, it remains an underutilized and almost underground treatment mechanism.[24] Moreover, the dearth of legal direction includes not only primary but also secondary authority. Commentators have recognized this lack of analysis, noting that VSED is just "now gaining wider understanding."[25] Law professor Lois Shepherd argues that the legality of VSED is "ripe for serious consideration."[26]

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20. *Id.* ¶ 7.

21. *Id.* ¶ 98

22. H Ltd v J & Anor [2010] SASC 176 ¶ 98 (Austl.). Soon after the judgment, Jane stopped eating and drinking and slipped into a coma. She died peacefully four days later. Jason Om, *Sounds of Summer: Angela's Last Wish*, THE WORLD TODAY (Jan. 21, 2011), http://www.abc.net.au/worldtoday/content/2011/s3118110.htm.

23. The status of VSED may also be well-settled in the Netherlands. *See generally* Tony Sheldon, *Row Over Force Feeding of Patients with Alzheimer's Disease*, 315 BRIT. MED. J. 327 (1997).

24. *See* Lynn A. Jansen & Daniel P. Sulmasy, *Physician Involvement in Voluntary Stopping of Eating and Drinking*, 137 ANNALS INTERNAL MED. 1010, 1011 (2002) (authors' response to claims made in a letter to the editor) ("The voluntary refusal of foods and fluids by patients who are capable of eating and drinking is not currently the standard of care in palliative medicine."). This may be, in part, because even physicians are misinformed about the process of dying from lack of hydration and nutrition. *See* CHABOT, *supra* note 8, at 37 ("Doctors still know too little about a self-directed death by voluntary refusal of fluids because not enough attention is devoted to it . . . ."); *id.* at 56 (describing VSED as the "'Cinderella' of end-of-life research"); Judith C. Ahronheim & M. Rose Gasner, *Viewpoint: The Sloganism of Starvation*, 335 LANCET 278, 278 (1990). Although providers may refuse to offer or to be involved with VSED for religious or for other reasons unrelated to legal concerns, this article addresses only legal concerns that providers may have with VSED.

25. Phillip M. Kleespies et al., *End-of-Life Choices*, *in* DECISION MAKING NEAR THE END OF LIFE: ISSUES, DEVELOPMENTS, AND FUTURE DIRECTIONS 119, 126 (James L. Werth & Dean Blevins eds., 2009). *See also* Norman L. Cantor, *On Hastening Death Without Violating Legal and Moral Prohibitions*, 37 LOY. U. CHI. L.J. 407, 418 (2006) [hereinafter Cantor 2006] ("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."); Timothy E. Quill, *Physician-Assisted Death in the United States: Are the Existing "Last Resorts" Enough?*, HASTINGS CTR. REP., Sept.-Oct. 2008, at 17, 22 (VSED "must become more standardized, available, and accountable."); Robert Schwartz, *End-of-Life Care: Doctors' Complaints and Legal Restraints*, 53 ST. LOUIS U. L.J. 1155, 1171 n.83 (2009) (noting the "ambiguity faced by physicians in this area" and observing that the status of VSED is not well established); *id.* at 1170 (suggesting that because certain provisions in a California bill that would specifically authorize VSED were later removed from the bill, VSED

In this article we aim to make the legal status of VSED clearer and more certain.[27] We argue that legal fears and concerns regarding VSED are unfounded.[28] We begin, in Part II, by placing VSED in a broader context. We examine why someone would want to hasten death in the first place. We then review five ways in which deaths can be (and are) hastened in the United States. And we show how, for some individuals, VSED offers a means for hastening death unmet by other options.

In Part III, we discuss the nature of VSED. We first describe exactly what the procedure entails and sketch a quick history. Most importantly, we explain the physiological process of dehydration and review relevant clinical studies that have consistently demonstrated that VSED is a peaceful and comfortable way to die.

Having established VSED as a potentially attractive option for some individuals, in Part IV we establish the legality of VSED. We first ground a right to VSED in common law torts. If someone refuses food and water, to force it upon him or her would constitute a battery. A right to VSED can also be grounded in a patient's common law, statutory, or constitutional right to refuse medical treatment. After making the affirmative case for a right to VSED, we make arguments refuting allegations that VSED constitutes abuse, neglect, or assisted suicide.

Throughout most of this article, we assume that our subject is a competent patient making a contemporaneous decision to VSED. But in Part V, we briefly examine the legality of VSED in situations in which the decision to VSED is made in an advance directive or by a surrogate. Here, when choosing VSED through an exercise of prospective autonomy, there are substantially more hurdles. Indeed, in some jurisdictions, this choice is barred

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"remain[s] in legal limbo"). *Cf.* FRIENDS AT THE END, ONE WAY TO DIE: STOPPING EATING AND DRINKING 4 (2009) ("[T]his may be a difficult matter for your doctor . . . . She may feel that she is at some legal risk if she helps you."); ALANA IGLEWICZ ET AL., VOLUNTARILY STOPPING ORAL INTAKE: SUICIDE VERSUS SELF-DETERMINATION? (2009), *available at* http://www.palliativemed.org/files/a-1221192-1260993670.pdf (Poster presented at the American Association of Geriatric Psychiatry Annual Meeting in March 2009) ("There is a clear dearth of literature guiding clinicians in their evaluation and treatment of patients who choose to hasten their death by declining oral intake.").

26. Lois Shepherd, *Heroes, Lawyers, and Writers–A Review of Two Schiavo Books*, 31 NOVA L. REV. 315, 324 (2007). *See also* Lois Shepherd, *Terri Schiavo: Unsettling the Settled*, 37 LOY. U. CHI. L.J. 297, 339 (2006) [hereinafter Shepherd 2006] ("Further consideration of the issue of feeding . . . by hand, is necessary . . . .").

27. Norman L. Cantor & George C. Thomas III, *The Legal Bounds of Physician Conduct Hastening Death*, 48 BUFF. L. REV. 83, 86 ("Clinicians deserve clarification of the scope of currently permissible practices . . . .").

28. Some clinicians have written that "[t]he most pressing need is to dispel the myths about suffering" and VSED. 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, 2727 (1993). To the extent that VSED is thought to be clinically appropriate but illegal, the mission of this article is to dispel those myths. *Cf.* Alan Meisel et al., *Seven Legal Barriers to End-of-Life Care: Myths, Realities, and Grains of Truth*, 284 JAMA 2495, 2496-97 (2000). *See generally* Alan Meisel, *Legal Myths About Terminating Life Support*, 151 ARCHIVES INTERNAL MED. 1497 (1991).

by explicit and direct statutory prohibitions. But even "advance VSED" is legal in most parts of the United States.

We conclude that healthcare providers' concerns regarding the legality of VSED are misplaced. Providers not only *may* but also *should* honor appropriate patient requests for VSED. Furthermore, providers should educate patients that VSED is an available treatment alternative. Informed consent requires more than just acceding to a decision to refuse treatment. It also requires making patients aware of their end-of-life options.[29] The situation is less clear when the VSED request is made by a surrogate instead of by the patient herself. But in many jurisdictions such a decision has the same status as a contemporaneous decision made by a patient with capacity.[30] Still, we recognize the limits of education to address providers' "bad law" claims.[31] Law review articles may be insufficient to dispel the myth of illegality. Consequently, legislators and regulators should clarify the safe harbor protections afforded to health care providers.

II. BACKGROUND: REASONS FOR HASTENING DEATH

Before turning to a factual description and legal analysis of VSED, it is important to examine why someone might want to hasten death in the first place. There are many circumstances under which a longer life is not a better life. When quality of life diminishes, some individuals would prefer to hasten death (or at least not prolong dying) rather than endure the perils of what, at least to them, is an exceedingly poor quality of life.[32] What exactly comprises a

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29. *See, e.g.*, Assemb. B. 2747, 2007-2008 Leg., Reg. Sess. (Cal. 2008), *codified at* CAL. HEALTH & SAFETY CODE § 442.5 (West 2010); H.B. 435, 2009-2010 Leg., 70th Sess. (Vt. 2009) (Patients' Bill of Rights for Palliative Care and Pain Management), *enacted as* 2009 Vt. Acts & Resolves 159 (codified at VT. STAT. ANN. tit. 18, § 1871 (2009)); S.B. 4498, 2009-2010 Leg., Reg. Sess. (N.Y. 2009) (codified at N.Y. PUB. HEALTH LAW § 2997-c (McKinney 2007); S.B. 1311, 49th Leg., Reg. Sess. (Ariz. 2009); S.B. 1447, 50th Leg., Reg. Sess. (Ariz. 2010).

30. In these jurisdictions, there may be some limitations to a surrogate making a decision to VSED. *See* Charles P. Sabatino, *The Evolution of Health Care Advance Planning Law and Policy*, 88 MILBANK Q. 211, 221 (2010) (stating that "a dozen states . . . require a diagnostic precondition before an agent [or surrogate] may forgo life-sustaining procedures"); Thaddeus Mason Pope, *Comparing the FHCDA to Surrogate Decision Making Laws in Other States*, 16 N.Y. STATE BAR ASS'N HEALTH L.J. (forthcoming 2011).

31. *See* Sandra H. Johnson, *Regulating Physician Behavior: Taking Doctors' "Bad Law" Claims Seriously*, 53 ST. LOUIS U. L.J. 973, 1009-15 (2009) (examining how education may be insufficient to decrease physicians' fear of the legal consequences regarding certain treatments).

32. *See* Janet L. Abrahm, *Patient and Family Requests for Hastened Death*, HEMATOLOGY, Jan. 2008, at 475, 475 ("Patient and family requests for hastened death are not uncommon among patients with advanced malignancies."); Linda Ganzini et al., *Oregonians' Reasons for Requesting Physician Aid in Dying*, 169 ARCHIVES INTERNAL MED. 489, 489 ("One in 10 dying patients will, at some point, wish to hasten death.") (citation omitted); Jean-Jacques Georges et al., *Requests to Forgo Potentially Life-Prolonging Treatment and to Hasten Death in Terminally Ill Cancer Patients: A Prospective Study*, 31 J. PAIN & SYMPTOM MGMT. 100, 104 (2006); J. McCarthy et al., *Irish Views on Death and Dying: A National Survey*, 36 J. MED. ETHICS 454, 456 (2010) (finding that

"poor quality of life" covers a broad spectrum that varies significantly from person to person.

For some, loss of independence might diminish quality of life to the point where they would request a hastened death. For others, it may be extreme physical suffering. For these and other reasons, requests to hasten death are common throughout the United States and the world.[33] As Justice Brennan observed, "[f]or many, the thought of an ignoble end, steeped in decay, is abhorrent."[34]

The following subsections discuss some key reasons for wanting to hasten death and the medical means[35] by which it can be done in the United States. First, we discuss end-of-life suffering and the predicaments associated with common diseases and medical conditions that cause the most deaths in this country. Second, we offer a full list of recognized "exit options" or "last resorts" for those who do choose to hasten death: (1) refusal of life-sustaining medical treatment; (2) palliative sedation to unconsciousness; (3) administration of high dose opioids; (4) physician assisted suicide; and (5) voluntary active euthanasia. Third, we demonstrate that there are some people who, for clinical, practical, or legal reasons, are ineligible for any of these five options. It is primarily for these people that we explore VSED as a sixth exit option.

A. Suffering at the End of Life

Many people do not fear death, but rather dying.[36] Dying is a process that many associate with severe pain, embarrassment, prolonged hospital stays, and burdens on family and friends. Perhaps the worst problem and greatest fear when a person considers the end of life is the fear that suffering will be uncontrollable and independence will be lost.[37] Uncontrollable suffering could

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a majority of individuals strongly agreed with the statement, "If I were severely ill with no hope of recovery, the quality of my life would be more important than how long it lasted."); Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 NEW ENG. J. MED. 1193, 1195 (1998).

33. *See supra* note 32.

34. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 310 (1990) (Brennan, J., dissenting).

35. The individuals who seek to hasten death are often dependent upon healthcare providers in a long-term care facility or are afflicted with a condition under medical management. Moreover, many people want the assistance or supervision of healthcare providers to assure that any death hastening is appropriate, effective, and pain-free. *See* MARCA BRISTO, NAT'L COUNCIL ON DISABILITY, ASSISTED SUICIDE: A DISABILITY PERSPECTIVE, *available at* http://www.ncd.gov/newsroom/publications/1997/suicide.htm.

36. *Cf.* 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, 412 (2000) (arguing that informing patients of VSED is probably appropriate when "patients express fears about dying badly").

37. *See* Georges et al., *supra* note 32, at 104 (listing hopeless suffering, general weakness, loss of dignity, meaningless suffering, and loss of control as the most important reasons that patients request to forgo treatment or to hasten death). *See also* Fran Moreland Johns, *An October Morning, in* THE BEST WAY TO SAY GOODBYE: A LEGAL PEACEFUL CHOICE AT

encompass, among other things: physical pain, weakness, loss of dignity and independence, reliance on medical technology, and an inability to communicate or process information.[38] People at the end of life suffer in these ways as well as in many others.[39]

A suffering patient is likely in one or more of three basic scenarios: (1) the patient has control over cognition but is in pain; (2) the patient has control over cognition but is paralyzed or severely physically debilitated; and/or (3) the patient's body functions healthily, but his mind does not. Any of these situations may cause additional pain, suffering, and loss of dignity at the end of life. "While good palliative care is a great boon, it is not a panacea," and it cannot, and does not, alter the will of some patients who, nonetheless, wish to die.[40]

1. Hastening Death to Avoid Physical Pain

Many illnesses and injuries are marked by excruciating physical pain.[41] The cases are legion. Those several cases that we have the space to describe here

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THE END OF LIFE 77, 77 (Stanley A. Terman ed. 2007) ("The thought of dying didn't bother Mary Evelyn in the least. It was all those peripheral issues: the crippling osteoporosis, the near-blindness, the heart failure that had left her almost immobilized, the constant pain, and the frustration that no symptom ever got better.").

38. *Cf.* Linda Ganzini et al., *Nurses' Experiences with Hospice Patients Who Refuse Food and Fluids to Hasten Death*, 349 NEW. ENG. J. MED. 359, 360 (also identifying "hopelessness, depression, feeling unappreciated, a sense of the meaninglessness of continued existence, [and] readiness to die"); *id.* at 362 (ranking twenty-one reasons that patients chose to hasten death). Physical symptoms include pain, nausea, diarrhea, dyspnea, paralysis, pressure ulcers, and edema. Psychological symptoms include depression, anxiety, and delirium. Existential symptoms include meaningless of life, loss of control over self-care, loss of social role, becoming a burden or nuisance to others, and hopelessness. *See* Mohamed Y. Rady & Joseph L. Verheijde, *Continuous Deep Sedation Until Death: Palliation or Physician-Assisted Death?*, 27 AM. J. HOSPICE & PALLIATIVE MED. 205, 206 (2010).

39. *See* 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*, *in* GIVING DEATH A HELPING HAND: PHYSICIAN-ASSISTED SUICIDE AND PUBLIC POLICY. AN INTERNATIONAL PERSPECTIVE 49, 49 (Dieter Birnbacher & Edgar Dahl eds., 2008) [hereinafter Quill et al., *Palliative Options*].

40. Cantor 2006, *supra* note 25, at 429. *See also* Timothy E. Quill et al., *Last-Resort Options for Palliative Sedation*, 151 ANNALS INTERNAL MED. 421, 421 (2009) [hereinafter Quill et al., *Last-Resort Options*] ("Despite substantial advances in the delivery of palliative care and hospice, some dying patients still experience severe suffering that is refractory to state-of-the-art palliative care.") (footnotes omitted); Quill et al., *Palliative Options*, *supra* note 39, at 49 ("[E]ven the highest-quality palliative care fails or becomes unacceptable for some patients, some of whom request help hastening death."); Judith Schwarz, *Exploring the Option of Voluntarily Stopping Eating and Drinking Within the Context of a Suffering Patient's Request for a Hastened Death*, 10 J. PALLIATIVE MED. 1288, 1288 (2007) [hereinafter Schwarz 2007] ("[A] persistent proportion of dying patients . . . continue to suffer intolerably in the last weeks of life despite the best palliative care.") (footnotes omitted).

41. "End-stage disease is often accompanied by severe pain and other unpleasant symptoms that cause undue suffering." AM. SOC'Y FOR PAIN MGMT. NURSING, *ASPMN Position*

are only illustrative, not exhaustive, of the types of physical conditions and motivations for hastening death.

Perhaps the most famous case of a patient seeking to hasten his death to avoid pain is that of Donald "Dax" Cowart. In 1973, Dax was twenty-five years old when he became victim to a devastating gas line explosion that caused severe burns to over sixty-five percent of his body.[42] Moments after the explosion, Dax was in so much pain that he asked the man who rescued him for a gun so that he could take his own life. That man declined.[43] When Dax was later taken to the hospital by paramedics, he was forced to endure months of excruciatingly painful treatments for his burns, including being bathed in bleach.[44] He lost all of his fingers and became blind in both eyes.[45] Having the capacity to make healthcare decisions, Dax attempted to refuse treatment the entire time, because he believed that death would be far superior to his very painful existence, which he described as feeling like he was being "skinned alive" every single day.[46]

In 1991, Dr. Timothy Quill famously described Diane, a patient of his who refused treatment for leukemia because she wished to live the remainder of her life at home with friends and family rather than undergoing painful treatments that only had a twenty-five percent chance of success.[47] Eventually, when her quality of life diminished to the point where continuing to live would make her lose her dignity, she said goodbye to her family and ingested a lethal dose of barbiturates.[48] Dr. Quill noted that the patient was an independent person who liked to be in control of her own life.[49] When "[b]one pain, weakness, fatigue, and fevers began to dominate her life" she decided to end her life to avoid the inevitable "increasing discomfort, dependence, and hard choices between pain and sedation."[50]

Statement on Pain Management at the End of Life (2003), http://aspmn.org/Organization/documents/EndofLifeCare.pdf. *See also* GEOFFREY HANKS ET AL., OXFORD TEXTBOOK OF PALLIATIVE MEDICINE 3.1 (4th ed. 2010).

42. *See generally* NYU SCHOOL OF MED., *Film/Video/TV Annotations*, *Please Let Me Die* (1974), http://litmed.med.nyu.edu/Annotation?action=view&annid=10105; NYU SCHOOL OF MED., *Film/Video/TV Annotations*, DAX'S CASE (1985), http://litmed.med.nyu.edu/Annotation?action=view&annid=10114; ROBERT CAVALIER & PRESTON K. COVEY, A RIGHT TO DIE? THE DAX COWART CASE 1 (1996).

43. Keith Burton, *A Chronicle: Dax's Case as It Happened*, *in* DAX'S CASE: ESSAYS IN MEDICAL ETHICS AND HUMAN MEANING 1, 4 (Lonnie D. Kliever ed. 1989);

44. *See id.* at 5.

45. *Id.* at 5, 9.

46. *Dax's Story: A Severely Burned Man's Thirty-Year Odyssey*, UVA NEWSMAKERS (Oct. 2, 2002), http://www.virginia.edu/uvanewsmakers/newsmakers/cowart.html. Unfortunately, Dax's requests to stop treatment to hasten his death were continually denied, and he was forced, against his will, to endure the pain. *See* Burton, *supra* note 43, at 1-9; Robert B. White, *A Memoir: Dax's Case Twelve Years Later*, *in* DAX'S CASE, *supra* note 43, at 13, 13.

47. Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691, 692 (1991).

48. *Id.* at 693.

49. *Id.* at 692.

50. *Id.* at 693.

2. Hastening Death Due to Loss of Function

Often, in addition to or instead of pain, patients are motivated to hasten death because of a loss of bodily functions, resulting in a loss of independence and control.[51] Many right-to-die cases have been brought by individuals who were quadriplegic,[52] or by individuals who had amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease or motor neuron disease)[53] and were approaching a state of total paralysis.[54]

Recently, stockbroker Christian Rossiter became a quadriplegic after a series of accidents.[55] He was badly injured after a nearly 100-foot fall from a building in 1988. Then, in 2008, he was struck by an automobile while cycling. Before the accidents, Rossiter was an active sportsman who enjoyed keen bushwalking, rock climbing and cycling.[56] After the automobile accident, Rossiter found himself in a nursing home fed through a tube in his stomach.[57] Although he could live for an indefinite amount of time, his quality of life was incredibly diminished due to his dependence on institutions, his lack of family support, and his inability to move.[58] He described his life as a "living hell."[59]

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51. In Oregon, the most frequently mentioned concerns motivating use of the Death with Dignity Act were "loss of autonomy . . . , loss of dignity . . . , and decreasing ability to participate in activities that made life enjoyable." OR. DEP'T OF HUMAN SERVICES, 2009 SUMMARY OF OREGON'S DEATH WITH DIGNITY ACT, *available at* http://oregon.gov/DHS/ph/pas/docs/year12.pdf.

52. *See* Bouvia v. Sup. Ct., 225 Cal. Rptr. 297, 299 (Ct. App. 1986) (granting petition to stop feeding); State v. McAfee, 385 S.E.2d 651, 651-52 (Ga. 1989) (granting petition to disconnect ventilator); McKay v. Bergstedt, 801 P.2d 617, 619, 632 (Nev. 1990) (granting permission to disconnect ventilator); G. Andrew Kirkpatrick, Rodas v. ErkenBrack, 2 ISSUES L. & MED. 481, 481 (1987) (discussing *Rodas v. ErkenBrack*, a case heard in Colorado's Mesa County District Court, where the court granted petitioner's request to discontinue feeding through a gastrostomy tube); Margot Dougherty & Sandra Rubin Tessler, *Tiring of Life Without Freedom, Quadriplegic David Rivlin Chooses to Die Among Friends*, PEOPLE, Aug. 7, 1989, at 56, *available at* http://www.people.com/people/archive/article/0,,20120912,00.html. Interestingly, many quadriplegic individuals who seek and even secure the right to die do not actually proceed to hasten their death. *See, e.g.*, Annemarie Evans, *Hong Kong Euthanasia Plea Man Goes Home*, BBC NEWS (Aug. 19, 2010, 11:32 PM), http://www.bbc.co.uk/news/world-asia-pacific-11033789 (reporting on Tang Siu-pun's change of mind).

53. *See* Satz v. Perlmutter, 362 So. 2d 160, 161 (Fla. Dist. Ct. App. 1978); *In re* Farrell, 529 A.2d 404, 407 (N.J. 1987); Leach v. Akron Gen. Med. Ctr., 426 N.E.2d 809, 810 (Ohio Ct. Com. Pl. 1980); *In re* Doe, 45 Pa. D. & C.3d 371, 371 (Pa. Ct. Com. Pl. 1987). *Cf.* Leo McCluskey, *Amyotrophic Lateral Sclerosis: Ethical Issues from Diagnosis to End of Life*, 22 NEUROREHABILITATION 463, 465-67 (2007) (discussing end-of-life options).

54. This sort of situation has been popularly depicted in widely released films. *See* MILLION DOLLAR BABY (Warner Bros. 2004); THE SWITCH (Direct Source Label 1992); WHOSE LIFE IS IT ANYWAY? (Metro-Goldwyn-Mayer 1981).

55. Brightwater Care Group, Inc. v Rossiter [2009] WASC 229 ¶ 6 (Austl.).

56. *Australian Man Given the Right to Die*, MIBBA.COM (Aug. 15, 2009), http://news.mibba.com/World/2903/Australian-Man-Given-the-Right-to-Die.

57. Brightwater Care Group, Inc. v Rossiter [2009] WASC 229 ¶ 8 (Austl.).

58. *Id.* ¶ 9-10.

He told reporters, "'I'm Christian Rossiter and I'd like to die . . . . I am a prisoner in my own body. I can't move . . . [or even] wipe the tears from my eyes.'"[60]

Another more famous case is that of Elizabeth Bouvia. Bouvia was a twenty-eight-year-old quadriplegic with severe cerebral palsy.[61] She was mentally capable, but physically she was severely disabled.[62] She was in continual pain due to arthritis.[63] Bouvia was institutionalized and totally dependent upon others for all her needs.[64] In particular, she had to be spoon fed.[65]

When Bouvia determined that life was no longer worth living, she refused to eat.[66] "In Elizabeth Bouvia's view, the quality of her life [had] been diminished to the point of hopelessness, uselessness, unenjoyability and frustration."[67] Because she was "not consuming a sufficient amount" and because of a "previously announced resolve to starve herself," the hospital fed her against her will.[68] But the California Court of Appeal ordered the hospital to respect Bouvia's wishes.[69]

3. Hastening Death to Avoid Severe Dementia

While some illnesses and injuries affect the body, others affect the mind.[70] They leave people with an inability to recognize family and friends.[71] In this

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59. Richard Shears, *Quadriplegic Man Wins Legal Right to Starve Himself to Death While Watching TV*, DAILYMAIL.CO.UK (Aug. 14, 2009), http://www.dailymail.co.uk/news/worldnews/article-1206522/Quadriplegic-man-wins-legal-right-to-starve-death-watching-TV.html#.

60. *Id.* This was Rossiter's *own* assessment of his own life. As with all the cases in this section, the authors do not assert or defend any position regarding the appropriate treatment choices for any individual. The point is that some individuals, based on their own values and preferences, make an informed and deliberate decision to hasten death. Others make different choices. Quadriplegic Steven Fletcher, for example, has served in the Canadian Parliament since 2004. LINDA MCINTOSH, WHAT DO YOU DO IF YOU DON'T DIE? THE STEVEN FLETCHER STORY (2008). *See also* Carma Wadley, *Disabled Author Chooses to Laugh*, DESERET NEWS (Oct. 10, 2010), http://www.deseretnews.com/article/700072669/Disabled-author-chooses-to-laugh.html (after a surfing accident left him a quadriplegic, Jack Rushton became a religious leader and educator.).

61. Bouvia v. Sup. Ct., 225 Cal. Rptr. 297, 299 (Ct. App. 1986). We acknowledge that *Bouvia* is a troubling case from a disability perspective. *See generally* PAUL K. LONGMORE, WHY I BURNED MY BOOK AND OTHER ESSAYS ON DISABILITY 149-74 (2003).

62. *Bouvia*, 225 Cal. Rptr. at 300.

