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Terminal Sedation: A Legal and Necessary Solace

Peter Aaron Chacanias

Peter Chacanias

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I. Introduction

I was only fourteen-years-old when I had my first real encounter with death. My grandmother (on my mother's side) had gone into the hospital for surgery, and she never quite came back out. She was going in for some form of surgery on her back. My grandmother had been afflicted with scoliosis for many years, and as time progressed complications due to her scoliosis did something to the nerve-endings in her back, leaving her in a constant state of back pain. Sometimes the pain was so excruciating that she could barely walk. As such, she chose surgery to fix the problem. However, something went wrong. During the surgery, while she was under a general anesthetic, my grandmother suffered a series of strokes that left her in a comatose state. She could no longer breathe on her own or feed herself; her doctors put her on a respirator and provided her with a feeding tube.

I remember the first time I went to visit her in the hospital. My father was waiting for my sister and me when we returned home from school that day. My mother was already at the hospital. As my sister and I drove to the hospital with my father, I remember him trying to prepare us for what we were about to see, while at the same time keeping in mind that we were both still teenagers who had never really encountered death before. We arrived at the hospital just as the sun was beginning to set. I vividly remember walking into my grandmother's room. First, I saw my grandfather. He looked exhausted. The skin around his eyes was so dark it

looked almost bruised, and his normally caring brown eyes were bloodshot. The same was true for my uncle. Then I saw my mother. Her cheeks were stained with tears that she hastily wiped away once she caught a glimpse of my sister and me. Her chestnut-colored eyes, however, remained watery. She walked up and gave each of us a gentle hug. It was then that I saw my grandmother, and it was a sight I will never forget.

Her eyes were open, but they were blank and seemed glued to the ceiling above her, as if she was stuck in a daze that she just could not shake. Her skin was pasty white, and in some places looked almost yellowish. Her chest rose and fell steadily, but every time it did I heard the respirator. I was so shocked that I almost envied her the respirator; for once I looked at her I could barely breathe. 'That can't be her,' I remember thinking to myself. 'That can't be my grandmother.' To this day some part of me still thinks that. My grandmother was a warm, loving, gentle soul, and one of few who could honestly say (but never would) that she cared for others more than for herself. This was not my grandmother. But it was, and she remained like that for a few weeks before my mother, uncle, and grandfather – her daughter, son, and husband – were finally willing to concede to what the doctors had told them: that things were not going to get better for my grandmother. I was not there when the respirator was removed. Thankfully, my mother said later, my grandmother did not seem to struggle or suffer any pain when it was. She died soon after, at the age of sixty-four.

This paper will address "terminal sedation," which, thank God, was not necessary for my grandmother. But it gets me thinking, 'What if my grandmother was conscious following the botched surgery?' 'What if she was able to feel everything?' 'What if she was able to breathe on her own?' 'What if she had looked at my mother, my grandfather, my uncle, my father, or even me, with sad, desperate eyes, begging us to put her out of her misery?' That it is what, or

better yet, whom this paper concerns: all those fully conscious, fully competent, terminally ill patients whose final days are filled with intolerable suffering – whether it is physical, mental, and/or emotional. These patients – suffering, terminally ill patients – must be granted the option of "terminal sedation." Furthermore, the law must make efforts to distinguish between "terminal sedation" and what has been termed as "slow euthanasia." Such a distinction can and must be found in the principle of double effect, for according to this principle, a physician who administers a sedative that will render a certain patient unconscious until death is doing so not to cause and/or hasten death, but to relieve intolerable end-of-life suffering.