63. *Id.*

64. *Id.*

65. *Id.*

66. *Id.*

67. *Id.* at 304.

68. *Bouvia*, 225 Cal. Rptr. at 300.

69. *Id.* at 307.

70. We examine VSED as a means to avoid severe dementia separately, in Part V, *infra.*

71. NANCY L. MACE & PETER V. RABINS, THE 36-HOUR DAY: A FAMILY GUIDE TO CARING FOR PEOPLE WITH ALZHEIMER DISEASE, OTHER DEMENTIAS, AND MEMORY LOSS IN

third group are persons suffering from Alzheimer's, Huntington's, Parkinson's, or other forms of severe dementia.[72] Often, people in these predicaments prefer to hasten the dying process rather than to prolong it because quality of life is greatly diminished and will inevitably only further deteriorate.[73]

Take, for example, the case of Judge Robert I.H. Hammerman. In 1998, upon reaching the mandatory retirement age of seventy, Judge Hammerman left the Baltimore, Maryland bench on which he had served for over forty years.[74] Five years later, in July 2003, Judge Hammerman discovered that he was suffering from the onslaught of dementia, observing: "Alzheimer's has attacked me."[75] This distressed him greatly:

> For one who all of his life has enjoyed an exceptional memory, it has seen degeneration at a quicker and quicker pace for two or three years or so. . . . This has been embarrassing and difficult to deal with in all aspects of my life. The most common things—every day—I find great difficulty with. . . . What particularly grieves me is the loss of memory. . . . The simplest tasks are now becoming more and more difficult to do. Confusion is my daily companion. . . . The thought of Alzheimer's is dreadful to me. I'd need institutionalization. . . . The awareness that I could become disabled that would require me to be shipped out to assisted living or worse . . . I could not accept.[76]

Judge Hammerman carefully deliberated for sixteen months before finally committing suicide in November 2004.[77] He concluded that living with severe dementia would be "breathing, not really living."[78]

LATER LIFE 157-58 (4th ed. 2006). Dementia indicates problems with at least two brain functions, such as memory, speech, coordination, or sense of time.

72. *See id.* at 20-43.

73. *See* LADISLAV VOLICER, END-OF-LIFE CARE FOR PEOPLE WITH DEMENTIA IN RESIDENTIAL CARE SETTINGS 2, 6 (2005), *available at* http://www.alz.org/national/documents/endoflifelitreview.pdf (stating that "[a]ggressive medical treatment for residents with advanced dementia is often inappropriate for medical reasons [and] has a low rate of success" and that "advanced dementia is often not perceived as a terminal illness," inferring that although one could conceivably live many years with dementia, medical treatment will likely not improve a patient's condition).

74. Allison Klein, *Despite Detailed Letter, Judge's Suicide Baffling*, WASH. POST, Nov. 15, 2004, at B01, *available at* http://www.washingtonpost.com/wp-dyn/articles/A49813-2004Nov14.html.

75. STANLEY A. TERMAN, THE BEST WAY TO SAY GOODBYE: A LEGAL PEACEFUL CHOICE AT THE END OF LIFE 324 (2007).

76. *Id.* at 324-25 (emphasis omitted).

77. *Id.* at 324.

78. *Id.* at 325.

4. Summary

Many seriously ill patients find their lives marked with extreme suffering and both physical and mental deterioration. Unfortunately, many do not have (or perceive that they do not have) access to a medically-supervised, peaceful death like Diane or Christian Rossiter. Too many patients commit suicide through violent means such as shooting, hanging, or various other forms of self-deliverance.[79] Moreover, being uncertain about their future options and being worried about future loss of dignity, comfort, and control, many patients die prematurely. VSED provides an alternative: the assurance that they can die when they want based on their own criteria and can enjoy life for a longer period of time.[80]

Certainly, life is valuable; and societal values reinforce attempting to extend life indefinitely. But death is unavoidable. People suffering from the diseases that cause the majority of deaths in this country will often experience significant suffering and loss of independence.[81] In this situation, the preference, for some, may be to hasten death so that death can be on an individual's terms and with some predictability, rather than risking the unknown and potential loss of comfort and dignity.[82]

B. Five Options for Hastening Death in Order to Avoid Suffering

Fortunately, for those who can no longer bear living with their physical or mental impairments, there are five options by which they can hasten death to avoid suffering. First, if dependent upon life-sustaining medical treatment such as a ventilator or artificial hydration, patients can simply refuse that treatment either before or during its administration. Second, for those with intense physical pain, high dose opioids to treat the pain can hasten death. Third, for terminally ill patients with intractable physical (and/or perhaps existential) suffering, they can be sedated to unconsciousness. This makes the patient dependent upon artificial nutrition and hydration which can be refused (per option 1). Fourth, for terminally ill patients in some states, where assisted suicide is legal, they can get a lethal dose of barbiturates. Fifth, there is voluntary active euthanasia, in which the physician instead of the patient takes the final overt step causing death.

1. Refusing Life-Sustaining Medical Treatment

Modern advances in science and medicine have made possible the prolongation of the lives of many seriously ill individuals, without always

79. Matthew Miller et al., *Cancer and the Risk of Suicide in Older Americans*, 26 J. CLINICAL ONCOLOGY 4720, 4722 (2008); Peter M. Marzuk, *Suicide and Terminal Illness*, 18 DEATH STUDIES 497, 500 (1994).

80. *See* TERMAN, *supra* note 75, at 326.

81. Judith K. Schwarz, *Stopping Eating and Drinking*, AM. J. NURSING, Sept. 2009, at 53, 54.

82. Quill et al., *Palliative Options*, *supra* note 39, at 49.

offering realistic prospects for improvement or cure.[83] "Half-way" technologies, such as mechanical ventilation and artificial nutrition and hydration, can sustain biological life for practically indefinite periods of time but cannot themselves lead to improvement or cure.[84] As a consequence of the availability of these life-sustaining technologies, most deaths in America occur in an institutional setting such as a hospital.[85] And most of these institutional deaths are the result of an intentional, deliberate decision to stop life-sustaining medical treatment and allow death.[86] "Death is a negotiated event; it happens by design. . . . 70% of the 1.3 million Americans who die in health care institutions [each year] do so after a decision has been made and implemented to forgo some or all forms of medical treatment."[87]

In the United States, people have the legal right to refuse medical treatment, even if such treatment is necessary to sustain life.[88] These life-sustaining interventions include ventilators, dialysis, feeding tubes, and even ventricular-assist devices.[89] This right is well-recognized in American jurisprudence. It stems from the common-law principle that any unwanted touching is a

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83. *See generally* WILLIAM H. COLBY, UNPLUGGED: RECLAIMING OUR RIGHT TO DIE IN AMERICA 57-71 (2006) (discussing the ascent of medical technology); JOHN D. LANTOS & WILLIAM L. MEADOW, NEONATAL BIOETHICS: THE MORAL CHALLENGES OF MEDICAL INNOVATION 18-52 (2006) (discussing the era of scientific innovation with regard to medicine).

84. John Lantos, *When Parents Request Seemingly Futile Treatment for Their Children*, 73 MOUNT SINAI J. MED. 587, 588 (2006); Gay Moldow et al., *Why Address Medical Futility Now?*, MINN. MED., June 2004, at 38, 38.

85. *See* Thomas Wm. Mayo, *Living and Dying in a Post*-Schiavo *World*, 38 J. HEALTH L. 587, 587-88 (2005) (citing S. 570, 109th Cong. § 2(a)(1) (2005)).

86. *See* Arthur E. Kopelman, *Understanding, Avoiding, and Resolving End-of-Life Conflicts in the NICU*, 73 MOUNT SINAI J. MED. 580, 580 (2006) ("Eighty percent of the deaths that occur in the neonatal intensive care unit (NICU) are preceded by decisions to limit, withhold, or withdraw life support . . . ."); Alan Meisel & Bruce Jennings, *Ethics, End-of-Life Care, and the Law: Overview*, *in* LIVING WITH GRIEF: ETHICAL DILEMMAS AT THE END OF LIFE 63, 63 (Kenneth J. Doka et al. eds., 2005) ("Today, decisions on whether or not to forgo 'artificial' life-sustaining interventions must be made more intentionally, openly, and with appropriate deliberation, consultation, and accountability."); Edmund D. Pellegrino, *Decisions at the End of Life – The Abuse of the Concept of Futility*, PRACTICAL BIOETHICS, Summer 2005, at 3, 3 ("[T]he majority of patients in modern hospitals today die as a result of a deliberate decision to withhold or withdraw treatment."); Thomas J. Prendergast & John M. Luce, *Increasing Incidence of Withholding and Withdrawal of Life Support from the Critically Ill*, 155 AM. J. RESPIRATORY & CRITICAL CARE MED. 15, 15 (1997) ("[M]ost patients and surrogates accept an appropriate recommendation to withhold or withdraw life support . . . .").

87. Nancy Dubler, *Limiting Technology in the Process of Negotiating Death*, 1 YALE J. HEALTH POL'Y L. & ETHICS 297, 297 (2001) (reviewing MANAGING DEATH IN THE INTENSIVE CARE UNIT: THE TRANSITION FROM CURE TO COMFORT (J. Randall Curtis & Gordon D. Rubenfeld eds., 2001)) (endnote omitted). *See also* COLBY, *supra* note 83, at 95-108 (discussing how we die in America today); Thomas J. Prendergast et al., *A National Survey of End-of-Life Care for Critically Ill Patients*, 158 AM. J. RESPIRATORY & CRITICAL CARE MED. 1163, 1163, 1165 (1998) (stating that many patients choose to withhold or withdraw life support).

88. *See* ALAN MEISEL & KATHY L. CERMINARA, THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING 2-4 – 2-5 (3d ed. Supp. 2010).

89. *See* Quill, *supra* note 25, at 19.

battery.[90] It also derives from state statutes and state constitutions.[91] This right has even arguably been read into the United States Constitution as a liberty interest in the right of privacy and consequently, the right to be free from bodily intrusion.[92] Patients with capacity, i.e. the ability both to understand the risks and benefits of treatment and to use reasoning to make a decision, can refuse life-sustaining medical treatment at any time.[93]

2. High Dose Opioids

Another option for terminally ill patients[94] who are in intense physical pain is the liberal administration by medical providers of opioids, a class of medication that is widely accepted in the medical community for pain relief.[95] In dying patients, opioids, when given in high doses, can be very effective for relief of otherwise uncontrollable pain.[96] Palliative care physicians will usually administer opioids to the extent that they are necessary to relieve pain.[97] When pain is extreme, the amount necessary may be a very high dose.[98] This can cause death by respiratory distress or other effects of the medication.[99]

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90. *See* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 269 (1990) ("At common law, even the touching of one person by another without consent . . . was a battery."); *id.* at 305 (Brennan, J., dissenting) ("The right to be free from medical attention without consent . . . *is* deeply rooted in this Nation's traditions . . . . This right . . . is securely grounded in the earliest common law.") (citations omitted). The right to refuse is a corollary of the patient's right to bodily integrity and informed consent. *See* Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir. 1972) (stating that a fundamental concept in American jurisprudence is that every human has the right to decide what will happen to his or her own body). Since the birth of bioethics in the early 1970s, the right of the patient to be the primary decision maker in decisions regarding her own health care has been valued and protected. *See* Thaddeus Mason Pope, *Surrogate Selection: An Increasingly Viable, but Limited, Solution to Intractable Futility Disputes*, 2 ST. LOUIS U. J. HEALTH L. & POL'Y 183, 205 (2010) [hereinafter Pope 2010].

91. *See* MEISEL & CERMINARA, *supra* note 88, at 2-31.

92. *Cruzan*, 497 U.S. at 287-89 (O'Connor, J., concurring); Washington v. Glucksberg, 521 U.S. 702, 720 (1997) (observing that the court "strongly suggested" the existence of a constitutional right in *Cruzan*); Vacco v. Quill, 521 U.S. 793, 807 (1997). *But see Glucksberg*, 521 U.S. at 725 (clarifying that the right in *Cruzan* was assumed for the purpose of constitutional analysis and since the state had a compelling interest, there was not need to reach the question).

93. To have capacity, a patient would need to substantially understand and appreciate his or her medical condition. This includes an appreciation for available treatments versus non-treatment, the risks and benefits of each, and the treating physician's professional opinion about how to proceed. THE MERCK MANUAL OF DIAGNOSIS AND THERAPY 2771 (Mark H. Beers et al. eds., 18th ed. 2006); Paul S. Appelbaum, *Assessment of Patients' Competence to Consent to Treatment*, 357 NEW ENG. J. MED. 1834, 1834 (2007).

94. "Terminally ill" is typically defined as having a medical prognosis with a life expectancy of six months or less. *See* 42 U.S.C. § 1395x(dd)(3)(A) (2006); OR. REV. STAT. § 127.800(12) (2007).

95. *See* Quill, *supra* note 25, at 18-19; Schwarz, *supra* note 81, at 57.

96. *See* Quill, *supra* note 25, at 18-19.

97. *See* Timothy E. Quill, *Principle of Double Effect and End-of-Life Pain Management: Additional Myths and a Limited Role*, 1 J. PALLIATIVE MED. 333, 334 (1998) [hereinafter Quill 1998].

98. *See id.*

99. *See id.*; *see also* Cantor & Thomas, *supra* note 27, at 110.

Nevertheless, administering high doses of opioids is legal because the primary intent is to relieve pain, not specifically to cause death.[100] Although there is no specific evidence showing that high dose opioids actually cause or hasten death, there is a widespread belief in the medical community that death could be a "double effect" of high dose opioids.[101] The double effect doctrine proposes that administering these drugs is legitimate because it accomplishes the intended goal of pain relief, even though it may also (unintentionally and coincidentally) cause or contribute to the unintended consequence of death.[102]

Unfortunately, this approach has limitations. First, the drugs may cause side effects, such as nausea and muscle twitching, that are intense and distressing.[103] Second, and more significantly, the administration of high dose opioids is only available to people who are in extreme pain that cannot be controlled in any other way.[104] Therefore, this option is unavailable to those whose physical pain is under control.

3. Palliative Sedation to Unconsciousness

If a person is terminally ill, suffering, and at the very end stages of life, palliative sedation to unconsciousness (PSU) may be a treatment option to hasten death.[105] The National Hospice and Palliative Care Organization defines PSU as "the lowering of patient consciousness using medications for the express purpose of limiting patient awareness of suffering that is *intractable* and *intolerable*."[106] With ordinary sedation, the goal is relief of suffering without reducing the patient's level of consciousness.[107] But even high doses

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100. *See* Vacco v. Quill, 521 U.S. 793, 807, 808 n.11 (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." *Id.* (quoting NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 163 (1994)); *see also* Washington v. Glucksberg 521 U.S. 702, 737-38 (1997) (O'Connor, J., concurring) ("There is no dispute that dying patients . . . can obtain palliative care, even when doing so would hasten their deaths."); Schwarz, *supra* note 81, at 57; Quill 1998, *supra* note 97, at 334.

101. *See* Schwarz, *supra* note 81, at 56; Quill 1998, *supra* note 97, at 333.

102. *See* Schwarz, *supra* note 81, at 56-57. Unfortunately, because of aggressive enforcement, providers may be chilled from prescribing adequate pain care. *See generally* Diane E. Hoffmann, *Treating Pain v. Reducing Drug Diversion and Abuse: Recalibrating the Balance in Our Drug Control Laws and Policies*, 1 ST. LOUIS U. J. HEALTH L. & POL'Y 231 (2008).

103. *See* Jeffrey T. Berger, *Rethinking Guidelines for the Use of Palliative Sedation*, HASTINGS CTR. REP., May-June 2010, at 32, 32.

104. *See* Schwarz, *supra* note 81, at 57; Quill 1998, *supra* note 97, at 334.

105. *See* Schwarz, *supra* note 81, at 57.

106. Timothy W. Kirk & Margaret M. Mahon, *National Hospice and Palliative Care Organization (NHPCO) Position Statement and Commentary on the Use of Palliative Sedation in Imminently Dying Terminally Ill Patients*, 39 J. PAIN & SYMPTOM MGMT. 914, 914-15 (2010) (emphasis in original).

107. *See* Quill et al., *Last-Resort Options*, *supra* note 40, at 421.

of pain medicine may not be sufficient to ameliorate the patient's agony and torment. With PSU, on the other hand, the medical provider administers medication where the intended goal is unconsciousness (not death).[108] The operative assumption is that when a person is unconscious, he or she does not feel any pain.[109] This way, the person is able to die without pain and suffering.[110]

Through PSU, death is usually caused either by the underlying illness or by dehydration. The underlying illness or some complication of it could cause death since PSU is only used when the patient is in the very end stages of illness.[111] Death could also be caused by dehydration. PSU patients, who are unconscious, cannot eat or drink and are dependent upon artificial nutrition and hydration. However, these patients almost always refuse such measures.[112]

PSU is lawful by its nature because it combines the administration of nonlethal amounts of medication with the refusal of life-sustaining medical treatment. Each of these two methods is universally accepted as being a legal treatment choice.[113] PSU is available, however, only to persons who are terminally ill and who are experiencing extreme suffering.[114] It is not available to those, like Elizabeth Bouvia or Christian Rossiter, who could (and did) live for many more years without quality of life. Furthermore, PSU may be limited to those whose suffering is physical in etiology. There is no consensus that PSU is indicated for existential suffering when the patient has "a loss or interruption of meaning, purpose, or hope in life."[115] Finally, even among

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108. *See* Quill, *supra* note 25, at 19; Schwarz, *supra* note 81, at 57.

109. *See* Schwarz, *supra* note 81, at 57.

110. *See id.* (rendering the patient unconscious will result in the patient being unaware of symptoms).

111. *See* Quill et al., *Palliative Options*, *supra* note 39, at 51; Schwarz, *supra* note 81, at 57.

112. Rady & Verheijde, *supra* note 38, at 212 ("Continuous deep sedation is associated with intentional dehydration and starvation."); Quill et al., *Palliative Options*, *supra* note 39, at 51-52; Quill et al., *Last-Resort Options*, *supra* note 40, at 422. *See also* Abrahm, *supra* note 32, at 479 ("The vast majority of patients who need palliative sedation to unconsciousness (or their surrogates) decide not to use artificial hydration . . . ."); Berger, *supra* note 103, at 33; Bernat et al., *supra* note 28, at 161; Lynn A. Jansen & Daniel P. Sulmasy, *Careful Conversation About Care at the End of Life*, 137 ANNALS INTERNAL MED. 1008, 1010 (2002) (author's response to claims made in a letter to the editor) [hereinafter Jansen & Sulmasy 2002] ("[T]erminal sedation and voluntary stopping of eating and drinking can be combined . . . ."). Where PSU is combined with refusal of food and fluid, it looks a great deal like VSED except that the PSU has made oral eating and drinking impossible. Boudewijn E. Chabot & Arnold Goedhart, *A Survey of Self-Directed Dying Attended by Proxies in the Dutch Population*, 68 SOC. SCI. & MED. 1745, 1746 (2009). Death is not caused by the PSU itself. *See generally* M. Maltoni et al., *Palliative Sedation Therapy Does Not Hasten Death: Results from a Prospective Multicenter Study*, 20 ANNALS OF ONCOLOGY 1163-69 (2009).

113. Quill et al., *Palliative Options*, *supra* note 39, at 51.

114. Kirk & Mahon, *supra* note 106, at 915.

115. *Id.* at 916 (endnotes omitted). *See also* Molly L. Olsen et al., *Ethical Decision Making with End-of-Life Care: Palliative Sedation and Withholding or Withdrawing Life-Sustaining Treatments*, 85 MAYO CLINIC PROC. 949, 950 (2010) ("Usually, PS is used to treat physical symptoms . . . . [T]he use of PS for existential or psychological suffering . . . remains controversial.").

those for whom PSU is legally and clinically available, some may find it repugnant to linger on in a state of unconsciousness.[116]

4. Physician-Assisted Suicide

A less common option for deliberately hastening death is physician-assisted suicide (PAS).[117] This entails a physician prescribing a lethal dose of drugs, usually barbiturates. The patient then obtains the drugs and ingests them (or at least has them available to ingest) when and where he or she chooses.[118]

PAS could be effective for competent, terminally ill people who are neither dependent upon any life-sustaining medical treatment nor in pain. Thus, PAS is an option for those who cannot exercise the right to refuse and who are ineligible for high-dose opioids or PSU. For example, a cancer patient may fall into this category. Many times, people with terminal cancer do not wish to endure the final stages of it.[119] Terminal cancer can be incredibly painful and is associated with a loss of dignity at the end of life. Patients in the end stages are unable to care for their own hygiene or go to the bathroom independently; they may have nausea and vomiting, weakness, fatigue, loss of appetite, and loss of taste. Knowing that these end stages and symptoms are inevitable (or at least forecast), the person may want to die before entering them. At the (earlier) point, when this person may choose physician-assisted suicide, there may be few other options because he or she is not dependent on any life-sustaining medical treatment and is ineligible for terminal sedation or high dose opioids.

But while PAS may be an attractive option, it is a very limited one. Specifically, it is limited in two ways. First, it is legal in only three states: Montana,[120] Oregon,[121] and Washington.[122] Second, even in these states, PAS

116. *See* Cantor & Thomas, *supra* note 27, at 135.

117. *See* Schwarz, *supra* note 81, at 57. We recognize that the increasingly accepted terms are "aid in dying" or "[p]hysician-assisted dying." *See* Kathryn L. Tucker, *In the Laboratory of the States: The Progress of* Glucksberg*'s Invitation to States to Address End-of-Life Choice*, 106 MICH. L. REV. 1593, 1595-96 (2008); Kathryn L. Tucker, *Privacy and Dignity at the End of Life: Protecting the Right of Montanans to Choose Aid in Dying*, 68 MONT. L. REV. 317, 317 (2007).

118. *See* Kathy L. Cerminara & Alina Perez, *Therapeutic Death: A Look at Oregon's Law*, 6 PSYCHOL., PUB. POL'Y, & L. 503, 506 (2000).

119. *See* Cristina Monforte-Royo et al., *The Wish to Hasten Death: A Review of Clinical Studies* (2010) (footnote omitted), *available at* http://onlinelibrary.wiley.com/doi/10.1002/pon.1839/pdf (publication forthcoming 2011) (stating that "[b]etween 1998 and 2001, a total of 140 people, almost all of them with end-stage cancer, requested PAS under the law in Oregon"); Keith G. Wilson et al., *Desire for Euthanasia or Physician-Assisted Suicide in Palliative Cancer Care*, 26 HEALTH PSYCHOL. 314, 319-22 (2007).

120. Baxter v. State, 224 P.3d 1211, 1211 (Mont. 2009). The Montana Legislature reconvenes in January 2011, when bills, both to implement and to override this decision, will be introduced. Charles S. Johnson, *Missoula Lawmaker Wants to Implement Court's Physician-Assisted Suicide Ruling*, BILLINGSGAZETTE.COM (July 8, 2010), http://billingsgazette.com/news/state-and-regional/Montana/article_f72e6544-8af1-11df-9802-001cc4c002e0.html.

121. Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.800-995 (2007).

is legal only under narrowly defined circumstances.[123] Among other things, the patient must: (a) be a resident of the state; (b) be terminally ill; (c) find a physician willing to prescribe; (d) make both written and oral requests over a minimum time period; (e) be competent at the time of the requests; and (f) be able to ingest the medication him or herself. Moreover, even if all these conditions are satisfied, many patients have difficulty finding a physician willing to write the prescription.[124] While some PAS occurs in other states as an underground practice, its availability is extremely limited and uncertain.[125]

5. Voluntary Active Euthanasia

In contrast to physician-assisted suicide, voluntary active euthanasia (VAE) involves a physician who both prescribes *and* administers the lethal medication.[126] This practice is suitable for patients who are either unable or unwilling to ingest or inject medication themselves.[127] VAE is illegal in all United States jurisdictions.[128] However, like physician-assisted suicide, it is still used despite its illegality.[129] But given its risks and rarity, VAE is generally not a true option for those suffering at the end of life.[130]

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122. The Washington Death with Dignity Act, WASH. REV. CODE § 70.245 (Supp. 2010).

123. Unlike Oregon and Washington, "Montana has not enacted statutes with specific requirements governing provision of aid in dying." Kathryn L. Tucker & Christine Salmi, *Aid in Dying: Law, Geography and Standard of Care in Idaho*, THE ADVOCATE, Aug. 2010, at 42, 44.

124. *See* Howard Wineberg, *Physician-Assisted Suicide in Oregon: Why so few Occurrences?*, 174 MED. J. AUSTL. 353, 353 (2001).

125. *See* MEISEL & CERMINARA, *supra* note 88, at 12-37 – 12-39; Roger S. Magnusson, "*Underground Euthanasia" and the Harm Minimization Debate*, 32 J. L., MED. & ETHICS 486, 486 (2004); Quill, *supra* note 25, at 17; Stephen W. Smith, *Some Realism About End of Life: The Current Prohibition and the Euthanasia Underground*, 33 AM. J. L & MED. 55, 86 (2007).

126. Quill et al., *Palliative Options*, *supra* note 39 at 54.

127. *See id.*

128. *See id.* at 55. VAE is legal in the Netherlands. JOHN GRIFFITHS ET AL., EUTHANASIA AND LAW IN EUROPE 29 (2008); MEISEL & CERMINARA, *supra* note 88, at 12-92 – 12-94.

129. *See* Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919, 921 (1996) (fourteen of the fifty-eight physicians who had been asked by patients to administer lethal injections complied with those requests); Schwarz 2007, *supra* note 40, at 1291.

130. Patients in the United States also have the option of traveling to a country that permits PAS or euthanasia. Medical tourism is experiencing tremendous growth. *See* I. Glenn Cohen, *Protecting Patients with Passports: Medical Tourism and the Patient-Protective Argument*, 95 IOWA L. REV. 1467, 1476-77 (2010). There has been a growth in suicide tourism in particular. *See* Thaddeus Mason Pope, *Legal Briefing: Medical Futility and Assisted Suicide*, 20 J. CLINICAL ETHICS 274, 279-82 (2009).

C. Choosing an Exit Option from an Incomplete Menu

The preceding "menu" of exit options is not quite a complete list. Rather, it is a survey of what is now available in this country.[131] With the exception of voluntary active euthanasia, all of these options are legal in some way. People who wish to hasten death can often choose one of these options depending upon their particular predicament. Those dependent on technology will likely refuse that technology. Terminally ill patients with intractable suffering may choose PSU. People in excruciating pain may opt for high doses of opioids. Terminally ill residents of Montana, Oregon, and Washington may ask a physician to prescribe a lethal amount of barbiturates.

Noticeably absent from this survey of exit options is an exit option for people, like Jane in South Australia[132] and Elizabeth Bouvia,[133] who are not dependent on medical technology, who are not terminally ill, and/or who are not in intractable pain. Absent is an option for people with severe forms of dementia, cancer that is not in the end stages, AIDS, quadriplegia, Huntington's disease, ALS, and other chronic illnesses. Some individuals with these conditions wish to hasten death *before* reaching end stages that they find heinous. This group of people would prefer to preserve dignity and independence, and to avoid altogether the pain and suffering associated with the end of life in these circumstances.

For this population there is a sixth "exit option" by which death can be hastened: voluntarily stopping eating and drinking (VSED). VSED is appropriate for those who are unable to use any of the other exit options because they lack dependence on machines, because the end stages of illness have not yet come, or because of legality.[134]

Moreover, even if VSED fills no gap not already filled by other options, many patients still prefer VSED to the other options. In Oregon, for example, physician-assisted suicide is a legitimate option. But PAS-eligible patients choose VSED twice as often as PAS.[135] A preference for one means over the other may depend on several factors. First, it might depend on the importance placed on control. While PAS entails a single instantaneous and irrevocable

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131. There are other nonmedical options for hastening death. For example, various books and organizations advise individuals about how to use a helium hood and how to obtain and take Nembutal. *See, e.g.*, PHILIP NITSCHKE & FIONA STEWART, THE PEACEFUL PILL HANDBOOK 32-34, 42-53 (2006); Pope, *supra* note 130, at 279.

132. *See supra* notes 1 to 22 and accompanying text.

133. *See supra* notes 61 to 69 and accompanying text.

134. Sarah-Kate Templeton, *Terminally Ill Opt for Suicide by Starvation*, THE TIMES (U.K.) (March 8, 2009), http://www.timesonline.co.uk/tol/life_and_style/health/article5864857.ece (reporting on how physicians advise patients about VSED as an alternative to assisted suicide).

135. *See* Ganzini et al., *supra* note 38, at 363; Joan Arehart-Treichel, *Terminally Ill Choose Fasting Over M.D.-Assisted Suicide*, PSYCHIATRIC NEWS, Jan. 16, 2004, at 15, 15. VSED has more support amongst healthcare providers. *See, e.g.*, Theresa A. Harvath et al., *Voluntary Refusal of Food and Fluids: Attitudes of Oregon Hospice Nurses and Social Workers*, 10 INT'L J. PALLIATIVE NURSING 236, 239 (2004).

act, VSED occurs over several days, allowing time for the patient to change his or her mind. Second, the slower process permits relationship reconciliation and a healing goodbye. Third, a preference for VSED over PAS might also depend on access to a physician who will prescribe lethal medication, other beliefs, and family views.[136] VSED, for some patients, in short, is either their only option and/or their preferred option.

Currently, VSED is an option available to many terminally ill patients. However, it was, until recently, rarely discussed as a viable alternative to the other means of hastening death.[137] Due to the lack of discussion and study of VSED, there are many unanswered questions about it. Its advocates profess its legality and practicality.[138] Its opponents liken it to torture and call it illegal.[139] In Part III, we explain the mechanism of VSED and why it may be the best exit option for some people. In Part IV, we analyze the legal status of VSED.

III. VOLUNTARILY STOPPING EATING AND DRINKING

Voluntarily stopping eating and drinking is an intentional decision to refuse oral food and fluid for the specific purpose of hastening death.[140] This concept is difficult to fathom; in a society that is completely obsessed with food, we are more accustomed to gluttony than starvation or dehydration.[141] We are taught to love food and turn to it when we are happy, sad, excited, or afraid.[142] We are inundated with high-fat, high-calorie, high-chemical foods

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136. Ganzini et al., *supra* note 38, at 364. *See also* FRIENDS AT THE END, *supra* note 25, at 1 ("For some it is the *only* way out, and some may see it as a *more natural* way of dying than a drug overdose.") (emphasis added).

137. *See generally* BERNAT, *supra* note 9, at 215 (stating that, "[u]ntil the past 15 years, the euthanasia debate failed to include [VSED] as an alternative").

138. *See infra* notes 275-277. *See also* RODNEY SYME, A GOOD DEATH: AN ARGUMENT FOR VOLUNTARY EUTHANASIA 181-82 (2008) (recognizing, though not his first choice for hastening death, that VSED is legal and peaceful); MARY WARNOCK & ELISABETH MACDONALD, EASEFUL DEATH: IS THERE A CASE FOR ASSISTED DYING? 103-05 (2008); Franklin G. Miller & Diane E. Meier, *Voluntary Death: A Comparison of Terminal Dehydration and Physician-Assisted Suicide*, 128 ANNALS INTERNAL MED. 559, 560 (1998); Lori Montgomery, *Right-to-Die Leaders Endorse Starvation: Easy, Painless, Legal*, CHARLOTTE OBSERVER, Nov. 28, 1996, at 43A ("Experts . . . said they see few legal barriers to the method."); Quill et al., *Palliative Options*, *supra* note 39, at 64 ("TS and VSED are probably legal and are widely accepted by hospice and palliative care physicians.")

139. *Medical Decisions at the End of Life*, LIFETREE, INC. http://www.lifetree.org/resources/pcbrochure.pdf (a pro-life Christian educational ministry stating that "[d]eath by starvation and dehydration is painful and inhumane.").

140. *See* Quill et al., *Palliative Options*, *supra* note 39, at 50.

141. *See* DAVID A. KESSLER, THE END OF OVEREATING: TAKING CONTROL OF THE INSATIABLE AMERICAN APPETITE 173-74 (2009).

142. *Cf.* Johan Pottier, *Food*, *in* ENCYCLOPEDIA OF SOCIAL AND CULTURAL ANTHROPOLOGY 238, 239-40 (Alan Barnard & Jonathan Spencer eds., 2002); Joanne Lynn & James F. Childress, *Must Patients Always be Given Food and Water?*, HASTINGS CTR. REP., Oct. 1983, at 17, 17 ("[F]ood and water are so central to an array of human emotions that it is almost impossible to consider them with the same emotional detachment that one might feel toward a respirator or a dialysis machine.").

and drinks. In this over-stuffed world, it is hard to imagine why a person would opt to refuse the food and drink that we hold so dearly, especially as a way to die.

Persons suffering at the end-of-life, however, have many good reasons to cease eating and drinking.[143] Like Jane in South Australia, they choose VSED because of "a readiness to die, [a] belief that continuing to live [is] pointless, [a] poor quality of life, a desire to die at home, and a desire to control the circumstances of dying."[144] VSED offers patients "a way to escape agonizing, incurable conditions that they consider to be worse than death."[145] A death incident to VSED is peaceful, painless, and dignified.[146] Many people choose this option so that they may be in control of their own deaths, knowing that they will be dignified deaths.[147] Furthermore, many people benefit not only from using this option, but also from the mere knowledge that it is available.

For example, Margaret Page suffered a brain hemorrhage in 1991.[148] Her speech and movement were severely limited, and she needed assistance to shower and eat.[149] On March 14, 2010, Margaret stopped eating and drinking, and affirmed that she had made that decision because she no longer wanted to live.[150] "She had been thinking about trying to die for a long time."[151] She was assessed by psychologists three times and each found her mentally competent.[152] The nursing home in which she resided respected Margaret's decision, and she died on March 30, 2010.[153]

Partly because VSED is underexplored by major medical associations, it is referred to by at least eight different terms.[154] Some refer to it as "Voluntary Refusal of Food and Fluid" (VRFF).[155] Others refer to it as "Voluntary

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143. *See* Melissa A. Taylor, *Benefits of Dehydration in Terminally Ill Patients*, 16 GERIATRIC NURSING 271, 271 (1995).

144. Schwarz 2007, *supra* note 40, at 1292.

145. Miller & Meier, *supra* note 138, at 559.

146. *See infra* note 191.

147. *See* Sandra Jacobs, *Death by Voluntary Dehydration — What the Caregivers Say*, 349 NEW ENG. J. MED. 325, 325-26 (2003). *See also* Bernat et al., *supra* note 28, at 2725; Quill, *supra* note 25, at 21 (VSED "has the advantage of putting the decision in the patient's hands . . . ."). This is important because many people wish to maintain independence and control at the end of life. VSED allows this because ultimately the patient is able to make a purposeful, independent decision to stop eating and drinking.

148. Kiran Chug, *Hunger Striker Dies*, DOMINION POST (N.Z.), Mar, 31, 2010, at A1.

149. *Id.*

150. *See* Kate Newton, *Starving Herself to Death*, DOMINION POST (N.Z.), Mar. 24, 2010, at A1.

151. *Id.*

152. *Id.*

153. Chug, *supra* note 148.

154. The more general concept of withholding oral food and fluids, not specifically for the purpose of hastening death, is often referred to as "Nil by Mouth." MARK BELHAM, TRANSESOPHAGEAL ECHOCARDIOGRAPHY IN CLINICAL PRACTICE 4 (2009).

155. *See* TERMAN, *supra* note 75, at 175; Chabot & Goedhart, *supra* note 112, at 1746; Ganzini et al., *supra* note 38, at 360; Quill & Byock, *supra* note 36, at 408. Since the individual is

Terminal Dehydration" (VTD),[156] "Voluntary Death by Dehydration" (VDD),[157] or just "Terminal Dehydration."[158] Still others refer to it as "Stopping Eating and Drinking" (STED),[159] "Patient Refusal of Hydration and Nutrition" (PRHN),[160] or as "Indirect Self-Destructive Behavior" (ISDB).[161] The fundamental concept described by these various names is basically the same. We use "VSED" because it seems to have more currency in recent academic and professional literature.[162]

In this section, we will first provide a basic description of VSED. Second, we will quickly trace its history, from ancient Greece to the contemporary United States. Third, we methodically explain, both biologically and medically, how VSED enables a good quality death. Finally, to address prevalent common misconceptions, we distinguish VSED from cases of "bad" dehydration.

A. Parameters of VSED

VSED entails deliberately ceasing the (self or assisted) oral intake of all food and fluids, except for those small amounts of fluids necessary for mouth comfort or for the administration of pain medication.[163] The patient[164]

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often being fed rather than feeding themselves, VRFF may be more precise and accurate than VSED.

156. Alan D. Lieberson, *Treatment of Pain and Suffering in the Terminally Ill*, PRECIOUSLEGACY.COM (1999), http://preciouslegacy.com/chap13.html.

157. James Leonard Park, *Voluntary Death by Dehydration*, U. MINN. (Aug. 1, 2010), http://www.tc.umn.edu/~parkx032/CY-VD-H2.html. Park has also suggested the term "merciful death by dehydration" (MDD). James Leonard Park, *First Books on Voluntary Death by Dehydration*, U. MINN. (Oct. 25, 2010), http://www.tc.umn.edu/~parkx032/B-VDD.html.

158. *See* Miller & Meier, *supra* note 138, at 559; Joan L. Huffman & Geoffrey P. Dunn, *The Paradox of Hydration in Advanced Terminal Illness*, 194 J. AM. C. SURGEONS 835, 835 (2002). Erich Loewy uses the term "terminal sedation." Erich H. Loewy, *Terminal Sedation, Self-Starvation, and Orchestrating the End of Life*, 161 ARCHIVES INTERNAL MED. 329, 329 (2001).

159. CHABOT, *supra* note 8, at 18.

160. BERNAT, *supra* note 9, at 215; Bernat et al., *supra* note 28, at 2723; Ira Byock, *Patient Refusal of Nutrition and Hydration: Walking the Ever-Finer Line*, AM. J. HOSPICE & PALLIATIVE CARE, Mar.-Apr. 1995, at 8, 8 (1995); Barbara A. Olevich, *"Dying Comfortably" of Starvation and Dehydration: What is the Evidence?*, CATHOLIC EXCHANGE (Feb. 21, 2005, 12:00 AM), http://catholicexchange.com/2005/02/21/93986.

161. Elliot M. Berry & Esther-Lee Marcus, *Disorders of Eating in the Elderly*, 7 J. ADULT DEV. 87, 90 (2000); Yeates Conwell et al., *Indirect Self-Destructive Behavior Among Elderly Patients in Nursing Homes: A Research Agenda*, 4 AM. J. GERIATRIC PSYCHIATRY 152 (1996).

162. *See, e.g.*, Cantor 2006, *supra* note 25, at 418; Cantor & Thomas, *supra* note 27, at 84; Jansen & Sulmasy 2002, *supra* note 112, at 1010; Quill et al., *Palliative Options*, *supra* note 39, at 50; Schwarz 2007, *supra* note 40, at 1288; Cynthia Kellam Stinson et al., *Ethical Dilemma: Voluntarily Stopping Eating and Drinking*, 23 DIMENSIONS CRITICAL CARE NURSING 38, 39-40 (2004).

163. *See* CHABOT, *supra* note 8, at 18 ("Definition: A person who is otherwise physically capable of taking nourishment makes an explicit decision to discontinue all oral intake and, if this decision is sustained, will die of dehydration or some intervening complication."); Quill et al., *Palliative Options*, *supra* note 39, at 50. It is important to minimize liquids because even a moderate amount will prolong the dying process. *See infra* Part III.D.

remains physically capable of taking oral sustenance but chooses not to do so in order to hasten his or her death.[165] For patients with the capacity to make healthcare decisions, the decision to stop eating and drinking can be made at any time and is completely voluntary.[166] The patient could simply refuse food and fluids. This causes a peaceful death by dehydration.[167]

VSED might be confused with, and therefore should be carefully distinguished from, two similar mechanisms.[168] First, VSED applies specifically to patients who choose to stop eating and drinking *orally*.[169] These are patients who are physically able to take food and fluid by mouth, but choose not to do so. VSED does not apply to persons dependent upon a feeding tube or upon any other form of artificial nutrition and hydration.[170]

Second, VSED applies specifically to patients who *deliberately choose* to stop eating and drinking in order to hasten death. It does not apply to patients who

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164. While VSED does not require the participation of healthcare professionals, we use the term "patient" for two reasons. First, individuals seeking to hasten their deaths are often dependent upon healthcare providers for treatment of their underlying illnesses. Second, medical supervision is recommended. *See* FRIENDS AT THE END, *supra* note 25, at 5 ("Sympathetic medical supervision is essential to ensure that any distressing side effects can be treated . . . ."); TERMAN, *supra* note 75, at 175-76; Cavin P. Leeman, *Distinguishing Among Irrational Suicide and Other Forms of Hastened Death: Implications for Clinical Practice*, 50 PSYCHOSOMATICS 185, 186 (2009) ("Medical attention is often helpful . . . ."); Quill, *supra* note 25, at 19 ("VSED . . . needs to be 'physician-supported' . . . .").

165. For example, the recently popular case of Christian Rossiter, while characterized as an individual's right to starve to death, was not about VSED. *See, e.g.*, Nicolas Perpitch, *Quadriplegic Christian Rossiter Wins Right to Starve to Death*, THE AUSTRALIAN (Aug. 14, 2009), *available at* http://www.seniorsworldchronicle.com/2009/08/australia-quadriplegic-christian.html; Shears, *supra* note 59. Rossiter was physically unable to eat or drink; nutrition was provided to him through a tube inserted directly into his stomach. Brightwater Care Group, Inc. v Rossiter [2009] WASC 229 ¶ 8 (Austl.).

166. Quill et al., *Palliative Options*, *supra* note 39, at 50 (noting the importance of VSED being voluntary since it requires willpower on the part of the patient). Since depression, paranoia, and dementia may result in food refusal, patients refusing food should be screened for these diagnoses. GEN. MED. COUNCIL, TREATMENT AND CARE TOWARDS THE END OF LIFE: GOOD PRACTICE IN DECISION MAKING 52 (2010) ("If a patient refuses food or drink . . . you should first assess and address any underlying physical or psychological causes that could be improved with treatment or care."); TERMAN, *supra* note 75, at 299 ("It is important that the refusal . . . is not contaminated by lack of information, misinformation, treatable depression, or coercion, and to ascertain that such a decision is authentic, consistent, and persistent."); Berry & Marcus, *supra* note 161, at 89-91; Lewis M. Cohen et al., *Psychiatric Evaluation of Death-Hastening Requests: Lessons from Dialysis Discontinuation*, 41 PSYCHOSOMATICS 195, 196 (2000).

167. *See infra* Part III.C.

168. Some have proposed limiting VSED to those patients with an irreversible lethal illness not responsive to standard palliative care. Otherwise, they argue, VSED looks too much like suicide. Lynn A. Jansen, *No Safe Harbor: The Principle of Complicity and the Practice of Voluntary Stopping of Eating and Drinking*, 29 J. MED. & PHIL. 61, 63-64 (2004). While we do not, in this paper, defend specific clinical indications, we do not think that VSED should be so limited.

169. *See* Chabot & Goedhart, *supra* note 112, at 1746.

170. *See id.*

lack the capacity to make a contemporaneous (or advance) choice to VSED.[171] It does not include those patients who cease to eat or drink spontaneously, perhaps because of a condition (such as a tooth abscess or gastric reflux) that interferes with their appetite or swallowing.[172]

VSED is an intentional act and is distinct from the involution of thirst that is a normal part of the dying process.[173] "When patients push away food . . . do such actions really mean that they do not want to be fed, or could they be uncomfortable, angry, depressed, or seeking attention?"[174] Feeding problems may be due to medical problems such as mouth lesions, psychosocial problems, or the manner of hand feeding such as feeding too fast, not small enough bites, unappealing taste, and/or consistency. Furthermore, VSED does not include those patients who lack capacity, whether due to anorexia nervosa or dementia, as many of those suffering from dementia do not recognize their food *as food*.[175] VSED applies only to those patients who are

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171. *See* Miller & Meier, *supra* note 138, at 561.

172. "Food refusal behavior is not an uncommon problem in both community and hospital settings." Berry & Marcus, *supra* note 161, at 87 (citation omitted). While some patients "deliberately refused food because he or she wished to die," others refused because of dementia and "reflexive withdrawal behavior," dislike of a certain food, or "lack of ability to eat (dysphagia)." *Id.* at 88. *See also* ROYAL C. OF PHYSICIANS, ORAL FEEDING DIFFICULTIES AND DILEMMAS: A GUIDE TO PRACTICAL CARE, PARTICULARLY TOWARDS THE END OF LIFE 3-8 (2010) (discussing various causes of feeding problems) [hereinafter ORAL FEEDING DIFFICULTIES]; Jansen, *supra* note 168, at 62; Janet C. Mentes, *A Typology of Oral Hydration: Problems Exhibited by Frail Nursing Home Residents*, J. GERONTOLOGICAL NURSING, Jan. 2006, at 13, 15-16 (reviewing different reasons for refusing fluids, including "concerns about being able to reach the toilet"); Katherine Wasson et al., *Food Refusal and Dysphagia in Older People with Dementia: Ethical and Practical Issues*, 7 INT'L J. PALLIATIVE NURSING 465, 465, 468-69 (2001) (typical problems suffered by people with dementia include clamping the mouth shut, distractibility, and reduced concentration; furthermore, quality and attractiveness of meals is important to promote self-feeding). Ninety-two-year-old Mary Hier, for example, suffered from a cervical diverticulum in her esophagus, which greatly impeded her ability to ingest food orally. *In re* Hier, 464 N.E.2d 959, 960 (Mass. App. Ct. 1984).

173. BERNAT, *supra* note 9, at 152-53.

174. Bernard Lo & Laurie Dornbrand, *Guiding the Hand that Feeds: Caring for the Demented Elderly*, 311 NEW ENG. J. MED. 402, 402 (1984). Patients refusing food and fluid should be screened for these conditions. Areas of concern are: swallowing disorders, poor oral health, inadequate staffing, improper bed position, and food choices. *See To Force Feed the Patient with Dementia or Not to Feed: Preferences, Evidence Base, and Regulation*, ANNALS OF LONG TERM CARE (2002) [hereinafter ANNALS OF LONG TERM CARE] (discussing a dietary analysis of one hundred nursing home residents with Dr. Jeanie Kayser-Jones), *available at* http://annalsoflongtermcare.com/article/3310.

175. *See* DANA K. CASSELL & DAVID H. GLEAVES, THE ENCYCLOPEDIA OF OBESITY AND EATING DISORDERS 23-36 (3d ed. 2006) (discussing anorexia nervosa); Wasson et al., *supra* note 172, at 469 (stating that patients with dementia do not recognize food as edible). "Success with oral intake is often impacted as dementia progresses. The individual with dementia may have issues with self-feeding, recognizing food, maintaining attention, persistence of action, or apraxia . . . ." Sharon J. Emley et al., *Practical Strategies: Nourishing Liquid Diet*, 13 PERSPECTIVES ON GERONTOLOGY 33, 33 (2008).

physically able to consume food or fluid by mouth but make an informed, voluntary decision not to do so.[176]

B. History of VSED

Ongoing debates surrounding when to use or to stop use of many types of end-of-life treatment, such as CPR and ventilators, date only to the 1960s.[177] The option to hasten death by withholding or withdrawing these types of treatment did not exist (and could not have existed) prior to their development. In contrast, VSED is a method of hastening death that dates back thousands of years.[178]

Jainism, for example, is an Indian religion dating to the ninth century B.C. In one of its rituals, Santhara (or Sallekhana), a Jain stops eating with the intention of preparing for death.[179] The intention is to purify the body and to remove all thought of physical things from the mind: "The supreme goal is to minimize the damage [that] one does to their environment."[180] Santhara is undertaken only when the body is no longer capable of serving its owner as an instrument of spirituality and when the inevitability of death is a matter of undisputed certainty.[181] Santhara is seen as the ultimate way to expunge all sins, liberating the soul from the cycle of birth, death and rebirth.[182] Starvation

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176. VSED should be distinguished from stopping eating for political reasons, from spontaneous diminishment of eating and drinking, and from incapacitated decisions to stop eating and drinking. *See* CHABOT, *supra* note 8, at 22; Cantor 2006, *supra* note 25, at 417 (discussing prisoners going on hunger strikes); D.M.T. Fessler, *The Implications of Starvation Induced Psychological Changes for the Ethical Treatment of Hunger Strikers*, 29 J. MED. ETHICS 243, 245 (2003) (discussing political reasons for which prisoners go on hunger strikes); Jansen, *supra* note 168, at 62.

177. *See* John M. Luce, *A History of Resolving Conflicts Over End-of-Life Care in Intensive Care Units in the United States*, 38 CRITICAL CARE MED. 1623, 1624 (2010).

178. *See* Chabot & Goedhart, *supra* note 112, at 1750 (stating that Greek and Roman societies used an antiquated form of VSED to hasten death). *See also* BERNAT, *supra* note 9, at 215 (dating VSED to "the Jainist method of *bhaktapratyakhyana*, or fasting and meditating until death") (citing S. SETTAR, PURSUING DEATH: PHILOSOPHY AND PRACTICE OF VOLUNTARY TERMINATION OF LIFE 11 (1990)); Whitny Braun, *Sallekhana: The Ethicality and Legality of Religious Suicide by Starvation in the Jain Religious Community*, 27 MED. & L. 913, 918, 918 n.23 (2008) ("The practice of ritual suicide by starvation is not unique to the Jains.") (citing Buddhism as a religious source); Montgomery, *supra* note 138, at 43A ("Patient refusal of nutrition and hydration . . . is nothing new. Centuries ago, elderly members of Native American tribes wandered into the woods to die without food or drink. Eskimo families sent the elderly off on ice floes to meet their maker."); BALLAD OF NARAYAMA (Toei Company 1983) (depicting the practice of ubasuteyama in a 19th century Japanese village, where all people are banished to the top of Mount Nara to die when they reach the age of seventy).

179. Braun, *supra* note 178, at 913.

180. *Id.* at 915.

181. *Id.* (stating that Santhara comes from spiritual purification).

182. *Id.* at 915-16.

prevents the accumulation of karma, and ascendance is achieved through strict asceticism.[183]

Hundreds of Jains use Santhara each year.[184] But widespread attention was focused on the practice in 2006. Sixty-one-year-old Vimli Devi Bansali, a resident of the Indian state of Rajasthan, was suffering from incurable brain cancer.[185] In September 2006, she observed Santhara, and died after not eating or drinking for fourteen days.[186] Her fast led to a petition being filed in the state's high court seeking to ban the practice as tantamount to suicide.[187] The case has not yet been heard.

Hinduism includes a similar practice called Prayopavesa. While it also entails fasting to death, Prayopavesa is limited to those: (a) who are unable to perform normal bodily purification; (b) whose death appears imminent or whose condition is so bad that life's pleasures are nil; and (c) who engage in the ritual under community regulation.[188] The process allows one to settle differences with others and to ponder life.[189] Notably, it is distinguished from "sudden suicide," which is prohibited as disturbing the cycle of death and rebirth.[190]

C. VSED Enables a Good Quality Death

VSED ensures a comfortable, natural, and dignified death. VSED itself causes no pain. Moreover, by hastening death, VSED permits the patient to avoid her baseline physical and/or existential suffering. Next, we review the clinical experience, which demonstrates that deaths hastened by VSED were comfortable and without pain. We explain the physiological effects of VSED. In short, we demonstrate not only that VSED poses little risk of pain, but also that it can provide significant benefit by helping patients avoid suffering.

1. Clinical Experience with VSED Is Positive

There is a good amount of anecdotal evidence that a death incident to VSED is peaceful, painless, and dignified.[191] Perhaps the most famous of

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183. *Id.* at 917.

184. *Id.* at 914-15.

185. Randeep Ramesh, *Cancer Victim Revered for Fasting to Death*, GUARDIAN (Sept. 30, 2006), http://www.guardian.co.uk/world/2006/sep/30/india.randeepramesh.