This paper will begin by exploring the concept of "suffering" and what that entails, for it can refer to either physical and/or psychological pain, and then it will define what it means to be "terminal," or terminally ill. Next, this paper will define "terminal sedation" and describe what specific steps comprise the practice, and in doing so will attempt to clarify some confusion that seems to surround the procedure. After that, this paper will describe how the law currently views terminal sedation. More specifically, this paper will look at three Supreme Court cases: *Vacco v. Quill*, *Washington v. Glucksberg*, and *Cruzan v. Director of Missouri Department of Health*. This paper will briefly outline these cases and show that not only did the Court acknowledge the existence of a "right to die," or at the very least a "right to refuse medical treatment," in *Cruzan*, but that the Court also "tacitly endorsed"[1] terminal sedation itself in the other two cases. This paper will then define "euthanasia," or "slow euthanasia" – a phrase that some critics have applied to terminal sedation – and, relying primarily on the law's constant focus on intent, seek to distinguish the two practices. It is here where this paper will define the principle of double effect, a principle that relies chiefly on the physician's intent, and in doing so will discuss how

[1] Rob McStay, *Terminal Sedation: Palliative Care for Intractable Pain, Post Glucksberg and Quill*, 29 AM. J.L. & MED. 45, 45 (2003).

this principle is the way in which physicians and commentators can and must distinguish between terminal sedation and euthanasia.

Finally, this paper will explain **why** the law must distinguish between terminal sedation and euthanasia, and emphasize that State, and the Federal, legislatures must craft laws that preserve the option of terminal sedation for suffering, terminally ill patients.

II. Definitions of Terms: Suffering, Terminal, and Terminal Sedation

This paper posits that suffering, terminally ill patients must be given the option of terminal sedation as a part of their end-of-life care. But before describing terminal sedation, what it entails, and why it must be an option for suffering, terminally ill patients, one must first define what it means to be a "suffering, terminally ill" patient. Suffering, or "to suffer," is defined in *Black's Law Dictionary* as "to experience or sustain physical or emotional pain, distress, or injury."[2] Furthermore, "to suffer" is described by certain online sources as "to undergo or feel pain or distress…to undergo, be subjected to, or endure (pain, distress, injury, loss, or anything unpleasant)."[3] Yet another definition is that of Merriam-Webster, where "to suffer" is defined as "to experience pain, illness, or injury; to experience something unpleasant."[4] All of these definitions are pretty much unanimous. Suffering deals with pain: physical, mental, and/or emotional pain.

However, it is also worth noting that suffering, while real, especially when arising "from sources external to the person – from the injury or disease," is largely subjective to the individual.[5] Or as Eric J. Cassell points out in his book, *The Nature of Suffering*, "Suffering is

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[2] BLACK'S LAW DICTIONARY 728 (4th pocket ed. 2011).
[3] *Suffer Definition*, DICTIONARY.COM, http://dictionary.reference.com/browse/suffer (last visited Dec. 4, 2013)
[4] *Suffer Definition*, MERRIAM-WEBSTER ONLINE, http://www.merriam-webster.com/dictionary/suffer (last visited Dec. 4, 2013).
[5] ERIC J. CASSELL, THE NATURE OF SUFFERING AND THE GOALS OF MEDICINE 48 (1991).

ultimately a personal matter – something whose presence and extent can only be known to the sufferer."[6] Cassell also stresses "Although pain and suffering are closely identifiable in the minds of most people and in the medical literature, they are phenomenally distinct."[7] More specifically,

> People in pain frequently report suffering from pain when they feel out of control, when the pain is overwhelming, when the source of the pain is unknown, when the meaning of the pain is dire, or when the pain is apparently without end. In these situations, persons perceive pain as a threat to their continued existence…That this is the relation of pain to suffering is strongly suggested by the fact that suffering can often be relieved *in the presence of continued pain*, by making the source of the pain known, changing its meaning, and demonstrating that it can be controlled and that the end [of it] is in sight.[8]

Futhermore, Cassell claims that whether or not a person will suffer as a result of a disease, even a painful one, largely depends on that person's life experiences and the attitude resulting from them. Put in his words, "Life experiences – previous illness, experiences with doctors, hospitals, medications, deformities and disabilities, pleasures and successes, or miseries and failures – form the background for illness. The personal meaning of the disease and its treatment arise from past as well as the present."[9] For example, "If cancer occurs in a patient with self-confidence resulting from many past achievements, it may give rise to optimism and a resurgence of strength." However, "The outcome would be [very] different," Cassell points out, "in a person for whom life had been a succession of failures."[10]

This is not to say that Cassell rejects the idea that physical pain, while distinct from suffering, can be so excruciating as to be overwhelming to a patient. In fact, he points out that

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[6] *Id.* at 35.
[7] *Id.*
[8] *Id.* at 36.
[9] *Id.* at 38.
[10] *Id.*

suffering frequently follows intolerable physical pain even when the source of the pain is known – "the pain of a dissecting aortic aneurysm is of that type."[11] And pain at the end of life, due to a terminal illness, is sometimes found to be particularly excruciating. More specifically,

> At the end stage of life, terminally ill patients may develop intolerable symptoms of pain, shortness of breath, agitated delirium or persistent vomiting that are refractory to the usual therapies. Intolerable pain may be caused by a number of conditions, including cancer that has spread to the spine…intestinal obstruction, or severe headache due to massive…build-up of fluid in the brain. Intolerable shortness of breath also may be cause by a number of conditions, including emphysema, lung and other cancers, and congestive heart failure.[12]

So, even if one is to accept Cassell's idea that "suffering," while usually stemming from some form of physical stimuli, is its own entity and largely subjective, this does not change the fact that patients suffering from a terminal disease frequently suffer as a result of physical pain that is overwhelming. And it is very possible for that pain to be intensified, or possibly take on a psychological or emotional aspect, when coupled with the knowledge that one is terminal.

The use of the word "terminal" is usually used to describe "those at 'the threshold of death' or those 'facing imminent and inevitable death.'"[13] Medically, however, the word "terminal" is often used to describe "a condition or illness that will result in death within six months' time."[14] In other words, if a patient, due to some disease, has six months or less to live, than that patient is considered to be "terminal," or terminally ill. However, there is a small amount of controversy over what it means to be "terminal." This controversy usually revolves around whether or not physicians can, on a consistent basis, accurately predict how much longer

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[11] *Id.* at 36.

[12] David Orentlicher, *The Supreme Court and Terminal Sedation: Rejecting Assisted Suicide, Embracing Euthanasia*, 24 HASTINGS CONST. L.Q. 947, 954-955 (1997).

[13] Yale Kamisar, *Are the Distinctions Drawn in the Debate About End-of-Life Decision Making "Principled"? If Not, How Much Does It Matter?*, 40 J.L. MED. & ETHICS 66, 74 (2012).

[14] *Id.*

a certain patient has left to live. For example, George P. Smith, II writes,

> Legislative definitions may be proffered for what is a terminal medical condition, and may include incurable and irreversible conditions that "within reasonable medical judgment" will…cause death "within a reasonable period of time"…Depending…of course, upon individual patient profiles and disease etiologies, medical judgment will vary as to when conditions are terminal.[15]

In other words, according to commentators such as Smith, legislatures can offer up all of the definitions they want as to what it means to be "terminal," but the simple fact of the matter is that whether or not a patient is terminal, or whether or a not a physician believes a patient to be terminal, depends upon too many factors. Thus, it is likely that even if the medical profession is given a specific definition of "terminal" by the legislature – e.g., when a patient has an incurable and irreversible condition that will eventually kill him or her within six months – "medical judgment will [still] vary as to when conditions are terminal" due to factors like "patient profiles and disease etiologies."[16]

To fix the problem, commentators like Smith offer alternatives. For example, "One approach to resolving this quandary is to be found in wider acceptance of the doctrine of medical futility. By utilizing 1 of 5 operative standards under this doctrine, a physician could conclude that a patient's condition is indeed terminal and proceed to…palliation options."[17] The five operative standards are: (1) where a cure is physiologically impossible, (2) when continued treatment is non-beneficial, (3) when a desired or positive benefit is unlikely to be achieved, (4) when a particular treatment, although plausible, has yet to be validated, and (5) when a