186. *Id.*

187. Narayan Bareth, *Dispute as Woman Fasts to Death*, BBC NEWS (Sept. 29, 2006), http://news.bbc.co.uk/2/hi/south_asia/5390162.stm; Ramesh, *supra* note 185.

188. SATGURU SIVAYA SUBRAMUNIYASWAMI, DANCING WITH ŚIVA: HINDUISM'S CONTEMPORARY CATECHISM 833 (6th ed. 2003).

189. *Id.* at 833.

190. *Id.*

191. In addition, studies not specific to VSED have found that dying patients who are dehydrated and malnourished do not feel hunger or thirst. *See* Mary J. Baines, *Control of Other Symptoms*, *in* THE MANAGEMENT OF TERMINAL DISEASE 99 (Cicely M. Saunders ed., 1978); A.G.O. Crowther, *Management of Other Common Symptoms of the Terminally Ill*, *in* THE DYING PATIENT: THE MEDICAL MANAGEMENT OF INCURABLE AND TERMINAL ILLNESS 222-23 (Eric

these is Dr. David Eddy's account of his own mother's VSED.[192] Mrs. Eddy was suffering from progressive debilitation, chronic depression, anemia, recent surgery, and recurrent rectal prolapse.[193] Mrs. Eddy asked her son about the option of refusing food and fluids. He assured her that without nutrition and, especially without adequate fluid, the end would come quickly.[194] Mrs. Eddy was elated and, following the celebration of her eighty-fifth birthday and with the support of her primary care physician, she stopped eating and drinking.[195] Her last morsel was chocolate. She died peacefully six days later.[196]

The description of Mrs. Eddy's last few days is compelling:

> Over the next four days, my mother greeted her visitors with the first smiles she had shown for months. She energetically reminisced about the great times she had had and about things she was proud of. . . . She also found a calming self-acceptance in describing things of which she was not proud. She slept between visits but woke up brightly whenever we touched her to share more memories and say a few more things she wanted us to know. On the fifth day it was more difficult to wake her. When we would take her hand she would open her eyes and smile, but she was too drowsy and weak to talk very much. On the sixth day, we could not wake her. Her face was relaxed in her natural smile, she was breathing unevenly, but peacefully. We held her hands for another two hours, until she died.197

A similar positive account is provided of Joshua Segar's death. Joshua was a man who chose to stop eating and drinking after becoming increasingly ill with Parkinson's disease.[198] Joshua's family described his death as comfortable and without pain.[199] They recounted that Joshua was happy when he made the decision to stop eating and drinking, and that his death was a week-long process that was "peaceful and . . . beautiful."[200]

A third notable story is that of Michael Miller, an eighty-year-old retired surgeon with end-stage cancer. As a physician, Miller was well aware of the benefits of palliative care and hospice, but he wanted to have more control

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Wilkes ed., 1982); Phyllis Schmitz & Merry O'Brien, *Observations on Nutrition and Hydration in Dying Cancer Patients*, *in* BY NO EXTRAORDINARY MEANS: THE CHOICE TO FORGO LIFE-SUSTAINING FOOD AND WATER 29, 36 (Joanne Lynn ed., 1986).

192. David M. Eddy, *A Conversation with My Mother*, 272 JAMA 179 (1994) [hereinafter Eddy, *Conversation*]; David Eddy, "*I'm Still Telling Others How Well This Worked for My Mother*", *in* THE BEST WAY TO SAY GOODBYE: A LEGAL PEACEFUL CHOICE AT THE END OF LIFE 82-84 (Stanley A. Terman ed. 2007).

193. Eddy, *Conversation*, *supra* note 192, at 180-81.

194. *Id.* at 181.

195. *Id.*

196. *Id.*

197. *Id.*

198. Richard Davis, *The Death of Joshua Segar*, BRATTLEBORO REFORMER, May 23, 2008, *available at* homepages.sover.net/~asegar/TheDeathofJoshuaSegar.doc.

199. *Id.*

200. *Id.*

over the circumstances of his death.[201] He wanted to do something that was "gentle [and] natural."[202] So, he stopped eating and drinking, resulting in his death thirteen days later.[203] Because Miller wanted his death to be used as a teaching tool, he had it recorded in a short film that was released in 2008.[204]

There are many more published accounts of good deaths from VSED.[205] And, fortunately, evidence concerning VSED is more than just anecdotal. There have been several independent studies with both treating nurses and family members aimed at understanding patient experiences with VSED at the end of life.[206] For example, a 2005 study from a Dutch nursing home revealed that during the two weeks in which people lived after stopping eating and drinking, feelings of discomfort leveled out to acceptable levels after day two.[207]

Similarly, a widely-discussed 2003 study of United States hospice nurses found that "patients' deaths [by VSED] were characterized by little suffering or pain and were peaceful."[208] The study then noted that the "data suggest that not eating and drinking in dying patients causes little suffering."[209] In an

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201. Pam Vetter, *"Dying Wish" Documents Death of Dr. Michael Miller with Conscious Choice to Stop Eating and Drinking*, AM. CHRONICLE (July 28, 2008), http://www.americanchronicle.com/articles/view/69683.

202. *Id.*

203. *Id.*

204. DYING WISH (WordWise Productions 2008).

205. *See* TERMAN, *supra* note 75, at 97-98 (citing six separate types of sources for the conclusion that "Voluntarily Refusing Food & Fluid is NOT uncomfortable"); Johns, *supra* note 37, at 77-79; Ronald Baker Miller, *A Peaceful End to a Beautiful Life*, *in* THE BEST WAY TO SAY GOODBYE: A LEGAL PEACEFUL CHOICE AT THE END OF LIFE 296-99 (Stanley A. Terman ed., 2007); Montgomery, *supra* note 138, at 43A ("'I've been around a lot of people who have chosen it, and it's not painful.'") (quoting Connie Holden, executive director of Hospice of Boulder County, Colorado).

206. *See* Byock, *supra* note 160, at 9-10 (reviewing several studies); Louise A. Printz, *Terminal Dehydration, A Compassionate Treatment*, 152 ARCHIVES INTERNAL MED. 697, 700 (1992) (citing testimony of heath care providers claiming that patients dying of dehydration are generally more comfortable than other dying or end-stage patients). *See also* Kimberly Vullo-Navich et al., *Comfort and Incidence of Abnormal Serum Sodium, BUN, Creatinine and Osmolality in Dehydration of Terminal Illness*, 15 AM. J. HOSPICE & PALLIATIVE CARE 77, 77-78 (1998).

207. Linda Ganzini, *Artificial Nutrition and Hydration at the End of Life: Ethics and Evidence*, 4 PALLIATIVE & SUPPORTIVE CARE 135, 139 (2006). *See also* Robert J. Miller & Patricia G. Albright, *What is the Role of Nutritional Support and Hydration in Terminal Cancer Patients?*, AM. J. HOSPICE CARE, Nov.-Dec. 1989, at 33, 34-35 (stating that "[d]eath associated with dehydration or malnutrition was not perceived as painful").

208. Ganzini, *supra* note 207, at 139; Ganzini et al., *supra* note 38, at 362.

209. Ganzini, *supra* note 207, at 139. Additionally, "it is the consensus of experienced physicians and nurses that terminally ill patients dying of dehydration or lack of nutrition do not suffer if treated properly." Bernat et al., *supra* note 28, at 2725. *Cf.* Maria R. Andrews & Alan M. Levine, *Dehydration in the Terminal Patient: Perception of Hospice Nurses*, AM. J. HOSPICE CARE, Jan.-Feb. 1989, at 31, 31 (reporting that hospice nurses who witnessed the effects of terminal dehydration had positive perceptions of it); Maria Andrews et al., *Dehydration in Terminally Ill Patients: Is It Appropriate Palliative Care?*, 93 POSTGRADUATE MED. 201, 201-08 (1993); Jean M. Flick, A Comparative Study of Observations of Terminal Dehydration Between Beginning and Experienced Hospice Nurses (Dec. 1990) (unpublished M.S. thesis, Texas Women's University) (on file with authors).

unrelated survey of about 800 members of the American Academy of Hospice Physicians, nearly ninety percent of respondents reported that their patients who refused hydration and nutrition experienced peaceful and comfortable deaths.[210] In a large Dutch survey, seventy-four percent of respondents judged death by VSED as a dignified death.[211]

We more fully discuss clinical experience with VSED below. But first, to better grasp how and why VSED leads to a peaceful and comfortable death, it is useful to understand, biologically, how exactly it leads to death.

2. The Physiological Effects of VSED

When a person voluntarily stops eating and drinking, death occurs by dehydration. Terminal dehydration occurs by a complicated physiological process over a seven to fourteen day period.[212] As humans, we constantly lose water through sweating, respiration, and urination. The only way to compensate for this water loss is intake via food and fluids. Once a person stops eating and drinking, there is only water loss and no water gain, causing dehydration.

During the first twenty-four hours without food and fluid, the only symptoms that patients feel (due to dehydration) are hunger and thirst,[213] and not all patients even feel hungry.[214] The feeling of thirst comes from the slow process of dehydration that occurs in the kidneys and in the brain.[215] In this

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210. BERNAT, *supra* note 9, at 215 (citing Robert J. Miller, Nutrition and Hydration in Terminal Disease (unpublished manuscript)).

211. CHABOT, *supra* note 8, at 27.

212. Cantor 2006, *supra* note 25, at 415. This time period may vary based on a person's physical condition at the time he or she chooses to stop eating and drinking. A person who is particularly well hydrated or obese will sense the effects of dehydration much more slowly than someone who is already dehydrated, malnourished, or physically ill. *See* CHABOT, *supra* note 8, at 27-28 (reporting in a sample of ninety-seven deaths by VSED that while some, especially those with a fatal illness, died in as few as seven to nine days, the majority died within sixteen days); Byock, *supra* note 160, at 10 (noting that an obese woman took longer to die); Quill et al., *Palliative Options*, *supra* note 39, at 51 (stating that death by VSED could take weeks); Quill & Byock, *supra* note 36, at 410 (noting that the time period before death can depend on one's physical state before the start of VSED); Schwarz 2007, *supra* note 40, at 1291 (noting that death can take one to three weeks depending on the person's physical state before the onset of VSED).

213. *See* MERCK MANUAL, *supra* note 93, at 2766; *see also* Jacobs, *supra* note 147, at 325-26; Diana McAulay, *Dehydration in the Terminally Ill Patient*, NURSING STANDARD, Oct. 10-16, 2001, at 33, 33-34; Taylor, *supra* note 143, at 271; Charlotte J. Molrine, Difficult Discussions Regarding End of Life 5 (unpublished manuscript) (on file with authors) ("The only limited discomfort associated with terminal dehydration is dry mouth and dry skin.").

214. *See* Byock, *supra* note 160, at 9.

215. This process is an endocrine process, as opposed to the fast process in the form of massive blood loss wherein the baroreceptors inside blood vessels sense drastic blood loss and begin to compensate for it. DEE UNGLAUB SILVERTHORN ET AL., HUMAN PHYSIOLOGY 521, 643, 648-49, 653, 662 (4th ed. 2007). Slight decreases in blood volume also trigger the

slow process, receptors in the brain detect a change in the concentration of solutes in the body, causing a secretion of a chemical called vasopressin.[216] Vasopressin, also called antidiuretic hormone, tells the kidneys, through receptors in their functional unit, the nephron, that there is a decreased amount of water in the body.[217] In response, the kidneys begin to conserve water.[218] The brain then signals the mouth to feel thirst, which under usual circumstances induces the person to drink water to rehydrate.[219] Although the kidneys can conserve water to some extent, intake of fluids is the only way to bring the body back to normal.[220]

The "feeling" of thirst, while likely uncomfortable, is easily overcome *without* rehydrating because receptors in the mouth tell the brain that thirst is quenched even *before* water enters the bloodstream.[221] This means that the feeling of thirst can be remedied merely by sucking on ice chips or by taking small sips of cold water, without actually rehydrating and increasing the body's volume of water.[222]

Following the first twenty-four hours, patients' urine content is markedly reduced as the kidneys reabsorb water into the blood.[223] This lack of excretion also causes the kidneys to reabsorb hydrogen into the body, making the blood acidic, and alerting the body to the fact that it is severely dehydrated.[224] During this time, due to a chemical reaction that the body uses to maintain acid-base balance, the concentration of hydrogen and carbon dioxide in the body increases, causing the person to enter a state called metabolic acidosis.[225]

At this time, patients begin to hyperventilate to attempt to compensate for the increased carbon dioxide and the acidic nature of the blood.[226] No intervention is necessary to make the patient comfortable during this time period, unless the patient is suffering from some kind of respiratory distress. In a healthy person, hyperventilating could reduce the effects of

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cardiac/baroreceptor response which sets in motion a different chemical pathway that allows arteries to constrict in order to increase blood pressure. *Id.* at 643.

216. *Id.* at 648-49.

217. *Id.* at 644-46. Human beings lose water constantly from breathing, sweating, and urinating. *Id.* at 644. The body is normally able to compensate for this water loss because of a pathway that causes thirst. *See id.* at 644-46.

218. *Id.* at 646.

219. *Id.* at 642-43, 653, 661.

220. *Id.* at 663.

221. Byock, *supra* note 160, at 9, 11; SILVERTHORN ET AL., *supra* note 215, at 658.

222. SILVERTHORN ET AL., *supra* note 215, at 658; Robert J. Sullivan, *Accepting Death Without Artificial Nutrition or Hydration*, 8 J. GEN. INTERNAL MED. 220, 221-22 (1993). A complaint of thirst should not be construed as a desire to drink unless the patient specifically asks for that. Instead, the patient should be attended to with mouth care such as ice chips, small sips of water, treatment of local mouth infections, mouthwash, and brushing. *See infra* note 249.

223. SILVERTHORN ET AL., *supra* note 215, at 666-67, 670-71.

224. *Id.*

225. *Id.*

226. *See Id.* at 670; Christie P. Thomas & Khaled Hamawi, *Metabolic Acidosis*, http://emedicine.medscape.com/article/242975-overview (last updated Sept. 16, 2009). The blood is acidic because of increased hydrogen. The higher the concentration of hydrogen, the lower the pH. SILVERTHORN ET AL., *supra* note 215, at 670.

dehydration.[227] But respiratory compensation is limited to balancing slight forms of acidosis, not those severe forms as found in people who cease eating and drinking entirely.[228]

At the twenty-four to forty-eight hour mark, when the body has exhausted its carbohydrate stores, it begins to metabolize muscle tissue.[229] Although this process sounds painful, it actually often has the opposite effect. When the body metabolizes muscle, molecules classified as ketones are released into the bloodstream, sending the body into a phase called ketosis or ketonemia.[230] Ketosis causes many people to enter a state of euphoria.[231] It has also been credited with impairing hunger, relieving pain, and increasing the quality of life for the dying person.[232]

The euphoric state experienced by patients as a result of ketosis can last for several days or longer, depending on the pre-VSED physical state of the patient.[233] Throughout this time, patients are able to interact with family and friends, tell stories, and enjoy life's last moments.[234] Eventually, the cells in the brain, which require water and ions to function, lose the ability to exchange molecules with their surrounding environment due to the imbalance of water and ions caused by dehydration.[235] This causes the brain cells to become less excitable, allowing the person to slip into a permanent coma.[236]

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227. SILVERTHORN ET AL., *supra* note 215, at 666 (stating that "[c]hanges in ventilation can correct disturbances in acid-base balance, but they can also cause them.").

228. *Id.* at 663 (noting that the only way to compensate for severe dehydration is by fluid intake).

229. Byock, *supra* note 160, at 11 (noting a "shift from adipose to protein metabolism").

230. *Id.* at 9. This process is distinct from the process which occurs in diabetics. That process is also referred to as metabolic acidosis, but the mechanism is different. SILVERTHORN ET AL., *supra* note 215, at 670-71.

231. *See* CHABOT, *supra* note 8, at 22, 30, 45; MERCK MANUAL, *supra* note 93, at 2766. S*ee also* Byock, *supra* note 160, at 9; Huffman & Dunn, *supra* note 158, at 836; Printz, *supra* note 206, at 700; Louise A. Printz, *Is Withholding Hydration a Valid Comfort Measure in the Terminally Ill?*, GERIATRICS, Nov. 1988, at 84, 85; Paul C. Rousseau, *How Fluid Deprivation Affects the Terminally Ill*, RN, Jan. 1991, at 73, 73-74.

232. *See* MERCK MANUAL, *supra* note 93, at 2766; Byock, *supra* note 160, at 9. Voluntarily stopping eating and drinking is a flexible process that allows people to be in control of their own death. It is recommended, however, that people who choose VSED quit eating and drinking cold-turkey because taking in small amounts of food and drink prevents ketosis and prohibits the euphoric and analgesic effects of the onset of ketosis. *See infra* note 274.

233. Presumably, if a person is well hydrated before choosing to stop eating and drinking, it will take longer for the body to deplete its water and sugar stores. If the person is frail and already dehydrated, the VSED process would be shorter. *See supra* note 212.

234. *See* Eddy, *Conversation*, *supra* note 192, at 181; Schwarz, *supra* note 81, at 55 ("Once oral intake stops, the patient usually remains wakeful and responsive for several days . . . ."); Schwarz 2007, *supra* note 40, at 1292. *See also* HELEN NEARING, LOVING AND LEAVING THE GOOD LIFE 183-85 (1992).

235. In healthy, well hydrated humans, the brain, liver, and kidneys work in harmony to maintain the precise equilibrium of water that keeps us alive. Each human cell requires water to have the proper balance of ions (mainly sodium, potassium, and calcium) so that it can

The ultimate cause of death in a dehydrated person is usually a cardiac arrhythmia.[237] A cardiac arrhythmia is any type of irregular heartbeat.[238] In many circumstances, arrhythmias have little to no impact on the human body.[239] However, in some situations, an arrhythmia can cause death.[240] Cardiac tissue relies on electric potentials to make the heart pump.[241] During dehydration, the body loses the ability to generate these electric impulses because of ion imbalances, making the heart unable to pump normally.[242] This inability to pump causes missed heart beats, which, by definition, are cardiac arrhythmias.

The ultimate cardiac arrhythmia occurs when the dying person is in a coma and experiencing euphoria incident to ketosis.[243] The comatose state would prevent the patient from feeling any pain.[244]

3. VSED Involves Very Little Pain

Death by VSED involves very little pain, if any.[245] In fact, "[t]he general impression among hospice clinician[s] is that starvation and dehydration do not contribute to suffering among the dying and might actually contribute to a comfortable passage from life."[246]

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function and communicate with other cells. SILVERTHORN ET AL., *supra* note 215, at 129-31, 642, 659. Dehydration has physical benefits, including: (1) decreased urine output; (2) less nausea and vomiting; and (3) less peripheral edema and pressure sores. Sullivan, *supra* note 222, at 221-22; Taylor, *supra* note 143, at 271.

236. SILVERTHORN ET AL., *supra* note 215, at 252-53, 269, 642, 663 (explaining that action potentials are significantly affected by osmolarity and that decreases in pH (as in acidosis) cause neurons and the central nervous system to fail for an inability to create those action potentials); Thomas & Hamawi, *supra* note 226 ("Coma and hypotension have been reported with acute severe metabolic acidosis").

237. Byock, *supra* note 160, at 12; Sullivan, *supra* note 222, at 222.

238. SILVERTHORN ET AL., *supra* note 215, at 483.

239. *Id.* at 484.

240. *Id.*

241. *See id.* at 472-78.

242. *See* Lantz v. Coleman, No. HHDCV084034912, 2010 WL 1494985, at *11 (Conn. Super. Ct. Mar. 9, 2010).

243. *See supra* notes 233-42 and accompanying text.

244. *Id.*

245. *See* Candace Jans Meares, *Terminal Dehydration: A Review*, AM. J. HOSPICE & PALLIATIVE CARE, May-June 1994, at 11, 13.

246. Byock, *supra* note 160, at 8. *See also* Huffman & Dunn, *supra* note 158, at 836 (noting other benefits such as "less coughing, choking, and shortness of breath") (citations omitted); Molrine, *supra* note 213, at 4 (listing numerous benefits, including: (1) "[c]alorie deprivation from terminal starvation results in a partial loss of sensation, adding to the patient's comfort during the dying process;" (2) "[t]he combined effects of starvation and dehydration cause toxin buildup and body chemistry changes which stimulate the production of natural endorphins;" (3) "[t]he resultant mild euphoria may also act as a natural anesthetic to the central nervous system, blunting pain and other noxious symptoms, reducing narcotic requirements;" and (4) "[b]ecause terminal dehydration decreases total body water, it can have potential beneficial effects and thus facilitate a peaceful death.")

Expectedly, many patients do report feelings of hunger and thirst in the first few days. These appear to be the only true side effects of VSED.[247] To address these symptoms, the medical profession calls for excellent oral care.[248] Specifically, caregivers of patients who choose VSED should provide mouth care involving swabbing the mouth, giving ice chips, and applying lip balm to keep lips supple and free from cracks.[249] This type of care prevents and remedies the symptom of thirst, the symptom most notably associated with dehydration.[250]

In addition to oral care, patients who choose VSED are likely to need two other forms of palliative care. First, for the many VSED patients who are physically ill, pain medication may be necessary to alleviate the pain of their

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247. *See, e.g.*, Byock, *supra* note 160, at 11 ("The literature is consistent on two points: a) rarely does fasting cause any discomfort beyond occasional and transient hunger, and b) symptoms referable to dehydration are few–mostly dry oral and pharyngeal mucous membranes–and are readily relieved by simple measures."); Schwarz 2007, *supra* note 40, at 1291. The occasional side effects of VSED include delirium and agitation. Schwarz, *supra* note 81, at 55. Other potential burdens such as confusion, restlessness, and neuromuscular irritability can be addressed with palliative care. *See* Huffman & Dunn, *supra* note 158, at 836. *But see* Cantor & Thomas, *supra* note 27, at 95 n.42 ("Death by dehydration is not always a tranquil process."). Although, what has been recognized as delirium is likely, in fact, simply a state of euphoria that the dying person experiences due to ketoacidosis and endorphin releases in the brain. *See* Stinson et al., *supra* note 162, at 41.

248. *See* BERNAT, *supra* note 9, at 215 ("Dry mouth, the major symptom of dehydration, can be relieved adequately by ice chips, methyl cellulose, artificial saliva, or small sips of water insufficient to reverse progressive dehydration.") (citing Robert M. McCann et al., *Comfort Care for Terminally Ill Patients: The Appropriate Use of Nutrition and Hydration*, 272 JAMA 1263 (1994)); ANTHONY RUDD ET AL., STROKE 69 (2d ed. 2005); ALEXANDER WALLER & NANCY L. CAROLINE, HANDBOOK OF PALLIATIVE CARE IN CANCER 135-46 (2d ed. 2000). *See also* J. Andrew Billings, *Comfort Measures for the Terminally Ill: Is Dehydration Painful?*, 33 J. AM. GERIATRICS SOC'Y 808, 810 (1985); Huffman & Dunn, *supra* note 158, at 838; Robert J. Miller, *Hospice Care as an Alternative to Euthanasia*, 20 L. MED. & HEALTH CARE 127, 127 (1992); Phyllis Schmitz, *The Process of Dying With and Without Feeding and Fluids by Tube*, 19 L. MED. & HEALTH CARE 23, 24 (1991); Joyce V. Zerwekh, *Should Fluid and Nutritional Support be Withheld from Terminally Ill Patients?*, AM. J. HOSPICE CARE, July-Aug. 1987, at 37, 38.

249. *See* H Ltd v J & Anor [2010] SASC 176 ¶ 98 (Austl.) (holding that the provider "is under no duty, and has no lawful justification to act to hydrate [a resident], except for such incidental hydration as may be indicated in connection with oral hygiene or the use of mouth swabs to palliate pain and discomfort . . ."); FRIENDS AT THE END, *supra* note 25, at 9-10 (describing, in addition to recommending nose, eye, and face care, four methods of mouth care: (1) refreshing the mouth; (2) saliva stimulating products; (3) saliva substitutes; and (4) cleansing to prevent fungal infection); TERMAN, *supra* note 75, at 102-05 (describing comfort care for those who refuse food and fluid); Cantor & Thomas, *supra* note 27, at 95; Molrine, *supra* note 213, at 5.

250. *See* CHABOT, *supra* note 8, at 30 ("If the mouth can be kept lubricated, it appears that the feeling of thirst can be tolerated."); *id.* at 32-33 (summarizing the "main methods and products used in mouth care"); Cantor & Thomas, *supra* note 27, at 95. Some hospices use a dry sponge dipped in the patient's favorite liquid. But this is inappropriate because the liquid is aqueous. *See infra* Part III.D (death by "bad" dehydration). It is preferable to use a non-aqueous organic base such as glycerin or sprays with methyl cellulose. *See supra* note 248.

underlying illness.[251] Medical professionals who specialize in palliative care may provide sufficient medication to patients at this stage, especially considering the patient's choice to hasten death.[252] The ability to have palliative care readily available throughout the VSED process contributes to the overall quality of death for people who choose VSED.[253]

Second, competent and incompetent patients also require comfort care during the course of VSED. This comfort care is similar to the typical care given to the elderly or sick. It varies from patient to patient, but can certainly include turning, bathing, and attending to the requests of the person.[254]

In short, pain management combined with appropriate comfort care make VSED an end-of-life option that carries with it either very little or no pain.[255] But this means that patients choosing VSED usually rely on caregivers to provide three types of care. First, patients need mouth care such as tooth brushing and swabbing. Second, they may need pain and other medication. Third, they may need help with everyday hygiene or anything else that makes the patient comfortable.

4. VSED Allows Patients to Avoid Suffering

The little pain associated with dying by VSED is not only easily mitigated but it is also a sharp contrast to the pain and suffering felt by persons dying of illnesses such as cancer.[256] Indeed, people with cancer can choose VSED as a way to hasten death. VSED allows cancer patients or those with other illnesses to choose death prior to feeling the full effects and pain of a terminal illness.

Furthermore, VSED not only provides for a less painful death, but it can also provide for a more meaningful and independent experience at the end of life.[257] Patients choosing VSED can die at home rather than in a hospital or

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251. *See* Schwarz 2007, *supra* note 40, at 1291.

252. *See* Bernat et al., *supra* note 28, at 2727. For those patients who are not physically ill, but rather, are simply mentally incompetent and have made the non-contemporaneous decision to stop eating and drinking, medical staff can provide pain medication if unexpected symptoms arise.

253. This care would involve pain medication in addition to providing ice chips, mouth swabs, and lip balm to relieve oral symptoms of dehydration, along with everyday care such as bathing, turning, and general comfort care. Cantor & Thomas, *supra* note 27, at 95.

254. *See* BERNAT, *supra* note 9, at 216 ("Once a dying patient has refused hydration and nutrition, the physician has the continued responsibility to maintain her comfort. Comfort measures include proper mouth care, suppression of dyspnea, and provision of adequate analgesia."). This sort of care could actually be less demanding because, for example, the patient's diapers would need to be changed less frequently.

255. *See* Joyce V. Zerwekh, *The Dehydration Question*, NURSING, Jan. 1983, at 47, 47-50.

256. This concept applies to other diseases and terminal illnesses as well.

257. Zail S. Berry, *Responding to Suffering: Providing Options and Respecting Choices*, 38 J. PAIN & SYMPTOM MGMT. 797, 798-99 (2009); WARNOCK & MACDONALD, *supra* note 138, at 103, 107. "Advantages of this method are its accommodation of patient ambivalence, relative ease of maintaining comfort through the process, and little risk of impulsive or hasty action." *Id.* at 797. The duration of the VSED process has advantages of: (a) opportunity for reconsideration; and (b) family interaction. BERNAT, *supra* note 9, at 216. On the other hand, the duration of time

hospice setting. This will likely contribute to a more comfortable death in a familiar setting.[258] Quality of life and death is furthered by VSED even more so by the fact that, since it is a natural option, it requires no intervention of doctors or lawyers.[259] Unlike physician-assisted suicide, there is no waiting period after choosing to stop eating and drinking. [260] VSED allows patients to spend the time with family and friends instead, with "an improved sense of confidence that death will occur peacefully."[261] Moreover, even if VSED is not used, just knowing that the option is available gives comfort and control, or a security blanket.[262]

D. VSED Dehydration versus "Bad" Dehydration

We have already established that the dehydration associated with VSED results in little to no pain. It results in only mouth discomfort and/or hunger that can be readily minimized and eliminated through simple established treatments. Still, dehydration has negative connotations that run strong and deep. For example, in some contexts withholding food and water can constitute torture.[263] Accordingly, it is useful to specifically distinguish VSED from more popular conceptions of "bad" dehydration.

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for the VSED to succeed is a noted disadvantage. Berry, *supra*, at 797; Dan W. Brock, *Physician-Assisted Suicide as a Last-Resort Option at the End of Life*, *in* PHYSICIAN-ASSISTED DYING: THE CASE FOR PALLIATIVE CARE AND PATIENT CHOICE 130, 131 (Timothy E. Quill & Margaret P. Battin eds., 2004); Miller & Meier, *supra* note 138, at 561 (noting that the "relatively long interval" makes VSED "seem less humane" and "burdensome and stressful" to family).

258. *See* Andrea Gruneir et al., *Where People Die: A Multilevel Approach to Understanding Influences on Site of Death in America*, 64 MED. CARE RESEARCH & REV. 351, 352 (2007); Quill & Byock, *supra* note 36, at 412 (anecdotal evidence that some patients and their families would prefer death to occur at home); Alexi A. Wright et al., *Place of Death: Correlations with Quality of Life of Patients With Cancer and Predictors of Bereaved Caregivers' Mental Health*, 28 J. CLINICAL ONCOLOGY 4457, 4457, 4461-63 (2010).

259. *See* Ganzini et al., *supra* note 38, at 360 (noting that VSED "does not necessarily require the participation of a physician.") (footnotes omitted); Quill et al., *Palliative Options*, *supra* note 39, at 50. *But cf. supra* note 164 (collecting sources that recommend medical supervision of VSED).

260. *See, e.g.*, *supra* notes 117 to 125. Some argue that another advantage is the absence of mandatory procedures; this allows patients to enjoy the final days and weeks of life, rather than subjecting themselves to court proceedings and psychiatric evaluations. Byock, *supra* note 160, at 13. While we do not fully articulate them here, VSED should have some analogous safeguards. *See, e.g.*, *supra* notes 171 and 176 (on assuring voluntariness).

261. Byock, *supra* note 160, at 11.

262. Berry, *supra* note 257, at 799 ("Many more patients receive a benefit from the discussion itself, with the knowledge of their own control . . . ."); Donald G. McNeil Jr., *First Study on Patients Who Fast to End Lives*, N.Y. TIMES (July 31, 2003), http://www.nytimes.com /2003/07/31/us/first-study-on-patients-who-fast-to-end-lives.html; *see* Quill, *supra* note 25, at 20 ("[T]he *availability* of such an escape may be much more important to many patients than its actual use.").

263. People v. Lewis, 16 Cal. Rptr. 3d 498, 501 (Ct. App. 2004). *Accord* CAL. PENAL CODE § 206 (West 2010).

Death by dehydration sounds terrifying.[264] Thinking about it conjures images of suffering persons pleading for water and food while stranded in desiccated deserts, on deserted tropical islands, or in prisoner camps. These perceptions could be prompted, in part, by the media, television, and films. Many Americans are familiar with *Save the Children* print and television ads featuring Sally Struthers. The ads display "horrific images of fly-covered starving children."[265] Dehydration is perceived as a horrible death filled with intense uncontrollable suffering.[266] Indeed, some of this perception is deliberately propagated by those with certain political agendas, such as promoting Catholicism[267] or assisted suicide.[268]

Despite the misguided belief of the general population (and even many healthcare professionals)[269] that a death by dehydration would come with excruciating pain, there is compelling evidence that patients who use

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264. *See* Lynn & Childress, *supra* note 142, at 20 ("[T]he common image of severe malnutrition or dehydration is one of unremitting agony.").

265. MICHAEL MAREN, THE ROAD TO HELL: THE RAVAGING EFFECTS OF FOREIGN AID AND INTERNATIONAL CHARITY 137 (1997).

266. *See, e.g.*, Brophy v. New England Sinai Hosp., 497 N.E.2d 626, 641 n.2 (Mass. 1986) ("The [probate] judge found that death by dehydration is extremely painful and uncomfortable for a human being."); ORAL FEEDING DIFFICULTIES, *supra* note 172, at 19 ("It is commonly believed that death from absent nutrition or hydration is distressing or painful for the patient."); Sam Hjelmeland Ahmedzai, *Dehydration and Perfect Care at the End of Life*, THE TIMES (U.K.) (Oct. 2, 2009), http://www.timesonline.co.uk/tol/comment/letters/article6857395.ece ("A 'care' pathway that effectively leads to the vast majority of terminal patients not being hydrated stands to be seen as inhumane."); Natalie Paris et al., *'Right to Die' Fight Abandoned*, TELEGRAPH (Apr. 19, 2007), http://www.telegraph.co.uk/news/uknews/1549067/Right-to-die-fight-abandoned.html (reporting that Kelly Taylor abandoned an attempt to starve herself because "it became too painful"); Simon Johnson, *Retired GPs Advise Terminally Ill on Suicide by Starvation*, TELEGRAPH (Mar. 8, 2009), http://www.telegraph.co.uk/health/healthnews/4957436/Retired-GPs-advise-terminally-ill-on-suicide-by-starvation.html (reporting on the case of Efstratia Tuson).

267. *Medical Decisions at the End of Life*, *supra* note 139 (a pro-life Christian educational ministry stating that "[d]eath by starvation and dehydration is painful and inhumane.").

268. *See* SYME, *supra* note 138, at 119-20; Chug et al., *supra* note 148 ("[I]t was sad that Mrs. Page had had [sic] to starve herself to achieve the end she wanted.") (attributing language to voluntary euthanasia activist Lesley Martin); Nicky Park, *Disabled NZ Woman Starving Herself*, SYDNEY MORNING HERALD (Mar. 25, 2010), http://news.smh.com.au/breaking-news-world/disabled-nz-woman-starving-herself-20100325-qyp4.html ("'It's very tragic that a person has to go down that path . . . a final 'grim process' to death.'") (quoting Australian euthanasia campaigner Philip Nitschke); Templeton, *supra* note 134; Fergus Walsh, *Locked-In Man Seeks Right to Die*, BBC NEWS (July 19, 2010), http://www.bbc.co.uk/news/health-10689294 (while recognizing a "lawful means of ending his life is by starvation - refusing food and liquids," Tony Nicklinson initiated legal proceedings to clarify whether his wife could legally inject him with a lethal dose of drugs). *Cf.* Bill Johnson, *Fighting for a Right Way to Die*, DENVER POST, Nov. 9, 2009, at A15, *available at* http://www.denverpost.com/news/ci_13744692 ("'I don't want another human being to die the way Kathy did. . . . That is inhuman.'") (quoting Sally Odenheimer).

269. *See* Norma House, *The Hydration Question: Hydration or Dehydration of Terminally Ill Patients*, PROF'L NURSE, Oct. 1992, at 44, 46; P.P. Marin et al., *Attitudes of Hospital Doctors in Wales to Use of Intravenous Fluids and Antibiotics in the Terminally Ill*, 65 POSTGRADUATE MED. J. 650, 651 (1989).

dehydration as a way to hasten death feel little to no pain, and that dehydration can actually allow a person to die more comfortably.[270]

While salient, these bad deaths are distinguishable on several grounds. First, these deaths were likely involuntary. Whether in a prison camp or on a deserted island, the person probably did not choose to be deprived of water to hasten death. Second, the deaths were not accompanied with the comfort care discussed above that is essential for a good death by dehydration.[271] Third, people in these "bad" starvation scenarios suffer from a kind of semi-starvation rather than the complete cessation associated with VSED.[272] During this semi-starvation, the person continues to eat or drink small amounts of food or fluids.[273] This prolongs the process and prevents the body from entering into ketosis, the euphoric state that makes a death by VSED more comfortable.[274]

IV. VSED IS A LEGAL END-OF-LIFE OPTION

Non-lawyer supporters of VSED have professed its legality time and time again, both in the literature and in practice.[275] It has been officially endorsed

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270. *See supra* Part III.C; Molrine, *supra* note 213, at 4.

271. *See supra* notes 248-254.

272. Byock, *supra* note 160, at 9; Stinson et al., *supra* note 162, at 41-42 (noting that a patient lived for twenty-one days after choosing VSED because he drank soda throughout the time even though this intake might cause pain and prolong the dying process); CHABOT, *supra* note 8, at 39 ("[T]he feeling of hunger often disappears in 2-4 days, provided the person drinks water only."). Molrine, *supra* note 213, at 5 (stating that "feeding even small amounts can prevent ketonemia and prolong the sense of hunger . . . . Indeed hunger rapidly reappears when ketosis is relieved by ingesting small amounts of carbohydrate . . .")

273. *See* LESTER I. TENNEY, MY HITCH IN HELL: THE BATAAN DEATH MARCH 51-52, 70, 92 (First Memories of War ed. 2007) (United States prisoners only received small amounts of water); GENE BOYT, BATAAN: A SURVIVOR'S STORY 131-35 (2004); HARRY SPILLER, AMERICAN POWS IN WORLD WAR II 15, 40, 55, 74, 174 (2009). *See also* Stefan Simanowitz, *The Body Politic: The Enduring Power of the Hunger Strike*, 292 CONTEMP. REV. 324, 325-26 (2010). A recent film compellingly depicts the hunger strike by Bobby Sands and other IRA prisoners during their 1981 incarceration in England. HUNGER (Icon Ent. 2008). Both the length of the strike (nine weeks) and its gruesomeness were due to the fact that it was not a complete cessation of food and fluid.

274. *See* Timothy Quill & Robert M. Arnold, *Responding to a Request for Hastening Death*, EPERC (July 2006), http://www.eperc.mcw.edu/fastFact/ff_159.htm (last modified Apr. 2009) ("[B]e sure everyone understands the importance of complete cessation of drinking or else the process can take months rather than weeks."); Stinson et al., *supra* note 162, at 41-42 (noting that a patient lived for twenty-one days after choosing VSED because he drank soda throughout the time, even though this intake might cause pain and prolong the dying process); Sullivan, *supra* note 222, at 222 ("In contrast to the intense discomfort associated with semistarvation, total starvation is associated with euphoria. Instead of pain, food deprivation may induce analgesia.") (footnotes omitted).

275. *See supra* note 138.

by professional medical associations.[276] Indeed, VSED is already practiced all over the country, probably under the assumption that it is legal in some way.[277] Despite this relative prevalence, the practice is thought to be quite rare.[278] This is due, in part, to the fact that VSED's legal status has yet to be thoroughly explored in a way that would give medical providers and prospective users (and their families) some peace of mind when exploring this end-of-life option.[279]

Legal uncertainties revolving around VSED lead some caregivers to undermine a patient's decision to stop eating and drinking.[280] Either the option is not offered, or, if it is requested, the request is ignored. Some would-be caregivers coerce and persuade patients to change their minds about VSED.[281] Settling the legal status of this exit option could give caregivers

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276. *See, e.g.*, AM. MED. WOMEN'S ASS'N, POSITION PAPER ON AID IN DYING (Sept. 9, 2007). Some organizations are even prepared to stop oral hydration in children. Don Brunnquell, *Medically Provided Nutrition and Hydration*, CHILDREN'S HOSPITALS AND CLINICS OF MINNESOTA, http://www.childrensmn.org/web/hospice/191269.pdf (last visited Feb. 6, 2011).

277. *See* BERNAT, *supra* note 9, at 215 ("Contemporary reviews of the management options available to terminally ill patients now consider [VSED] as a major option.") (citing 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 (1997)); Miller & Meier, *supra* note 138, at 559. Support for VSED, at least among hospice workers, is very high. Harvath et al., *supra* note 135, at 239.

278. *See* Quill, *supra* note 25, at 20 ("There are no reliable data about the frequency of voluntarily stopping eating and drinking in the United States, although the practice is thought to be rare [and accounts for less than one percent of deaths in hospice programs in Rochester, New York].").

279. *See supra* Part III. Legal uncertainty is not the only obstacle to more widespread use of VSED. Providers and families often just feel "a little uncomfortable" with it. Jacobs, *supra* note 147, at 325. This emotional reaction is hardly unique to VSED. *See* Neil J. Farber et al., *Physicians' Decisions to Withhold and Withdraw Life-Sustaining Treatment*, 166 ARCHIVES INTERNAL MED. 560, 563 (2006). In any case, the primary purpose of this article is to clarify the legal situation. There appears to be a growing recognition among healthcare providers that, for some patients, VSED is a legitimate and appropriate end-of-life option. *See supra* Part III.C. But these same providers may not practice what they preach because of legal concerns.

280. *See, e.g.*, H Ltd v J & Anor [2010] SASC 176 ¶ 21 (Austl.) ("H Ltd has refrained from giving an undertaking to comply with [its resident's] direction . . . . These proceedings are brought to resolve the resulting controversy and uncertainty as to whether such rights as J may have to personal integrity and self-determination must be respected by H Ltd."); Quill, *supra* note 25, at 22 ("Some patients may be denied access to [VSED] because clinicians or institutions are reluctant to use [it] . . . ."); Johnson, *supra* note 31, at 1030 (discussing risk averseness and "that doctors will avoid . . . particular treatments that in fact are legitimate"); Quill et al., *Palliative Options*, *supra* note 39, at 64 (VSED "may not be readily available because some physicians may continue to have moral objections and legal fears about these options."). Some providers recognize VSED as a good option for their patients but fail to provide it due to "defensive medicine" legal concerns. *See* Johnson, *supra* note 31, at 974-75; Tia Ghose, *Paralyzed Accident Victim Fights for Right to Die*, MILWAUKEE J. SENTINEL (Nov. 28, 2010), http://www.jsonline.com/features/health/110948384.html (reporting that when quadriplegic Dan Crews "initiated a hunger strike . . . his nurses quit"). We hope that this article helps serve one of the classic responses to such concerns: education.

281. *See* Miller & Meier, *supra* note 138, at 561 ("Patients who choose this means . . . remain vulnerable to persuasive pressure from family members or physicians to change their mind.").

some legal and moral footing upon which support of a VSED patient can be based.

The following four subsections provide this much needed legal analysis. First, we provide an affirmative reason for the lawful nature of VSED, rooted in common law battery. Second, we ground a right to VSED in the well established right to refuse medical treatment. Third, we defend VSED against charges that it constitutes abuse and neglect. Fourth, we defend VSED against charges that it constitutes assisted suicide.

A. Disallowing VSED Can Constitute a Battery

The simplest and most direct source of legality of VSED is the common law theory of battery.[282] Battery is the nonconsensual, intentional touching of a person with intent to harm or offend.[283] Although the most common batteries are probably those which are incident to physical altercations, what actually constitutes battery is generally far more expansive. Force feeding and even attempted force feeding can also constitute a battery.[284]

1. Battery at Common Law

Touching in battery must be nonconsensual.[285] This lack of consent can be express or implied, verbal or non-verbal.[286] For example, a person could

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282. *See generally* MEISEL & CERMINARA, *supra* note 88, at 2-21 – 2-23, 11-10 (discussing how the right to refuse is grounded in a right to refuse unwanted intrusions and that remedies include actions for assault, battery, and intentional infliction of emotional distress); Shepherd 2006, *supra* note 26, at 337:

> The answer . . . is not to be found . . . in likening it or distinguishing it from medical treatment or tube feeding. The basis for the . . . right to refuse tube feeding is . . . that tube feeding against a patient's will is an intrusion into the bodily integrity of the individual. . . . The critical issue is . . . whether it is unwanted, whether it is in a sense forced.

Id. (footnote omitted); Thomas I. Cochrane, *Unnecessary Time Pressure in Refusal of Life-Sustaining Therapies: Fear of Missing the Opportunity to Die*, AM. J. BIOETHICS, Apr. 2009, at 47, 51 ('[T]he proper defense of the right to refuse [oral hydration and nutrition] . . . [is to recognize that] patients with decisional capacity have the right to refuse any unwanted intervention . . . because of the right against unwanted interference . . . ."); *id.* at 53 ("The foundation of the right to refuse . . . does not rest on the 'medical'; it rests on the 'unwanted.' The word *medical* (or *artificial*) is unnecessary, given that the right to self-determination entails a right to refuse *any* unwanted interventions whatsoever." (emphasis in original)).

283. RESTATEMENT (SECOND) OF TORTS § 13 (1965); *id.* § 13 cmt. d.

284. Force feeding is often by tube. *See, e.g.*, *In re* Caulk, 480 A.2d 93, 99 (N.H. 1984) (Douglas, J., dissenting); Sondra S. Crosby et al., *Hunger Strikes, Force-Feeding, and Physicians' Responsibilities*, 298 JAMA 563, 564 (2007) ("Force-feeding . . . involves the use of force and physical restraints . . . and the placement of a nasogastric tube . . . .").

285. RESTATEMENT (SECOND) OF TORTS § 13 cmt. d. (1965).

affirmatively say "do not touch me," which would expressly refuse consent to the touching. A person could also say nothing at all, but by his or her conduct or course of action indicate either consent or a refusal to consent.[287] For example, when a person extends his or her arm to shake another person's hand, he or she is impliedly consenting to the handshake. Similarly, when a person enters a crowded New York City subway train, he or she impliedly consents to being touched, at least to some degree, by other passengers on the train. On the other hand, if in response to an outstretched hand, the person backs away, he impliedly refuses consent to the handshake.

The touching covered by battery is broad. The contact does not have to be direct person-to-person contact. The tortfeasor can touch something that is connected to or intimately associated with a person's body, like a cane or a plate.[288] Similarly, the tortfeasor himself does not have to contact the person, but rather, the tortfeasor can cause an object to touch the person. This could be in the form of something as simple as throwing a tennis ball at a person, or as intangible and amorphous as a cloud of smoke contacting a person.[289]

The harm or offensiveness caused by a battery also has a broad scope.[290] If the person committing the battery knows, or should know, that the touching would be offensive to the particular person, then this element has been satisfied *even if* the procedure is harmless or beneficial.[291]

2. Undermining VSED Can Constitute a Battery

Some actions taken by caregivers to undermine VSED can certainly constitute a battery. These actions include force feeding, and even worse, inserting a feeding tube against the wishes of the patient.[292] In practice, either

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286. *Id.* § 892 (1979); PROSSER AND KEETON ON THE LAW OF TORTS § 18 (W. Page Keeton et al. eds., 5th ed. 1984).

287. RESTATEMENT (SECOND) OF TORTS § 892 (1979).

288. *See* Fisher v. Carrousel Motor Hotel, Inc., 424 S.W.2d 627, 629-30 (Tex. 1967) (affirming battery verdict of compensatory and punitive damages where defendant snatched a plate out of plaintiff's hand but never touched plaintiff himself); Piggly-Wiggly Alabama Co. v. Rickles, 103 So. 860, 861-62 (Ala. 1925) (affirming jury verdict for battery where defendant touched plaintiff's clothing).

289. *See, e.g.*, Graham v. Gunter, No. 93-1186, 1993 WL 432565, at *2 (10th Cir. Oct. 27, 1993) (allowing battery claim for exposure to secondhand smoke).

290. RESTATEMENT (SECOND) OF TORTS § 15, cmt. a (1965) ("There is an impairment of the physical condition of another's body if the structure or function of any part of the other's body is altered to any extent even though the alteration causes no other harm."); *id.* § 19 ("A bodily contact is offensive if it offends a reasonable sense of personal dignity.").

291. *See* Duncan v. Scottsdale Med. Imaging, 70 P.3d 435, 438-39 (Ariz. 2003); Roberson v. Provident House, 576 So. 2d 992, 994 (La. 1991); Estate of Leach v. Shapiro, 469 N.E.2d 1047, 1051(Ohio Ct. App. 1984); Krause v. Bridgeport Hosp., 362 A.2d 802, 806 (Conn. 1975); Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914); Rolater v. Strain, 137 P. 96, 97 (Okla. 1913); Pratt v. Davis, 79 N.E. 562, 563 (Ill. 1906); Mohr v. Williams, 104 N.W. 12, 15-16 (Minn. 1905). *Cf.* Cobbs v. Grant, 502 P.2d 1, 7-8 (Cal. 1972).

292. Force feeding is often by tube. *Cf. In re* Caulk, 480 A.2d 93, 99 (N.H. 1984) (Douglas, J., dissenting); Crosby et al., *supra* note 284, at 564 ("Force feeding . . . involves the use of force and physical restraints . . . and the placement of a nasogastric tube . . . ."). In that

of these actions might be accomplished through physical or chemical restraints.[293] Slightly more attenuated, but perhaps still a battery, is the attempt to undermine VSED by placing food within a person's reach when the caregiver clearly knows that the patient is voluntarily refusing food.

a. Force Feeding is Battery

Force feeding a person who is voluntarily refusing food and fluid is battery. There is contact; it is unwanted; and it is harmful and/or offensive. First, the force-feeder intends to touch a person's lips with food. This touching is enough for battery because even if the tortfeasor's body does not touch the person, the tortfeasor still causes the food to touch the person. His or her conduct would not be materially different from the tortfeasor who fires a gun at a person, causing a bullet to come in contact with that person.[294]

Second, there is no consent in this situation, neither expressly nor impliedly. A person who opts for VSED expressly refuses consent to be fed because the person affirmatively chooses not to eat at all. Force feeding, by its very nature, cannot be consensual. If one must force another to participate in an action, that action cannot be consensual.[295] Moreover, courts have held that contact with unwanted food can constitute a battery.[296]

Third, force feeding is most certainly harmful or offensive to the VSED patient. While social norms would generally indicate that feeding someone is neither harmful nor offensive, VSED falls outside of this norm. Force feeding a person who has chosen VSED can undo the effects of this exit option and

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case, the patient has a clear right to refuse it. Where a patient's decision to VSED is undermined by inserting a feeding tube, that is definitely a battery. *Cf.* Cantor 2006, *supra* note 25, at 421 (projecting "legal acceptance of VSED . . . grounded on the distasteful specter of forcing a competent, dying patient to receive ANH"); Lynn & Childress, *supra* note 142, at 18 (noting that gastronomy tubes, nasogastric tubes, and intravenous feeding all "commonly require restraining the patient, cause minor infections and other ill effects").

293. *See* Lo & Dornbrand, *supra* note 174, at 402-03; Schwarz 2007, *supra* note 40, at 1291; Nevmerzhitsky v. Ukraine, App. No. 54825/00, 43 Eur. H.R. Rep. 32 ¶ 97-98 (2005) (characterizing the use of a mouth widener and handcuffs as "torture").

294. *See* Wasson et al., *supra* note 172, at 466 ("[I]f they are refusing food staff cannot force them to eat as this would constitute assault."); D. Robert McCardle & Sr. Diana Bader, *Confronting Conflict: A Nursing Home Comes to Grips with an Elderly Patient's Decision to Refuse Nutrition*, HEALTH PROGRESS, Apr. 1991, at 31, 33.

295. *See* RESTATEMENT (SECOND) OF TORTS § 58 (1965); RESTATEMENT (SECOND) OF TORTS §§ 892B(3), 892B cmt. j. (1979).

296. *See* Morton v. Wellstar Health Sys., 653 S.E.2d 756, 758 (Ga. Ct. App. 2007) (holding that feeding a patient scrambled eggs would constitute battery, if physician had given orders for only clear liquids); Siegel v. Ridgewells, Inc., 511 F. Supp. 2d 188, 194 (D.D.C. 2007) (suggesting that coming into contact with unwanted food can constitute a battery). *See also* Michael H. Shapiro, *Constitutional Adjudication and Standards of Review Under Pressure from Biological Technologies*, 11 HEALTH MATRIX 351, 468 (2001) (stating that the capability of "[f]eeding a person by hand . . . does not necessarily mean that she will – or can legally be – force-fed. (To do so might be battery.)").

cause the person pain. As discussed in Part III, lack of food and water causes a person to enter a euphoric state which results in natural pain relief.[297] Any amount of food or drink consumed by a VSED patient can prolong the onset of, or reverse the effects of this state of ketoacidosis, thus causing harm.[298] Force feeding is undoubtedly offensive to the VSED patient, since it deprives the person of dignity and autonomy in the decision to stop eating and drinking. Indeed, force feeding is not a dignified act.[299]

Furthermore, force feeding likely involves physically restraining the person, forcefully opening the person's mouth, shoving food inside it, and forcing the person to chew and swallow against his will, especially if swallowing is accomplished by reflex. If forcing treatment upon a patient is "unacceptably inhumane," it is "all the more so if the patient were physically to resist."[300] While such measures are sometimes unnecessary because the person ultimately cooperates, such cooperation is often achieved through coercion and duress. For example, when Elizabeth Bouvia—a quadriplegic who wished to VSED—refused to eat,[301] providers threatened her with a loss of smoking privileges and morphine unless she ate.[302] Such consent does not change the fact that the unwanted touching is a battery. "Consent is not effective if it is given under duress."[303]

b. Placing Food Near the VSED Patient Can Be a Battery

Sometimes, instead of force feeding, and even instead of the duress like that used against Elizabeth Bouvia, providers might attempt to manipulate a patient's consent to resume eating and drinking by placing food near the patient.[304] People choosing to voluntarily stop eating and drinking require a

297. *See supra* Part III.C.

298. *See supra* Part III.D.

299. *Cf.* Rochin v. California, 342 U.S. 165, 172 (1952) (finding that where officers sought to alter the contents of a suspect's stomach and "struggle[d] to open his mouth," it did "more than offend some fastidious squeamishness" but "shocks the conscience" and "is bound to offend even hardened sensibilities").

300. Dan W. Brock & Joanne Lynn, *The Competent Patient Who Decides Not to Take Nutrition and Hydration*, *in* BY NO EXTRAORDINARY MEANS: THE CHOICE TO FORGO LIFE-SUSTAINING FOOD AND WATER 202, 204 (Joanne Lynn ed. 1986). *See also WMA Declaration of Malta on Hunger Strikers*, WORLD MED. ASS'N, (Oct. 14, 2006), http://www.wma.net/en/30publications/10policies/h31/index.html ("Forced feeding contrary to an informed and voluntary refusal is unjustifiable. . . . Forcible feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment.").

301. *See supra* notes 61-69.

302. GEORGE J. ANNAS, JUDGING MEDICINE 298 (1988).

303. RESTATEMENT (SECOND) OF TORTS § 892B(3) (1979). *See also* JAMES F. DRANE, CLINICAL BIOETHICS: THEORY AND PRACTICE IN MEDICAL ETHICAL DECISION-MAKING 127 (1994).

304. Telephone Interview with Judith Schwarz, Regional Clinical Coordinator, Compassion & Choices (Nov. 30, 2009).

significant amount of will power and support to maintain the decision.[305] If food is placed in front of a person, sights and smells cause chemical reactions in the body that make the person salivate and feel hungry.[306] This undermines the decision to VSED because it coerces the person to waver in his or her decision.[307]

Battery is established not only by contact with the person herself but also with an object connected to or intimately associated with the person. Thus, the action of placing food on the patient or in an area in close proximity to the patient could constitute a battery. For example, touching someone's hat or umbrella would be enough contact for common law battery.[308] Similarly, it is very likely that placing food on a person's bed or on a table attached to the bed would constitute a battery.

Again, all the elements of battery are satisfied. There is contact because of the intimate association with the bed and table, as discussed above. There is no consent to this contact because the VSED patient refuses to consent to consuming food and water by the very nature of his decision to stop eating and drinking. Finally, the contact is harmful or offensive because the person is trying to reach the goal of dying with dignity by choosing VSED.

The mere fact that placing food very close to the person undermines that decision is enough to be both harmful to the mental wellbeing of the patient and offensive to his values. Of course, providers may bring food not to undermine the VSED decision, but rather to confirm that the patient wants to continue VSED. While the patient's refusal must be respected, it is permissible to delay compliance to see whether the patient will change his or her mind.[309]

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305. *See* Quill, *supra* note 25, at 21 (VSED "requires tremendous discipline not to drink if one is thirsty and capable of drinking . . . .").

306. *See* KESSLER, *supra* note 141, at 35-40, 88; PAUL INSEL ET AL., NUTRITION 106-07 (4th ed. 2011).

307. *See* LAWRENCE D. ROSENBLUM, SEE WHAT I'M SAYING: THE EXTRAORDINARY POWERS OF OUR FIVE SENSES 82-84 (2010) (discussing new research that suggests even the weakest odors – unnoticeable to our conscious being – can have subtle influences over an individual's thoughts and behavior); EUGEN BRUCE GOLDSTEIN, 1 ENCYCLOPEDIA OF PERCEPTION 63-64 (2010) (defining aromachology as the "scientific analysis of olfactory effects on mood, physiology, and behavior").

308. *See supra* note 288. *See also* Gowri Ramachandran, *Assault and Battery on Property*, 44 LOY. L.A. L. REV. 253, 257 (2010) (exploring battery on a person's "inorganic, discontinuous body").

309. *See* MARK FAIRWEATHER & ROSY BORDER, LIVING WILLS AND ENDURING POWERS OF ATTORNEY 4 (2d ed. 2004) (explaining that while patients cannot refuse "'the offer of'" food and drink, they can refuse food and drink itself); GEN. MED. COUNCIL, *supra* note 166, at 52 n.31 ("The *offer* of food and drink by mouth is part of basic care . . . and must always be *offered* to patients . . . . Food and drink can be refused by patients at the time it is offered . . . .") (emphasis added); Brock & Lynn, *supra* note 300, at 209 ("[T]he most that is justified is temporary intervention . . . to ensure that the person's choice is competently made and reflects a realistic understanding of his or her situation."); Catherine Jenkins & Eduardo Bruera, *Assessment and Management of Medically Ill Patients Who Refuse Life-Prolonging Treatments: Two Case Reports and*

3. Battery is Not a Legal Cure-All

A cause of action in battery is the most legally sound theory establishing the legality of VSED, but there are limitations. If a person attempts to undermine the decision of another person to VSED by force feeding or placing food in an area intimately associated with the patient's person, there is probably a good battery argument for why those actions are illegal, as discussed above.

There are, however, many other ways in which caregivers and medical professionals can undermine a patient's decision to VSED. The provider could never disclose the option to the patient in the first place. Or the provider could terminate the treatment relationship, leaving the patient to find a new provider. Consequently, the law of battery is probably not enough to completely protect a person's right to choose VSED.

B. Not Allowing VSED Violates the Right to Refuse Medical Treatment

While battery is the simplest and most direct basis for the legality of VSED, it is not the only basis. An additional or alternative basis is the right to refuse medical treatment. A patient's right to refuse medical treatment is grounded in common law, in constitutional law, and in statutory law. That right to refuse encompasses VSED because the administration of food and water to a patient is medical treatment that can be refused like any other medical treatment. Alternatively, even if the administration of hydration and nutrition is not technically medical treatment, it is sufficiently analogous that it should be treated the same way with respect to the right to refuse.

1. Right to Refuse Life-Sustaining Medical Treatment

A competent patient's right to refuse medical treatment is "virtually absolute."[310] The right to refuse life-sustaining medical treatment (LSMT) is arguably derived from the United States Constitution, individual state constitutions and statutes, and common law theories.[311] The right to refuse,

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Proposed Guidelines, 14 J. PALLIATIVE CARE 18 (1998); N.M. CORR. DEP'T, HUNGER STRIKES AND PERSONAL FASTS, POLICY CD-172400, http://corrections.state.nm.us/policies/current/CD-172400.pdf (last updated Mar. 31, 2010) ("During a hunger strike, the staff shall deliver three (3) meals per day to the inmate's cell . . . .") (requiring a mental health evaluation and requiring the prisoner to sign the "Inmate Acknowledgement of the Consequences of Refusing Food and/or Liquid" form and "Consent for Palliative Treatment" form). The line between informed consent and coercion, like the line between soft paternalism and hard paternalism, is fuzzy at best. But there certainly is such a line. *See* Thaddeus Mason Pope, *Is Public Health Paternalism Really Never Justified? A Response to Joel Feinberg*, 30 OKLA. CITY U. L. REV. 121, 129-30 (2005). Too-extended noncompliance in hopes that the patient will/may change his or her mind is not legitimate soft paternalism but illegitimate hard paternalism.

310. MEISEL & CERMINARA, *supra* note 88, at 2-15 (citing to several state court cases that hold that a competent patient has a right to refuse medical treatment); *see also id.* at 2-4 – 2-5, 2-21 – 2-22.

311. *Id.* at 2-21, 2-27 – 2-33, 2-38 – 2-40; Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 269-78 (1990).

however, is also the offspring of battery.[312] The theories of the right to refuse LSMT and battery are rooted in the same reasoning and policy: a person has the right to be free from bodily intrusion.[313]

The right to refuse LSMT first came in front of the United States Supreme Court in the case of *Cruzan v. Director, Missouri Department of Health*.[314] Although the case turned on an evidentiary question and did not directly address the issue of whether there is a constitutional right to refuse, the case was widely interpreted as carving out this right.[315] This interpretation likely stems from the fact that the Court assumed that the United States Constitution would permit a person to refuse LSMT because that refusal is probably a liberty interest and therefore protected as a fundamental right.[316]

2. VSED Is the Refusal of Medical Treatment

A patient's right to refuse medical treatment is well established. Accordingly, we might take this as the major premise in a categorical syllogism: "All patients have the right to refuse medical treatment." Therefore, if the provision of oral nutrition and hydration is medical treatment, then a patient has the right to refuse it.[317] The object of this section is to establish the truth of the minor premise in this syllogism: "Oral nutrition and hydration is medical treatment." It is initially worthwhile to observe that, in the few cases to directly confront the legality of VSED, courts have repeatedly accepted this premise in upholding patients' rights to VSED.

For example, New York Judge Donald H. Miller ruled that the Plaza Health and Rehabilitation Center was neither obligated nor empowered to force-feed G. Ross Henninger, a resident at Plaza Health who had been fasting to hasten his death.[318] The judge based his decision on state law permitting patients to

312. *Cruzan*, 497 U.S. at 269-78; MEISEL & CERMINARA, *supra* note 88, at 2-21 – 2-23.

313. *Cruzan*, 497 U.S. at 269-78.

314. *Id.* at 261.

315. *See* RONALD DWORKIN, FREEDOM'S LAW: THE MORAL READING OF THE AMERICAN CONSTITUTION 130-43 (1996); Louis Michael Seidman, *Confusion at the Border:* Cruzan, *"The Right to Die," and the Public/Private Distinction*, 1991 SUP. CT. REV. 47, 49-55 ("[T]he Court implied, without quite holding, that a competent person would have the constitutional right to refuse lifesaving hydration and nutrition."). *But see* RONALD D. ROTUNDA & JOHN E. NOWAK, TREATISE ON CONSTITUTIONAL LAW: SUBSTANCE AND PROCEDURE 210 (4th ed. 2008) ("The Court only assumed, and did not decide, that an individual had a right to refuse life saving treatment.").

316. *See supra* note 92.

317. *See* Miller & Meier, *supra* note 138, at 560 ("[T]he legitimacy of [VSED] derives from the patient's legal and moral right to refuse medical treatment."); Rebecca Dresser, *When Patients Resist Feeding: Medical, Ethical, and Legal Considerations*, 33 J. AM. GERIATRICS SOC'Y 790, 790 (1985).

318. David Margolick, *Judge Says Ailing Man, 85, May Fast to Death*, N.Y. TIMES, Feb. 3, 1984, at A1, *available at* http://www.nytimes.com/1984/02/03/nyregion/judge-says-ailing-man-85-may-fast-to-death.html (noting that the judge also found that Mr. Henninger could be force-fed only by being physically restrained). But even if restraint were not required, it would be odd

knowingly refuse medical treatment.[319] Two other New York courts similarly declined nursing home requests for authorization to prevent patients' deaths from VSED.[320]

In a better known opinion, the California Supreme Court reached a comparable conclusion. Howard Andrews, an inmate, refused to eat causing weight loss and threatening his life.[321] Andrews had recently been rendered a quadriplegic as the result of a fall, and was depressed about his "profoundly disabling" and "irreversible" condition.[322] The prison system petitioned the court for permission to insert a feeding tube over Andrews' objections. But since Andrews had the capacity to understand and appreciate his circumstances, the court refused to grant that permission.[323]

Other courts have issued similar rulings both in the prisoner "hunger strike" context[324] and in the nursing home context.[325] For example, Robert

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if healthcare providers could force feed those less able to fight back precisely because they could not fight back. The resident's identity was disclosed in John Gallagher, *Health Facilities' Obligations when a Patient Refuses Treatment*, HEALTH PROGRESS, Sept. 1984, at 40, 43. Dresser, *supra* note 317, at 793. The case citation has been identified as *In re* Plaza Health & Rehab. Ctr., N.Y. Sup. Ct. Onondaga County, Feb. 2, 1984.

319. Margolick, *supra* note 318, at A1.

320. A.B. v. C., 477 N.Y.S. 2d 281, 283 (Sup. Ct. 1984) (stating that though "[t]he Court is sympathetic with petitioner's plight [quadriplegia] and would honor her request . . . to take only whatever nourishment she chooses" it could not grant the relief requested for other reasons); Cantor 2006, *supra* note 25, at 417 (citing *In re* Brooks 258 N.Y.S. 2d 621 (Sup. Ct. 1987)).

321. Thor v. Superior Court, 855 P.2d 375, 379 (Cal. 1993).

322. *Id.* at 384.

323. *Id.* at 390.

324. *See, e.g.*, Zant v. Prevatte, 286 S.E.2d 715, 716-17 (Ga. 1982) (holding that a prisoner has the right to refuse food); State *ex rel.* White v. Narick, 292 S.E.2d 54, 58 (W. Va. 1982) (ruling against prisoner but indicating a hunger strike would be permitted by one "approaching certain, painful, uninvited death"); Singletary v. Costello, 665 So. 2d 1099, 1110 (Fla. Dist. Ct. App. 1996) (denying prison's request for injunction to impose treatment on fasting prisoner even where the fast was for protest); Wisconsin Dep't Corr. v. Lilly, No. 2007-CV-392 (Dodge Cty. Cir. Ct., Wisc. 2009) (ordering termination for force feeding). *Cf.* Sec'y of State for the Home Dep't v. Robb, [1995] 1 All E.R. 677 [678] (Eng.) (holding that an adult prisoner of sound mine has the right to refuse nutrition and hydration); Regina (Wilkinson) v. Broadmoor Special Hosp. Auth., [2001] EWCA (Civ) 1545, [2002] W.L.R. 419 [447] (Eng.) (stating "the decision to impose treatment without consent upon a protesting patient is a potential invasion of his [or her] rights"); Airedale NHS Trust v. Bland, [1993] All E.R. 821 [822] (Eng.) (holding "[m]edical treatment . . . could lawfully be withheld from an insensate patient with no hope of recovery"); CORR. SERV. CAN., COMMISSIONER'S DIRECTIVE, NO. 825, HUNGER STRIKES (1995), *available at* http://www.csc-scc.gc.ca/text/plcy/doc/825-cd.pdf ("The Service shall not direct the force feeding of an inmate who had the capacity to understand the consequences of fasting at the time he or she made the decision to fast."). Admittedly, courts typically do not respect prisoner refusals because of penological interests. But in almost all those cases the prisoner was not seeking a right to die but was engaged in a hunger strike as a form of protest or even attempted manipulation. *See* Martinez v. Turner, 977 F.2d 421, 422 (8th Cir. 1992); Garza v. Carlson, 877 F.2d 14, 17 (8th Cir. 1989); Doe v. United States, 150 F.3d 170, 172 (2d. Cir. 1998); People *ex rel.* Dep't of Corr. v. Fort, 815 N.E.2d 1246, 1250–51 (Ill. App. Ct. 2004); *Narick*, 292 S.E.2d at 58. *See also* 28 C.F.R. § 549.65 (2010) (stating that if an inmate refuses medical treatment, a physician may consider forced medical treatment if the inmate's health or life is threatened); Freeman v. Berge, 441 F.3d 543, 544 (7th Cir. 2006). For

Corbeil was left quadriplegic after an off-road vehicle accident.[326] While a resident in a Canadian nursing home, Corbeil wanted to refuse medical treatment and begin a fast.[327] The court ordered the facility to honor his wishes, explaining that the court can counter the will of the respondent no more than it could direct a patient to undergo chemotherapy, radiation therapy, or dialysis.[328] Notably, the court described Corbeil's assisted oral feeding as artificial feeding.[329]

The right to refuse medical treatment impliedly requires that the care or treatment be medical in nature. If disallowing VSED is accomplished through administering artificial nutrition and hydration, as the California prison system proposed for Howard Andrews, then the refusal more clearly concerns medical treatment. Nasogastric tubes (inserted through the nasal passageway for short-term use) and percutaneous endoscopic gastronomy (PEG) tubes (inserted directly into the stomach for long-term use) are uniformly considered medical treatment.[330] But what about oral nutrition and hydration? Is that also medical treatment?

Hand feeding seems to qualify. Leading medical ethicists include VSED within the category of voluntary passive euthanasia.[331] After all, most of the reasons that artificial nutrition and hydration (ANH) is considered to be medical treatment apply equally to oral hydration.[332] First, hand feeding is intrusive. It consists of carefully guiding food down the patient's throat,

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another example of government action regarding a prison hunger strike see Jerry Lawton, *Crossbow Cannibal Wins Right to Die in Prison*, DAILY STAR (Jan. 26, 2011), http://www.dailystar.co.uk/posts/view/173648 (reporting that prison officials allowed Stephen Griffiths to starve himself to death).

325. *See, e.g.*, Austl. Cap. Territory v JT [2009] ACTCS 105 ¶¶ 4, 64 (Austl.) (ruling that providers could, as they desired, defer to patient's fasting, if patient had been competent).

326. Manoir de la Pointe Bleue (1978) Inc. c. Corbeil, [1992] Carswell Quebec 1623 (Que. Super. Ct.) (Can.).

327. *Id.* at ¶ 121.

328. *Id.* at ¶ 94.

329. *Id.* at ¶ 87.

330. *See* MEISEL & CERMINARA, *supra* note 88, at 6-77 – 6-79.

331. *See* Byock, *supra* note 160, at 8; Steven H. Miles, *The Terminally Ill Elderly: Dealing with the Ethics of Feeding*, GERIATRICS, May 1985, at 112, 115; Schwarz, *supra* note 81, at 55 ("Many palliative care clinicians agree with ethicists who view stopping eating and drinking as a form of forgoing life-sustaining treatments that's consistent with the ethical and legal consensus supporting a competent patient's right to refuse interventions."). Furthermore, the fact that some state statutes specifically and expressly define oral nutrition and hydration as not constituting health care implies that there is a general understanding that but for such definition, oral nutrition and hydration are considered health care. *See infra* notes 420-22.

332. *See* BERNAT, *supra* note 9, at 215 ("[VSED] is consistent with traditional medical, moral, and legal practices because patients have the right to refuse life-sustaining therapies, including hydration and nutrition."); Franklin G. Miller et al., *Assisted Suicide Compared with Refusal of Treatment: A Valid Distinction?*, 132 ANNALS INTERNAL MED. 470, 472-73 (2000) (arguing that VSED cases "lie within the scope of the patient's right to refuse treatment" because "food and water are standard elements of care in clinical contexts").

which carries the risk of aspiration pneumonia.[333] Second, hand feeding requires either special personnel or special training.[334] It is typically ordered by physicians and administered by nurses. Even if it is administered by lay caregivers, they need special training.[335] Third, hand feeding often requires special eating aids such as padded cutlery, uni-valvular straws, plate guards, and two-handled cups.[336] Fourth, hand feeding often requires special nutritional formulations.[337] Different diet modifications are necessary depending upon the patient's nutritional needs and chewing and swallowing capabilities.[338] In short, for the VSED-appropriate patient population who depend on manual assistance with oral feeding and drinking, VSED is the refusal of *medical* treatment.

But logic can only take us so far. This is highly contested ground.[339] While there are good reasons to characterize hand feeding as medical treatment, some have advanced reasons to characterize it otherwise. These VSED opponents make two main arguments. First, many argue that not even ANH is medical therapy.[340] Therefore, any similarity between hand feeding and

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333. *See* Shepherd 2006, *supra* note 26, at 335-37.

334. *See* 42 C.F.R. §§ 483.35(h)(1), 483.160 (2009) (requiring training for feeding assistants); 42 C.F.R. § 483.35(h)(2) (2009) (requiring R.N. or L.P.N. supervision of feeding assistants); ORAL FEEDING DIFFICULTIES, *supra* note 172, at 12-13, 34 (reviewing strategies to support oral feeding); Wasson et al., *supra* note 172, at 469 (illustrating the importance of "the level of skill of staff feeding patients"); Chia-Chi Chang & Beverly L. Roberts, *Cultural Perspectives in Feeding Difficulty in Taiwanese Elderly with Dementia*, 40 J. NURSING SCHOLARSHIP 235, 236 (2008). *But see* Erik M. Clary, *On the Nature of Tube Feeding: Basic Care or Medical Treatment?*, ETHICS & MED., Summer 2010, at 81, 86 ("Spoon-feeding can be administered by virtually anyone and without specialized instrumentation . . . .").

335. *See* Shepherd 2006, *supra* note 26, at 335-37; Constance M. Dahlin & Tessa Goldsmith, *Dysphagia, Xerostomia, and Hiccups*, *in* TEXTBOOK OF PALLIATIVE NURSING 195, 202-07 (Betty R. Ferrell & Nessa Coyle eds., 2d ed. 2006).

336. Christine Eberhardie, *Assessment and Management of Eating Skills in the Older Adult*, NURSING TIMES, Feb. 1, 2004, at 318, *available at* http://www.nursingtimes.net/nursing-practice-clinical-research/assesment-and-management-of-eating-skills-in-the-older-adult/199540.article. *See* 42 C.F.R. § 483.35(g) (2009) ("The facility must provide special eating equipment and utensils . . . ."); Cindy H. DePorter, *Regulating Food Service in North Carolina's Long-Term Care Facilities*, 66 N.C. MED. J. 300, 302 (2005) (describing assistive devices and special eating equipment such as "plate guards" and "postural supports that help residents with positioning"); DISABLED LIVING FOUNDATION, CHOOSING EATING AND DRINKING EQUIPMENT: DLF FACTSHEET 8-15 (2005), *available at* http://www.dlf.org.uk/factsheets/Choosing_eating_and_drinking_equipment_sponsored.pdf.

337. *See* Shepherd 2006, *supra* note 26, at 335-37.

338. *See* Dahlin & Goldsmith, *supra* note 335, at 206-07.

339. *See, e.g.*, Shapiro, *supra* note 296, at 468 (emphasis in original) ("Feeding a person by hand (which obviously could not be done in *Cruzan*) is not *medical* care, even if administered by health care personnel when the patient can't feed herself. Thus, if a patient doesn't want to be fed, she cannot invoke the common law or the liberty interest in refusing medical treatment.").

340. *See* BERNAT, *supra* note 9, at 179; MEISEL & CERMINARA, *supra* note 88, at 2-6, 6-74; David Casarett et al., *Appropriate Use of Artificial Nutrition and Hydration - Fundamental Principles and Recommendations*, 353 NEW ENG. J. MED. 2607, 2608 (2005) ("Many people believe that nutrition must always be offered . . . . This view is deeply rooted in cultural and religious beliefs.").

ANH is wholly irrelevant. Even if, as we outlined in the previous paragraph, oral hydration is not materially different from ANH, that arguably undermines, not substantiates, the justifiability of VSED. If they are analogous and ANH is not medical treatment, then neither is oral hydration.

While this argument is logically valid, it is not sound. It proceeds from a false assumption: that ANH is not medical treatment. We recognize that there is an ongoing and simmering debate over the status of ANH.[341] But the United States Supreme Court in *Cruzan* supported the idea that it was indistinguishable from other medical treatment.[342] The overwhelming weight of judicial authority has similarly concluded that ANH is a form of medical treatment.[343]

Courts have determined that ANH constitutes medical treatment because it implicates the same concerns as other medical treatment like dialysis and mechanical ventilators, *viz.* bodily integrity.[344] Oral nutrition and hydration is intended for the same medical objective. And it is equally invasive and intrusive. Consequently, it too must be considered medical treatment.[345]

The second argument that VSED opponents make against deeming manually assisted oral nutrition and hydration as medical treatment is that nutrition and hydration are basic human needs as opposed to a medical

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341. *See* Alan Meisel, *Suppose the Schindlers Had Won the* Schiavo *Case*, 61 U. MIAMI L. REV. 733, 760 n.104 (2007) ("In many other states, bills were introduced to amend statutes to make it more difficult to terminate artificial nutrition and hydration . . . .").

342. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 288 (1990) (O'Connor, J., concurring) ("Artificial feeding cannot readily be distinguished from other forms of medical treatment."); *id.* at 307 (Brennan, J., dissenting) ("No material distinction can be drawn between . . . artificial nutrition and hydration – and any other medical treatment. . . . The artificial delivery of nutrition and hydration is undoubtedly medical treatment."). Interestingly, at oral argument, both Justices O'Connor and Scalia asked if a patient could "refuse food and water" even "if no feeding tube is required." Oral Argument at 6:56 & 8:34, Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990) (No. 88-1503), *available at* http://www.oyez.org/cases/1980-1989/1989/1989_88_1503/argument.

343. *See supra* notes 318-329. Prior to *Cruzan*, many state courts similarly acknowledged no distinction between the decision to forgo artificial hydration and nutrition and the decision to forgo other life-sustaining medical treatments. *See* Gray v. Romeo, 697 F. Supp. 580, 587 (D.R.I. 1988); *In re* Gardner, 534 A.2d 947, 954-55 (Me. 1987); *In re* Conroy, 486 A.2d 1209, 1235-37 (N.J. 1985); Brophy v. New England Sinai Hosp., 497 N.E.2d 626, 636-39 (Mass. 1986); *In re* Peter, 529 A.2d 419, 427-28 (N.J. 1987); *In re* Jobes, 529 A.2d 434, 444 n. 9 (N.J. 1987); *In re* Drabick, 245 Cal. Rptr. 840, 846 n.9 (Ct. App. 1988); McConnell v. Beverly Enterprises-Conn., 553 A.2d 596, 603 (Conn. 1989).

344. *See Cruzan*, 497 U.S. at 288 (O'Connor, J., concurring) (stating that "medical treatment on an unwilling competent adult . . . involves some form of restraint and intrusion . . . . Artificial feeding cannot readily be distinguished from other forms of medical treatment").

345. Thomas I. Cochrane & Robert D. Truog, *The Ethical Requirement to Provide Hydration and Nutrition*, 166 ARCHIVES INTERNAL MED. 1324, 1324 (2006) (authors' response to claims made in a letter to the editor) ("[T]he right to refuse an intervention does not depend on the 'artificiality' of the intervention.") (footnote omitted); Robert D. Truog & Thomas I. Cochrane, *Refusal of Hydration and Nutrition: Irrelevance of the "Artificial" vs. "Natural" Distinction*, 165 ARCHIVES INTERNAL MED. 2574, 2574 (2005).

intervention.[346] As such, it is argued that oral nutrition and hydration are morally necessary and cannot be refused.[347] After all, many of the arguments for the justifiability of withholding and withdrawing ANH rely upon distinguishing it from oral nutrition and hydration.[348] While patients can refuse *medical* interventions, "basic nursing care necessary to maintain hygiene, dignity, and comfort . . . should be maintained at all times."[349]

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346. ANNALS OF LONG TERM CARE, *supra* note 174 ("The choice to eat and drink . . . is not really a medical decision . . . . These activities fall into basic activities of living . . . . [S]ome decisions are so fundamental to the care provided that others should not be allowed to make them.") (attributing to Michael D. Cantor).

347. "[T]he administration of water and food, even when provided by artificial means, always represents a *natural means* of preserving life, not a *medical act*." Pope John Paul II, Address to the Participants in the International Congress on "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas" (Mar. 20, 2004), *available at* http://www.vatican.va/holy_father/john_paul_ii/speeches/2004/march/documents/hf_jpii_spe_20040320_congress-fiamc_en.html (emphasis in original). *See also* Alan Jotkowitz, *End-of-Life Treatment Decisions: The Opportunity to Care*, AM. J. BIOETHICS, Apr. 2009, at 59, 59 (stating that hand-feeding, unlike medical intervention, is a basic human need and is therefore morally necessary); Mark Siegler & Alan J. Weisbard, *Against the Emerging Stream: Should Fluids and Nutritional Support Be Discontinued?*, 145 ARCHIVES INTERNAL MED. 129, 130 (1985) (critiquing the acceptance of the emerging medical practice of withdrawing fluids and nutrition from dying patients); Daniel Callahan, *On Feeding the Dying*, HASTINGS CTR. REP., Oct. 1983, at 22, 22; Patrick G. Derr, *Nutrition and Hydration as Elective Therapy:* Brophy *and* Jobes *from an Ethical and Historical Perspective*, 2 ISSUES L. & MED. 25, 38 (1986) (arguing that many factors demonstrate the possibility of distinguishing the withholding of nutrition and fluids from the withholding of medical treatment).

348. Because the justification for ANH relies upon distinguishing it from oral nutrition and hydration, there is now an implication that patients do not have a right to refuse feeding by hand. Shepherd 2006, *supra* note 26, at 336 (citing *In re* Estate of Longeway, 549 N.E.2d 292, 296 (Ill. 1990)). Indeed, some statutes use terms like "[m]edically administered hydration and nutrition" to refer to nutrition and hydration through nasogastric, gastrostomy, and jejunostomy tubes or intravenously. *See* BERNAT, *supra* note 9, at 179. This implies that oral nutrition and hydration is *not* "[m]edically administered." *Id.* at 179 ("In an awake, alert person, eating and drinking obviously cannot be construed as medical therapies . . . ."). Similarly, some courts justified treating nasogastric and PEG tubes as medical treatment by distinguishing such interventions from "typical human ways of providing nutrition and hydration." *See* Barber v. Super. Ct., 195 Cal. Rptr. 484, 490 (Ct. App. 1983); *see also* McConnell v. Beverly Enterprises-Conn., 553 A.2d 596, 603 (Conn. 1989) (construing state statute to allow "a device such as a gastrostomy tube" but to not "under any circumstances, permit the withholding of normal nutritional aids such as a spoon or a straw") (footnote omitted); *In re* Guardianship of Grant, 747 P.2d 445, 453 (Wash. 1987) ("[N]asogastric tubes and intravenous infusions are significantly different from typical human ways of providing nutrition."); *In re* Conroy, 486 A.2d at 1236 ("[A]rtificial feedings such as nasogastric tubes, gastrostomies, and intravenous infusions are significantly different from bottle-feeding or spoonfeeding–they are medical procedures with inherent risks and possible side effects, instituted by skilled healthcare providers . . . .").

349. BERNAT, *supra* note 9, at 177. *See also* Harry R. Moody, *Cross-Cultural Geriatric Ethics: Negotiating Our Differences*, 22 GENERATIONS 32, 37 (1998) ("Even if patients do refuse . . . there may be ways to negotiate with them and persuade them to accept more aggressive palliative care."); *In re* Nadeau, 375 N.W.2d 85, 87 (Minn. Ct. App. 1985). If hand feeding is analogized to this "basic care," then it seems it cannot be refused. *See* Shepherd 2006, *supra* note 26, at 338. But a patient can refuse these feeding methods too. Hoffmann, *supra* note 102, at 302.

To the extent that this argument relies on the special status of nutrition and hydration, it has been almost uniformly rejected by courts and legislatures.[350] Therefore, all that can plausibly remain of this argument is that while food and water can be refused through one (more artificial or more technologically complex) means or mechanism, food and water cannot be refused when delivered through another (less technologically complex) means. But, so exposed, the argument essentially relies on the long rejected ordinary-extraordinary distinction.[351] As Chief Justice Rehnquist observed: "It seems odd that your bodily integrity is violated by sticking a needle in your arm but not by sticking a spoon in your mouth."[352] The VSED opponent's argument is more an assertion of the conclusion rather than an argument to support the conclusion.[353]

In sum, given numerous similarities to ANH, VSED literally is the refusal of medical treatment, or, at the very least, is sufficiently analogous to the refusal of medical treatment that it should be encompassed in that right. The Supreme Court of South Australia acknowledged that "[t]here is . . . a difference between the taking of food by natural means and the medical administration of nutrition."[354] Nonetheless, "those differences do not appear . . . to be sufficient to sustain a distinction between suicide and the exercise of the right to self-determination."[355]

C. Allowing VSED Is Not Abuse and Neglect

Our arguments, based on battery and on the right to refuse treatment, both attempt to ground a legal right to VSED. But healthcare providers' legal concerns with VSED extend beyond uncertainty over the scope of patient autonomy. Providers are also concerned that VSED is specifically prohibited

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350. *See supra* notes 318-329. Notably, the United States Supreme Court reversed the Missouri Supreme Court on this precise point. *Cf.* Cruzan v. Harmon, 760 S.W.2d 408, 423-24 (Mo. 1988), *with* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 279 (1990); *and id.* at 307 (Brennan, J., dissenting). Admittedly, some case law suggests that the provision of dietary services does not constitute the provision of "medical" services. *See, e.g.*, Stenton Hall v. Medical Liability Loss Fund, 829 A.2d 377, 384 (Pa. Cmwlth. 2003).

351. *Cf.* Lynn & Childress, *supra* note 142, at 19 (arguing that factors such as simplicity, naturalness, invasiveness, and customariness are "not morally relevant in distinguishing" eating and drinking); MEISEL & CERMINARA, *supra* note 88, at 5-20 – 5-21.

352. Oral Argument at 13:39 to 13:46, Vacco v. Quill, 521 U.S. 793 (1997) (No. 95-1858), *available at* http://www.oyez.org/cases/1990-1999/1996/1996_95_1858/argument.

353. *See* ALBERT R. JONSEN ET AL., SOURCE BOOK IN BIOETHICS 176 (1998). The artificial-natural distinction will continue to dissolve with the development and implementation of nanotechnology. *See* Jordan Paradise et al., *The Challenge of Developing Oversight Approaches to Nanobiotechnolgy*, 37 J.L. MED. & ETHICS 543, 543 (2009).

354. H Ltd v J & Anor [2010] SASC 176 ¶ 64 (Austl.).

355. *Id.*

because it constitutes abuse, neglect, and/or assisted suicide.[356] In this section, we will demonstrate that VSED does not constitute abuse or neglect. In the next subsection, we will establish that VSED does not constitute assisted suicide.

VSED can and does occur both at home and in institutions.[357] Most states have statutes that protect elders and other dependent or vulnerable individuals from abuse and neglect.[358] Dehydration, malnutrition, and the deprivation of essential services like food and water are key indicators of abuse and neglect.[359] Unfortunately, dehydration and malnutrition are common.[360] Both domestic[361] and institutional[362] providers are regularly charged with violations.

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356. Miller & Meier, *supra* note 138, at 560 ("The setting, however, may influence the availability of terminal dehydration because caregivers in some nursing homes and hospitals may be reluctant to comply with a patient's refusal of food and water."). *See* Johnson, *supra* note 31, at 1030 (discussing risk averseness and predicting "that doctors will avoid . . . particular treatments that in fact are legitimate"); Compassion & Choices of New York, *Counseling Patients*, CONNECTIONS (Fall 2005), at 3, 3, *available at* http://www.compassionandchoicesofny.org/downloads/CAC_NY_NEWS.1105.pdf. (describing a case in which a nursing home opposed a ninety-seven-year-old woman's plan to VSED).

357. Chabot & Goedhart, *supra* note 112, at 1749 (reporting use of VSED from a Dutch survey: forty-eight percent at home, forty-one percent in an institution, and thirteen percent other); CHABOT, *supra* note 8, at 26.

358. *See, e.g.*, D.C. CODE § 22-934 (Supp. 2009) (prohibiting the willful failure to maintain the health of a vulnerable adult including a failure to provide adequate food); FLA. STAT. ANN. § 825.102(3)(a)(1) (West 2006) (making neglect a felony and defining neglect to include "[a] caregiver's failure or omission to provide an elderly person or disabled adult with the care, supervision, and services necessary to maintain . . . physical and mental health, including, but not limited to, food [and] nutrition . . . ."); GA. CODE ANN. § 16-5-100(a) (2007) (stating that cruelty to a person sixty-five years or older occurs when someone willfully deprives an elder of necessary health care and sustenance).

359. *See* 42 C.F.R. § 483.25(i) (2009) (a facility "must ensure that a resident . . . [m]aintains acceptable parameters of nutritional status . . . [and] [r]eceives a therapeutic diet when there is a nutritional problem").

360. Debra Shipman & Jack Hooten, *Are Nursing Homes Adequately Staffed? The Silent Epidemic of Malnutrition and Dehydration in Nursing Home Residents*, 33 J. GERONTOLOGICAL NURSING, July 2007, at 15. In 2000, the federal agency that administers Medicare and Medicaid distributed educational materials titled "Nutrition and Hydration Care: A Fact Pac for Nursing Home Administrators and Managers." Press Release, Ctr. for Medicare & Medicaid Servs., HCFA Launches Nat'l Campaign to Train Nursing Home Workers to Prevent Weight Loss, Dehydration Among Residents (Sept. 18, 2000) http://cms.gov/apps/media/press/release.asp?Counter=231&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=0&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2c+5&intPage=&showAll=1&pYear=1&year=2000&desc=false&cboOrder=date.

361. Even family caretakers are charged with negligently or recklessly letting their wards starve to death. *See* State v. Buckley, 792 N.W.2d 518, 521 (N.D. 2010) (affirming the conviction of Stevie Buckley for starving her six-month-old baby to death); TERMAN, *supra* note 75, at 278-79 (discussing the cases of Kimberly Loebig and Delores Johnson, respectively); Martha Deller, *Woman Sentenced to Life for Abusing Bedridden Man*, STAR-TELEGRAM (Dec. 12, 2008), http://www.star-telegram.com/2008/12/12/1091130/woman-sentenced-to-life-for-abusing.html (reporting on the criminal conviction of caretaker Lowesta Halliburton); *Husband Let Wife Starve to Death*, BBC NEWS (Mar. 28, 2008), http://news.bbc.co.uk/2/hi/uk_news/england/berkshire/7318610.stm (reporting on the criminal conviction of William Pottinger for the death of his mentally ill wife).

For example, in 2009, a widow was awarded $6.5 million against an Ohio nursing home that failed to provide her husband with enough water.[363] Other caregivers are facing not only monetary judgments but even prison sentences for failing to provide sufficient food and nutrition to individuals they were taking care of.[364]

A significant body of federal and state law is specifically directed at preventing the dehydration and malnourishment of long term care residents.[365] For example, Medicare and Medicaid Conditions of Participation require nutritional assessment of residents.[366] They also require that the facility

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362. *See* MEISEL & CERMINARA, *supra* note 88, at 6-84, 6-86; Kiran Randhawa, *Nurse Who Denied Dying Patient Water is Struck Off*, EVENING STANDARD (London), Sept. 17, 2010, at 34, *available at* http://www.thisislondon.co.uk/standard/article-23879122-nurse-who-denied-dying-patient-water-is-struck-off.do; Warren Wolfe, *Stillwater Nursing Home Sued Over Man's Death*, STAR TRIB., Dec. 30, 2008, at 2B, *available at* http://www.startribune.com/local/east/36909734.html. Sometimes, the cases are hard to distinguish because the patients appear to have refused food and water. *See* Maria Nagle, *Judge Dismisses Charges in Dehydration Death*, J. COURIER (Sept. 9, 2009, 6:20 PM), http://www.myjournalcourier.com/articles/judge-23708-charges-death.html; David Ryan, *Local Nursing Home Sued for Wrongful Death*, NAPA VALLEY REG. (Dec. 12, 2007, 12:00 AM), http://napavalleyregister.com/news/local/article_c25d3389-400a-57b5-a0b5-ac0825d460b9.html.

363. *Nursing Home Dehydration Death Results in $6.5 Million Verdict*, ABOUTLAWSUITS.COM (April 30, 2009), http://www.aboutlawsuits.com/nursing-home-dehydration-death-verdict-3737/. A $628,000 settlement was reached in a False Claims Act case alleging malnutrition and dehydration. *See* Press Release, Dep't of Justice, Cathedral Rock Nursing Homes and a Nursing Home Operator Resolve Criminal and Civil Health Care Fraud Allegations Related to Failure of Care and Agree to Pay the United States Over $1.6 Million (Jan. 7, 2010), http://stlouis.fbi.gov/dojpressrel/pressrel10/sl010710b.htm. In addition, the homes had to enter into a five-year corporate integrity agreement that includes extensive quality-of-care provisions including retention of an independent monitor to assess the effectiveness of the homes' internal quality-control systems. *Id.*

364. *See* Press Release, Office of the Albany Cnty. Dist. Att'y, Three Doctors Agree: Schizophrenia Lead to Death of Mother/Court Allows Carol Adams to Seek Treatment for Mental Illness (Sept. 22, 2008), http://www.albanycountyda.com/press_releases/September_2008/Press%20Releases/92208_adams_plea.htm (reporting that Carol Adams pled not guilty by reason of mental disease to three felony charges for her role in the death of her mother, for whom she was caretaker); John Christoffersen, *2 Accused in Dehydration Death of Connecticut Toddler*, USA TODAY (Apr. 16, 2008, 5:34 PM), http://www.usatoday.com/news/nation/2008-04-16-1281725885_x.htm (reporting that Sharon Patterson was charged with manslaughter upon accusations that she deprived twenty-three-month-old Amari Jackson of fluid for a week as punishment for bed wetting); Lauren C. Williams, *Black Diamond Man Sentenced to Prison in Mother's Death from Bedsores*, SEATTLE TIMES (July 16, 2010, 10:46 PM), http://seattletimes.nwsource.com/html/localnews/2012377633_wise17m.html (reporting that Christopher Wise was sentenced to three years and three months in the death of his eighty-eight-year-old mother).

365. *See* James T. O'Reilly, *Litigating the Nursing Home Case*, 2009 A.B.A. TORT TRIAL & INS. PRAC. SEC. 130-32 (discussing federal and state standards of due care for long-term care residents, and the warning signs associated with dehydration).

366. 42 C.F.R. § 483.20(b)(1)(xi) (2009). To participate in the Medicare and Medicaid programs, nursing homes must be in compliance with the federal requirements for long term care facilities as prescribed in the United States Code of Federal Regulations. *Id.* § 483.5(i). The

"provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident."[367] State law similarly provides criminal penalties for "failing to provide . . . services necessary to preserve the health, safety, or welfare of a care-dependent person for whom he or she is responsible."[368]

The frequent imposition of criminal, regulatory, and civil sanctions for dehydration sends a strong signal.[369] Hearing this signal (albeit amplified and distorted), many physicians practicing in nursing homes do not discontinue ANH even when it has been validly refused because they fear legal sanctions.[370] If there is legal fear here (regarding jurisprudentially better settled ANH), then certainly there is as much, or more, with VSED.

This body of abuse and neglect law is totally distinguishable from VSED on the ground that it is directed at *involuntary,* not voluntary, dehydration and malnutrition.[371] While such statutes might paradigmatically apply when providers *fail* to provide wanted medical care, they do not apply when the medical care provided is unwanted. In one recent case, a patient's family sued Veterans Administration providers for failing to provide "enough nutrition to sustain his life."[372] But the federal court dismissed the claim because the

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regulations are interpreted in the CTRS. FOR MEDICARE & MEDICAID, STATE OPERATIONS MANUAL: APPENDIX PP – GUIDANCE TO SURVEYORS FOR LONG TERM CARE FACILITIES, http://www.cms.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf (last updated Jan. 7, 2011) [hereinafter CMS SOM].

367. 42 C.F.R. § 483.35 (2009); *see also* 42 U.S.C. § 1396r(b)(4)(A)(iv) (2006); DePorter, *supra* note 336, at 301 ("Nursing homes are required to maintain acceptable parameters of nutrition . . . [and] provide sufficient fluid intake to assure proper hydration and health.").

368. 18 PA. CONS. STAT. ANN. § 2713(a)(1) (West 2000).

369. *See, e.g.*, Windsor House, Docket No. C-99-227 (Dep't of Health & Human Servs., Departmental Appeals Board May 12, 2003) (final admin. review) (imposing civil sanctions of $5000 per day for each day the threat to resident's health and safety existed due to a nursing home's nutrition-related deficiencies).

370. *See* MEISEL & CERMINARA, *supra* note 88, at 6-83 – 6-84, 6-86; Alan Meisel, *Barriers to Forgoing Nutrition and Hydration in Nursing Homes*, 21 AM. J.L. & MED. 335, 342, 342 n.36 (1995) [hereinafter Meisel 1995]. Nursing homes are similarly reluctant to allow their residents to VSED. *See, e.g.*, Olivier Uyttebrouck, *Couple Transported Out of Facility After Refusing Food*, ALBUQUERQUE J. (Jan. 8, 2011), http://www.abqjournal.com/news/metro/08232859metro01-08-11.htm (reporting on the eviction of Armond and Dorothy Rudoph from their assisted living facility); Telephone Interview with Judith Schwarz, Regional Clinical Coordinator, Compassion & Choices (Dec. 3, 2010).

371. H Ltd v J & Anor [2010] SASC 176 ¶ 73 (Austl.) ("[T]he failure to provide sustenance will constitute an offence . . . only where there is a duty to provide it . . . . [If the patient refused, the provider] would have a lawful excuse not to provide her with sustenance."). *See also id.* ¶ 74 (When the patient refuses, "the effect will usually be to negate the duty and absolve the person who would otherwise owe the duty from any obligation."); *id.* ¶ 86 (A "provider does not have a responsibility to provide nutrition or hydration where a resident voluntarily and rationally directs the provider not to provide those services.").

372. Butler v. United States, No. 4:07CV00519 JMM, 2009 WL 1607912, at * 3 (E.D. Ark. June 9, 2009).

patient "clearly stated . . . that he did not want life-sustaining measures, which included a feeding tube."[373]

The Medicare and Medicaid Conditions of Participation clearly provide that residents have "the right to refuse treatment."[374] State law also provides that following a patient's or resident's instructions cannot constitute abuse or neglect.[375] While federal and state laws are aimed at protecting vulnerable individuals, these same laws place an even higher priority on honoring patient autonomy.[376] The regulations were never meant to override the right to refuse.[377] In short, while failing to provide adequate nutrition and hydration can constitute abuse and neglect, it constitutes neither when the patient specifically consented.[378] Indeed, providing nutrition and hydration over a patient's objections could constitute abuse.[379]

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373. *Id.* *See also* Nagle, *supra* note 362 (dismissing felony neglect charges where resident refused to eat or drink).

374. 42 C.F.R. § 483.10(b)(4) (2009); Medicare and Medicaid: Requirements for Long Term Care Facilities, 54 Fed. Reg. 5316, 5321 (Feb. 2, 1989) (to be codified at 42 C.F.R. §§ 405, 442, 447, 483, 488, 489, 498) ("When invasive procedures are necessary to accomplish this end [adequate liquids] . . . residents or their representatives may refuse just as they may refuse any other medical treatment."); CMS SOM, *supra* note 366, at § 483.20(k)(3)(ii); DePorter, *supra* note 336, at 301 ("Regardless of the resident's condition, all residents have the right to refuse food . . . . If a resident decides to refuse liquids, he/she has the right to do so. . . . The resident's wishes should be honored.").

375. *See* 18 PA. CONS. STAT. ANN. § 2713(e) (West 2000).

> A caretaker or any other individual or facility may offer an affirmative defense to charges . . . if the caretaker, individual or facility can demonstrate . . . that the alleged violations result directly from . . . the caretaker's, individual's or facility's lawful compliance with a care-dependent person's written, signed and witnessed instructions. . . .

Id.; ARIZ. REV. STAT. ANN. § 13-3623(E)(1) (2001) (stating that child or adult abuse does not apply to "[a] health care provider . . . who permits a patient to die . . . by not providing health care if that patient refuses."); Meisel 1995, *supra* note 370, 351, 351 n.100.

376. *See* 42 C.F.R. § 488.100 (2009) (containing detailed forms that health care providers must complete in order to comply with regulations); *id.* § 483.10(b)(4) (2009) (stating that a resident has a "right to refuse treatment").

377. Medicare and Medicaid: Requirements for Long Term Care Facilities, 54 Fed. Reg. at 5321; MEISEL & CERMINARA, *supra* note 88, at 6-85.

378. The line between respecting the patient's wishes and overriding the patient's wishes may be a fine one. Indeed, as is well documented in the context of pain medication, providers face legal risk at both ends: both for giving too much and for giving too little. *See* Hoffmann, *supra* note 102, at 289. Providers cannot force the patient to drink against his or her will. They also must ensure voluntariness and encourage the patient to drink. This gets awfully close to placing providers in a catch-22. They could be sanctioned for involuntary dehydration and "'[t]hey could also be cited for forcing her to drink against her will, but they at least have to encourage her to drink, they can't just leave her alone and expect her to pick up the glass and drink.'" Ryan, *supra* note 362 (quoting Elizabeth Mautner, Napa County Long-Term Care Ombudsman). *See also* Kiran Chug et al., *Margaret Page Dies in Rest Home After 16 Days*, STUFF.CO.NZ (March 31, 2010, 5:00 AM), http://www.stuff.co.nz/national/%20health/3531192/Margaret-Page-dies-in-rest-home-after-16-days (nursing home staff offered food and

D. Allowing VSED Is Not Assisted Suicide

As discussed above, assisted suicide is illegal in almost all United States jurisdictions.[380] Some argue that "[t]he common elements between facilitation of VSED and assisted suicide make the legal status of VSED somewhat uncertain."[381] Jansen, for example, argues that the deliberate cessation of food and drink is assisted suicide when the individual does not have an irreversible lethal illness.[382] Indeed, in *In re Caulk*, inmate Joel Caulk tried to starve himself to death.[383] Caulk was a "healthy male inmate . . . not suffering from any terminal or life-threatening disease."[384] Consequently, the Supreme Court of New Hampshire distinguished VSED from a paradigm situation involving refusal of life-sustaining medical treatment.[385] Caulk himself, the court noted,

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water to Margaret Page "whenever they went into her room"); Newton, *supra* note 150. A nursing home CEO reported

> the home had done everything in its power to convince Mrs [sic] Page to eat. But it was legally restricted by her right to choose to die. "We've made sure that we've continued to offer [food] and even now we ask if it's still something she wants to do. We've done everything we can."

Id. at A1 (quoting Ralph La Salle, St. John Chief Executive); *Cf.* 42 C.F.R. § 483.35(d)(4) (2009) (requiring only that a substitute be "offered" to a resident who refuses food served); ORAL FEEDING DIFFICULTIES, *supra* note 172, at 44 (requiring that basic care is mandatory only "in the absence of explicit refusal by the patient" and that providers need only make an "offer of oral nutrition and hydration").

379. *See In re* Axelrod, 560 N.Y.S.2d 573, 573 (App. Div. 1990) (affirming a commissioner's determination that a medical employee was guilty of patient abuse where "after the patient refused to take her medication, [employee] held the patient's chin and poured the medication down her throat"). A growing number of cases have allowed recovery of damages where providers performed unwanted breathing assistance. *See, e.g.*, Scheible v. Joseph L. Morse Geriatric Ctr., 988 So. 2d 1130, 1131-32 (Fla. Dist. Ct. App. 2008); Cardoza v. USC Univ. Hosp., No. B195092, 2008 WL 3413312, at *1-2 (Cal. Ct. App. Aug. 13, 2008) (remanding and allowing plaintiff to pursue claim).

380. *See supra* Part II.B.4.

381. Cantor 2006, *supra* note 25, at 416; *see* CHABOT, *supra* note 8, at 14 (stating that some doctors associate the deliberate cessation of nutrition as suicide); *see also* Cantor & Thomas, *supra* note 27, at 97; Bouvia v. Sup. Ct., 225 Cal. Rptr. 297, 307 (Ct. App. 1986) (Compton, J., concurring) (noting that providers were well motivated by a concern that allowing their patient to starve to death could constitute assisted suicide). In 2006, human rights activist Nikhil Soni filed a Public Interest Litigation with the High Court of the Indian state of Rajasthan, claiming that VSED (in its ritual form Santhara) is illegal suicide and those who facilitate it are assisting a suicide. *See* Braun, *supra* note 178, at 913-14, 919; Randeep Ramesh, *Cancer Victim Revered for Fasting to Death*, GUARDIAN (Sept. 29, 2006), http://www.guardian.co.uk/world/2006/sep/29/india.religion.

382. Jansen, *supra* note 168, at 62-64.

383. *In re* Caulk, 480 A.2d 93, 94-95 (N.H. 1984).

384. *Id.* at 96.

385. Other courts similarly permitted intervention with prisoner refusals where the prisoner did not have a life threatening condition. *See supra* note 324; Comm'r of Corr. v. Myers, 399 N.E.2d 452, 456 (Mass. 1979).

"has set the death-producing agent in motion with the specific intent of causing his own death."[386]

But there are four important distinctions between VSED and PAS. Individually and cumulatively, these distinctions overwhelmingly establish that VSED is not suicide. Therefore, assisting VSED cannot be assisted suicide. First, as we argued above, hand feeding is a form of medical treatment.[387] As such, its refusal is specifically and expressly defined, usually statutorily, as not constituting suicide.[388] Moreover, equating the removal of ANH with suicide has been rejected.[389] Given the similarity of hand feeding and ANH, the equation of VSED with suicide should similarly be rejected.

Second, VSED does not constitute "suicide" as that term is used in prohibitions of assisted suicide. Self starvation is not suicide, so failing to prevent it is not assisted suicide.[390] Assisted suicide prohibitions are targeted at active interventions such as the introduction of a lethal agent. VSED, in contrast, entails a passive refusal. The patient's natural state is to dehydrate unless fluids are affirmatively introduced.[391] VSED does not entail the acceleration of this process, but rather the mere absence of action to slow or stop it.[392]

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386. *Caulk*, 480 A.2d at 97.

387. *See supra* Part IV.B.

388. *See* ALASKA STAT. § 13.52.120(b) (2008); CAL. PROB. CODE § 4656 (West 2009); D.C. CODE § 7-628(a) (2001); GA. CODE ANN. § 31-32-11(a) (2009); 755 ILL. COMP. STAT. 45/4-8 (2007); KAN. STAT. ANN. § 65-28,108(a) (2002); MONT. CODE ANN. § 50-9-205 (2007); NEB. REV. STAT. § 20-412(1) (2008); NEV. REV. STAT. § 449.650(1) (2007); OHIO REV. CODE ANN. § 2133.12(A) (LexisNexis 2007); OKLA STAT. tit. 63, § 3101.12(A) (2004); R.I. GEN. LAWS § 23-4.10-9(a) (2008); TENN. CODE ANN. § 68-11-1814(b) (2006); H Ltd v J & Anor [2010] SASC 176 ¶ 59 (Austl.) ("[A] competent adult is not under a duty to take life sustaining medication and . . . a refusal to do so is therefore not suicide. Once that proposition is accepted it is difficult to maintain the proposition that self starvation is suicide as a matter of logic . . . .") (footnote omitted). *But see* ALA. CODE § 22-8A-9(a), (b) (LexisNexis 2006) (specifically providing that withholding or withdrawing "artificially provided nutrition and hydration" shall not "constitute a suicide and shall not constitute assisting suicide;" thereby implying that non-artificially provided nutrition and hydration is not included within the exception).

389. Meisel 1995, *supra* note 370, at 337-38, 337-38 nn. 17-19, 354 n.112.

390. H Ltd v J & Anor [2010] SASC 176 ¶ 67 (Austl.).

391. *See supra* Part III.C.

392. One might argue in response that the argument for permitting a healthcare provider to deprive a patient of water would also permit a provider to deprive the patient of air. After all, oxygen deprivation through a face mask or hood and helium is a mechanism used by assisted suicide organizations as an alternative to sodium pentobarbital. NITSCHKE & STEWART, *supra* note 131, at 42-49 (describing detailed information on the exit bag as a means of achieving hypoxic death); *id.* at 73-87 (detailing the use of carbon monoxide as a means of euthanasia); DEREK HUMPHRY, FINAL EXIT: THE PRACTICALITIES OF SELF-DELIVERANCE AND ASSISTED SUICIDE FOR THE DYING 123-28 (3d ed. 2002); Russel D. Ogden et al., *Assisted Suicide by Oxygen Deprivation With Helium at a Swiss Right-to-Die Organisation*, 36 J. MED. ETHICS 174, 174 (2010); *Helium in an 'Exit Bag' New Choice for Suicide*, VANCOUVER SUN (Dec. 8, 2007), http://www.canada.com/vancouversun/news/story.html?id=ce4139ae-d635-4030-ac92-a7b7d6fab09d. But this is not a *passive* failure to provide oxygen such as through a mechanical

Admittedly, the active-passive distinction has been widely attacked.[393] But the distinction has been endorsed by the United States Supreme Court.[394] And it was endorsed by the Supreme Court specifically because it has been consistently accepted by courts and legislatures across the United States. The act-omission distinction is, as the Court explained, deeply embedded in "our Nation's history, legal traditions, and practices."[395]

Third, the distinction between VSED and assisted suicide comports with the legal principle of intent. A healthcare provider who honors a patient's request for VSED "intends, or may so intend, only to respect his patient's wishes."[396] In the ordinary case of murder by positive act of commission, the consent of the victim is no defense. But where the charge is one of murder by omission to do an act, and the act omitted could only be done with the consent of the patient, refusal by the patient of consent to the doing of such act does, indirectly, provide a defense to the charge of murder. The doctor cannot owe to the patient any duty to maintain his life where that life can only be sustained by intrusive medical care to which the patient will not consent.[397]

While the physician need not honor a request for affirmative assistance ("making [the] patient die"), the physician must honor the patient's refusal ("letting [the] patient die").[398] Unlike a request for PAS, a request for VSED is grounded "on well-established traditional rights to bodily integrity and freedom from unwanted touching."[399]

Fourth, the distinction between VSED and assisted suicide comports with the legal principle of causation. When "a patient ingests lethal medication prescribed by a physician, he is killed by that medication."[400] But, according to the way in which the refusal of ANH has been traditionally explained, when a patient refuses nutrition and hydration, "he dies from an underlying fatal disease or pathology."[401]

The lives of those patients with a terminal or irreversible illness are obviously already endangered.[402] But VSED causation works the same way for other patients too. The typical person loses 2.5 liters of water each day:

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ventilator. Instead, this is affirmatively impeding the individual's ability to breathe air in the room. Suffocation, by the introduction of helium or carbon monoxide, is an *act* not an omission.

393. *See* Quill v. Vacco, 80 F.3d 716, 729 (2d Cir. 1996), *rev'd*, 512 U.S. 793 (1997); Brief for Ronald Dworkin et al. as Amici Curiae Supporting Respondents, Washington v. Glucksberg, 521 U.S. 702 (1997) (No. 96-110), 1996 WL 708956, at *10-11.

394. Vacco v. Quill, 521 U.S. 793, 807 (1997) (finding rational the distinction between assisted suicide and refusing medical treatment); Washington v. Glucksberg, 521 U.S. 702, 725-26 (1997) (distinguishing the "right to refuse" from the "right to assistance"). *Cf.* MEISEL & CERMINARA, *supra* note 88, at 12-29 – 12-30; Cantor & Thomas, *supra* note 27, at 104-05.

395. *Glucksberg*, 521 U.S. at 710.

396. *See Vacco*, 521 U.S. at 801.

397. Airedale NHS Trust v. Bland [1993] All E.R. 821, at 882 (Eng.).

398. *Vacco*, 521 U.S. at 807.

399. *Id.*

400. *Id.* at 801.

401. *Id.*

402. *See* Rebecca Dresser, *Suicide Attempts and Treatment Refusals*, HASTINGS CTR. REP., May-June 2010, at 10, 10-11.

through the kidneys as urine, through the skin as sweat, and through the lungs as water vapor.[403] This is a natural and automatic process that will, as described above,[404] eventually lead to the person's death. VSED does not cause this process; it is simply the omission of action to reverse it.[405] Moreover, the intent and consequence of the provider's actions are to provide comfort and reduce suffering. Death is an incidental byproduct, a double effect.

V. VSED IS OFTEN AN OPTION EVEN FOR INDIVIDUALS WITHOUT CAPACITY

Many proponents of VSED believe that it is an option only "when the patient retains mental capacity."[406] Indeed, this limitation was recently recounted in a New York Times online feature:

> I have always assumed that what my mother chose to do herself, I could have insisted upon for her, as her health care proxy. In other words, if she were no

403. *See* INDU KHURANA, TEXTBOOK OF MEDICAL PHYSIOLOGY 545 (2006) (indicating that the human body has an average intake and outtake of 2500 milliliters/day).

404. *See supra* Part III.C.

405. *See* Compassion in Dying v. Washington, 49 F.3d 586, 594 (9th Cir. 1995), *rev'd* 521 U.S. 702 (1997):

> Protected by the law of torts, you can have or reject such medical treatment as you see fit. . . . [But tort law has] never recognized a right to let others . . . kill you . . . . [Y]ou ask for more than being let alone . . . . The difference is not of degree but of kind. You no longer seek the ending of unwanted medical attention. You seek the right to have a second person collaborate in your death.

Id.; People v. Kevorkian, 527 N.W.2d 714, 728 (Mich. 1994).

> [W]hereas suicide involves an affirmative act to end a life, the refusal or cessation of life-sustaining medical treatment simply permits life to run its course, unencumbered by contrived intervention. Put another way, suicide frustrates the natural course by introducing an outside agent to accelerate death, whereas the refusal or withdrawal of life-sustaining medical treatment allows nature to proceed, i.e., death occurs because of the underlying condition.

Id. (footnote omitted); *But cf.* Neil M. Gorsuch, *The Right to Assisted Suicide and Euthanasia*, 23 HARV. J.L. & PUB. POL'Y 599, 645 (2000) (using this as an example of how the "act-omission distinction is . . . subject to manipulation"). Admittedly, it seems like a stretch to characterize the body's ever present need for fluid replenishment as an underlying pathology that cases death. But it is literally true. Moreover, we aim to show that this is consistent with the causation analysis applied to ANH. To the extent the argument is intuitively unappealing, that is due to the already-distorted, though accepted, logic in ANH analysis.

406. Quill, *supra* note 25, at 19; *see also* Cochrane, *supra* note 282, at 50 ("A right to refuse [oral nutrition and hydration] on behalf of a decisionally incapable patient is not widely recognized at the present time . . . ."). Certainly, this may be hard to establish on a best interests standard. ANNALS OF LONG TERM CARE, *supra* note 174.

> longer "decisionally capable," though not on the brink of death, I could have told the staff to stop spooning food into her mouth or bringing the straw to her lips, and they would have listened to me as her surrogate. . . . [T]his isn't so.[407]

The author concluded: VSED "should be considered a viable option only for cognitively intact men and women."[408]

But this conclusion is too sweeping. Incapacitated patients generally have the same right to refuse as patients with capacity.[409] Therefore, if a patient can contemporaneously engage in VSED, then a patient should be able to request it in advance.[410] We recognize that this position deserves more argumentation and attention. But while we do not provide that analysis here, we do briefly describe several key substantive and procedural limitations on advance VSED.

A. General Rule for Substitute Decision Making

As we discussed above, patients have an almost unlimited right to refuse treatment. Yet those conditions under which many patients would want to refuse treatment (such as a vegetative state or severe dementia) do not permit patients to make a voluntary contemporaneous decision.[411] Many patients at the end of life lack the capacity to make their own healthcare decisions.

Fortunately, because of the value placed on autonomy and self-determination, mechanisms have been devised through which an individual's autonomy is protected and promoted.[412] Courts and legislatures have recognized the patient's right to refuse through prior instructions or through a substitute decision maker. While they still retain capacity, patients can determine the circumstances under which VSED should (later) be implemented.[413] These wishes could be accomplished through the

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407. Jane Gross, *What an End-of-Life Adviser Could Have Told Me*, N.Y. TIMES, THE NEW OLD AGE (Dec. 15, 2008, 10:30 AM), http://newoldage.blogs.nytimes.com/2008/12/15/what-an-end-of-life-advisor-could-have-told-me/. Gross does note that "[o]ther end-of-life experts are less certain but know of no test cases." *Id.*

408. *Id.*

409. *See* MEISEL & CERMINARA, *supra* note 88, at 2-5, 2-17; Cochrane, *supra* note 282, at 51 ("[I]ncapacitated patients retain all of their prior rights . . . ."). There are complicated philosophical and metaphysical issues with advance VSED, especially for dementia patients. *See* Osamu Muramoto, *Socially and Temporally Extended End-of-Life Decision-Making Process for Dementia Patients*, J. MED. ETHICS (forthcoming 2011); Stephen R. Latham, *Living Wills and Alzheimer's Disease*, 23 QUINNIPIAC PROB. L.J. 425, 429-31 (2010).

410. *See* Shepherd 2006, *supra* note 26, at 338.

411. *See* Norman L. Cantor, *The Straight Route to Withholding Hand-Feeding and Hydration*, AM. J. BIOETHICS, Apr. 2009, at 57, 58.

412. *See* Pope 2010, *supra* note 90, at 189, 205.

413. One very interesting mechanism for doing this was thought up by Dr. Stanley Terman. Dr. Terman came up with a system of cards that would help a person determine whether or not life would be worth living in the presence or absence of a certain event. For example, a card might say "I can no longer bathe myself," or "I can no longer recognize my children." *See* Stanley A. Terman, *My Way Cards*, CARING ADVOCATES, http://caringadvocates.org/MyWayCards/ (last visited February 2, 2011). The person, before becoming incapacitated, would categorize the cards in two piles. One pile would be of cards

appointment of an effective surrogate decision maker.[414] Or it might be done through written instructions in an advance directive.

For example, one such advance directive provides:

> If I ever suffer irreversible central nervous system damage to the point that I do not recognize my family, I believe that it would be best for me to die. . . . [D]o not place food or water in my mouth. Instead, place it on my bed table. If I feed myself, I live another day; if I do not, I will die and that is fine.[415]

B. Substantive and Procedural Limitations

While patients can generally exercise prospective autonomy to the same extent to which they can exercise contemporaneous autonomy, the law imposes some limitations on the exercise of prospective autonomy. With respect to VSED, there are two substantive and two procedural limitations.[416]

The first substantive limitation on refusing treatment on behalf of incapacitated patients is that advance directive statutes often require the satisfaction of certain medical prerequisites, such as a diagnosis of terminal condition or permanent unconsciousness.[417] Patients who would not want to live with severe dementia may not be able to choose VSED for their later demented selves, because those selves may not be terminally ill.

The second substantive limitation is that many states have special limitations on consent by substitute decision makers to forgo artificial nutrition and hydration.[418] These range from an absolute bar to required

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which contain an averment that the person considers essential to continue life. For example, if the card says "I can no longer recognize my children," and the person believes that the failure to recognize her own children would be a circumstance under which she would no longer want to live, she would place that card in the first pile. The other pile would consist of cards which contain tasks or functions, the loss of which would not make the person want to die. This process assists people in setting up concrete circumstances under which they would not want to live. Once those circumstances are determined, they can be memorialized in an advance directive. This can occur along with instructions to discontinue treatment if, say, three of the conditions are met, or one, or all. This gives the person autonomy in the decision making process even though a surrogate might be charged with making the contemporaneous decision.

414. McNeil, *supra* note 262 ("[D]octors sometimes do surreptitiously agree to requests by family members for death by dehydration . . . .").

415. William A. Hensel, *My Living Will*, 275 JAMA 588, 588 (1996).

416. Even in these states, it is unclear that the statutes are an insuperable obstacle. *See, e.g.*, *In re* Guardianship of Browning, 568 So. 2d 4, 9, 12 (Fla. 1990) (holding that while there was no statutory right to remove feeding tube, there was a constitutional right); Meisel 1995, *supra* note 370, at 356, 356 nn.126-28 (stating that restrictions "can probably be circumvented"). Still, perhaps it is the practical considerations such as medical provider fear and legal uncertainty, as discussed above, that are the true obstacles.

417. Sabatino, *supra* note 30, at 221; Pope, *supra* note 30.

418. When Terri Schiavo's surrogate authorized the withdrawal of CANH, protestors charged that she was being "starved" to death. Shepherd 2006, *supra* note 26, at 326-27. Many states introduced bills similar to Florida's "Starvation and Dehydration of Persons with Disabilities Prevention Act". *Id.* at 327-28.

diagnostic preconditions.[419] Although some states, like California,[420] have broadly defined the right to refuse to include any care, other states have narrowly defined the right of surrogates to refuse life-sustaining treatment as applying only to artificial or mechanical interventions.

Statutes in these states specifically prohibit the forgoing of "normal feeding procedures" through an advance directive or surrogate decision maker.[421] For example, New Hampshire law provides that "[u]nder no conditions will your health care agent be able to direct the withholding of food and drink that you are able to *eat and drink normally*."[422] Missouri law similarly provides that "no attorney in fact may, with the intent of causing the death of the patient, authorize the withdrawal of nutrition or hydration which the patient may ingest *through natural means*."[423]

In addition to these two substantive limitations, there are also two procedural limitations. First, there is a good deal of skepticism about the accuracy of substitute decision makers.[424] Consequently, surrogate decision makers requesting the cessation of nutrition and hydration must meet substantially higher evidentiary hurdles.[425]

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419. Sabatino, *supra* note 30, at 221.

420. CAL. PROB. CODE § 4615 (West 2009) (defining "'Health care" as "any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a patient's physical or mental condition.").

421. *See, e.g.*, WIS. STAT. ANN. § 155.20(4) (West 2010) ("A health care agent may not consent to the withholding or withdrawal of orally ingested nutrition or hydration unless . . . medically contraindicated."); MEISEL & CERMINARA, *supra* note 88, at 7-97. *But see* MD. CODE ANN., HEALTH-GEN. § 5-611(d) (LexisNexis 2009) (requiring a healthcare provider to make only "reasonable efforts to provide an individual with food and water by mouth").

422. N.H. REV. STAT. ANN. § 137-J:19 (2005) (emphasis added). New Hampshire also defines both "life-sustaining treatment" and "medically administered nutrition and hydration" as specifically not including "natural ingestion of food or fluids by eating and drinking." *Id.* § 137-J:2(XIII) & (XV). Oregon defines "health care" as including only "*artificially* administered nutrition and hydration," which is itself defined as not including "the provision of nutrition and hydration by cup, hand, bottle, drinking straw or eating utensil." OR. REV. STAT. § 127.505(4) & (7) (2007) (emphasis added). Nebraska similarly defines "[h]ealth care decision" and "[l]ife-sustaining procedure" as not including "the usual and typical provision of nutrition and hydration." NEB. REV. STAT. § 30-3402(5) & (8) (2001). In turn, "usual and typical provision of nutrition and hydration" is defined as "delivery of food and fluids orally, including by cup, eating utensil, bottle, or drinking straw." *Id.* § 30-3402(14). *Cf.* MASS. GEN. LAWS ANN. ch. 201D, § 13 (West 2004) ("Nothing in this chapter shall preclude . . . non-artificial oral feeding . . . ."). The British medical licensing board issued guidance warning that "an advance refusal of food and drink has no force." GEN. MED. COUNCIL, *supra* note 166, at 52 n.31.

423. MO. REV. STAT. § 404.820(2) (2001) (emphasis added). In 2010, Missouri legislators introduced a bill that would prohibit even the withdrawal of artificial nutrition and hydration for sixty days during which providers must engage in "rehabilitative efforts regarding the patient's swallowing reflexes" and during which "oral feeding is offered to the patient at least three times per day." H.B. 1235, 95th Gen. Assemb., Reg. Sess. (Mo. 2010). *See also* H.B. 1178, Gen. Assemb., 2009-2010 Reg. Sess (Ga. 2010) (stating that a physician "[u]nder no circumstances shall . . . deprive a person receiving health care of nourishment or hydration unless . . . [it] is necessary as part of such person's medical treatment").

424. *See* Pope 2010, *supra* note 90, at 215-17.

425. In the wake of the Terri Schiavo case, many state legislatures introduced bills with titles such as the "Starvation and Dehydration of Persons with Disabilities Prevention

The second procedural hurdle concerns the concept of revocation. Advance directives and surrogate appointments can be revoked by the patient. Revocation is typically straightforward when dealing with a patient with capacity. But what exactly constitutes revocation from an incapacitated patient?[426] A severely demented patient might appear to request or desire food and water. Does a gesture such as pointing to one's mouth constitute a revocation of the patient's earlier (capacitated) instruction to not assist feeding under those circumstances?[427]

VI. CONCLUSION

Healthcare providers' concerns regarding the legality of VSED are misplaced. Providers not only *may* but also *should* honor appropriate patient requests for VSED. Furthermore, providers should educate patients that VSED is an available treatment alternative. Informed consent requires more than just acceding to a decision to refuse treatment. It also requires making patients aware of their end-of-life options in the first place.[428] "Physicians should educate their patients…that [VSED] is an acceptable alternative. . . ."[429]

Act." *See, e.g.*, Assemb. B. 2173, 213th Leg., Reg. Sess. (N.J. 2008). *But see* Consent to Medical Treatment and Palliative Care (Voluntary Euthanasia) Amendment Bill 2008 (Austl.) (bill introduced "to allow certain adult persons . . . who are in the terminal phase of a terminal illness . . . to end their suffering by means of voluntary euthanasia . . . .")

426. *See* H Ltd v J & Anor [2010] SASC 176 ¶ 91 (Austl.) ("If the direction is withdrawn or revoked . . . the duties will again be enlivened. . . . [T]he absolution of [the provider] from its responsibilities depends on it continuing to believe on reasonable grounds that the direction has not been withdrawn or revoked.").

427. *See generally* VT. STAT. ANN. tit. 18, § 9707(h) (West 2010) ("An advance directive . . . may contain a provision permitting the agent, in the event that the principal lacks capacity, to authorize or withhold health care over the principal's objection."); H.B. 2396, 2009 Gen. Assemb., Reg. Sess. (Va. 2009), *enacted as* 2009 Va. Acts Ch. 211 & 268 (codified at VA. CODE ANN. §§ 54.1-2982 to 54.1-2992 (2009) (authorizing an individual to make certain choices, though not regarding life-sustaining treatment, in an advance directive that are binding even if the individual later objects to those choices when lacking capacity; allowing a patient's agent or other decision maker to make treatment decisions, even when the incapacitated patient protests).

428. Assemb. B. 2747, 2007-2008 Leg., Reg. Sess. (Cal. 2008), *codified at* CAL. HEALTH & SAFETY CODE § 442.5 (West 2010); H.B. 435, 2009-2010 Leg., 70th Sess. (Vt. 2009) (Patients' Bill of Rights for Palliative Care and Pain Management), *enacted as* 2009 Vt. Acts & Resolves 159 (codified at VT. STAT. ANN. tit. 18 § 1871 (2009)); S.B. 4498, 2009-2010 Leg., Reg. Sess (N.Y. 2009) (codified at N.Y. PUB. HEALTH LAW § 2997-c (McKinney 2007); S.B. 1311, 49th Leg., Reg. Sess. (Ariz. 2009). VSED is not specifically mentioned in these bills and statutes, but the relevant regulators could and should construe VSED to be encompassed within the duty imposed. A recently-filed lawsuit seeks damages from providers for failing to inform about PSU in accordance with the doctrine of informed consent and the California Right to Know End-of-Life Options Act. Complaint at 4, 8, Hargett v. Vitas Healthcare Corp., No. RG10547255 (Cal. Super. Ct. Nov.18, 2010).

429. BERNAT, *supra* note 9, at 216; Byock, *supra* note 160, at 12 ("[T]he patient remains entitled to accurate medical information about the options available to them."); Bernard

The situation is less clear when the VSED request is made by a surrogate instead of by the patient herself. But in many jurisdictions such a decision has the same status.

Cantor and Thomas may be correct in predicting that judicial intervention in VSED cases is unlikely. Judges would likely find it "demeaning and inhumane" to order restraints and feeding for a patient "enmeshed in an inexorable dying process."[430] But this prediction, even if accurate, has been, and remains, insufficient to assuage provider concerns. Many providers are reluctant to tell patients that VSED is an option.[431] And many providers remain reluctant to honor requests for VSED. Education regarding legal rights, responsibilities, and risks may be insufficient.[432] Consequently, it may be necessary both to mandate disclosure of VSED as an option and to clarify safe harbor protection for supervising and supporting it.

Gert et al., *Physician Involvement in Voluntary Stopping of Eating and Drinking*, 137 ANNALS INTERNAL MED. 1010, 1011 (2002) (Letter to the Editor) ("Physicians may refer patients to another physician . . . but they should not impose their own . . . moral views on patients by refusing to inform them of their legally sanctioned options."); Quill et al., *Last-Resort Options*, *supra* note 40, at 422 ("[P]atients and their families deserve to know the full range of palliative options available to them."); Quill et al., *Palliative Options*, *supra* note 39, at 60 (arguing that physicians should "discuss all available alternatives"); Schwarz 2007, *supra* note 40, at 1296 ("VSED information ought to be provided when provision of comprehensive palliative care is unable to relieve suffering that the terminally ill patient finds intolerable, and other palliative options . . . are . . . inappropriate . . . [or] unacceptable to the patient."). It is not clear exactly at what point in the patient's illness this would be most appropriate. Kevin B. O'Reilly, *California Bill Would Mandate Discussions of End-of-Life Options*, AM. MED. NEWS (July 14, 2008), http://www.ama-assn.org/amednews/2008/07/14/prsc0714.htm (discussing California proposal requiring doctors to inform patients with a life expectancy of one year or less about their end-of-life options).

430. Cantor & Thomas, *supra* note 27, at 101-02.

431. CHABOT, *supra* note 8, at 28.

432. *See* Johnson, *supra* note 31, at 1009-15 (examining how education may be insufficient to decrease physicians' fears of the law regarding certain treatments).