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15 George P. Smith, II, *Terminal Sedation as Palliative Care: Revalidating a Right to a Good Death*, 7 CAMBRIDGE Q. HEALTHCARE ETHICS 382, 384 (1998).
16 *Id.*
17 *Id.*

determination is made that a course of treatment is either quantitatively or qualitatively futile.[18] According to Smith, depending on which standard a physician chooses, if it is indeed that case that, for example, "a cure is physiologically impossible," then a patient is terminal and "a physician is freed ethically from pursuing further medical treatment."[19]

Whatever one's definition of a "suffering, terminally ill" patient, the fact remains that for those fully conscious and fully competent patients who are suffering and terminally ill, terminal sedation must be one of their palliation options. This then begs the question: What is terminal sedation? This, similar to the definition of "terminal" itself, is subject to some controversy because the phrase "terminal sedation" has been used to describe different practices. However, all of them have at least one thing in common, and that is the administering of certain drugs, such as narcotics, benzodiazepine sedative drugs, barbiturates, and/or major tranquilizing drugs to sedate a patient.[20] In other words, terminal sedation is "the induction of an unconscious state [through the administration of these drugs] to relieve otherwise intractable distress, and is frequently accompanied by the withdrawal of any life-sustaining intervention [although this is not required]…This practice is a clinical option of 'last resort' when less aggressive palliative care measures have failed."[21] The state of unconsciousness, or sedation, is "maintained until the patient dies."[22]

The rendering of an unconscious state through the administration of drugs until the patient dies is not what is controversial about "terminal sedation." What is controversial about it

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[18] *Id.*

[19] *Id.*

[20] David Orentlicher, *The Supreme Court and Terminal Sedation: Rejecting Assisted Suicide, Embracing Euthanasia*, 24 HASTINGS CONST. L.Q. 947, 955 (1997).

[21] Rob McStay, *Terminal Sedation: Palliative Care for Intractable Pain, Post Glucksberg and Quill*, 29 AM. J.L. & MED. 45, 45 (2003).

[22] Orentlicher, *Supreme Court and Terminal Sedation*, *supra* note 20.

is that the induction of this unconscious state until death is usually, as mentioned earlier, accompanied by the removal or withholding of certain of life-sustaining treatments. And usually, this life-sustaining treatment is that of artificial hydration and nutrition. For once a patient is put under, he or she is unable to feed his or herself, thereby requiring the artificial provision hydration and nutrition so that the patient may live until the disease has run its course. In fact, some argue that terminal sedation **always** involves the removal or withholding of artificial nutrition and hydration. For example, according to Yale Kamisar, "To begin with, neither sedation of the terminally ill…nor sedation to the point of unconscious is TS [terminal sedation]. When most commentators refer to TS, when I do…what we all mean is a two-step procedure: (1) sedating the patient to unconsciousness and (2) withholding artificial nutrition and hydration."[23] And, as Kamisar also points out, this "second step of TS…is the feature that makes the permissibility of the procedure problematic."[24]

Kamisar is not the only commentator to make such a claim, for several physicians have also made the same claim. For example, Timothy E. Quill, MD, Bernard Lo, MD, and Dan W. Brock, MD, in their article "Palliative Options of Last Resort," state outright that once "the suffering patient is sedated to unconsciousness…all life-sustaining interventions are withheld."[25] Thus, according to Quill and company, "The patient then [typically] dies of dehydration, starvation, or some other intervening complication."[26] Another example includes David Orentlicher in his article "The Supreme Court and Terminal Sedation." In that article,

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[23] Yale Kamisar, *Are the Distinctions Drawn in the Debate About End-of-Life Decision Making 'Principled'? If Not, How Much Does It Matter?*, 40 J.L. MED. & ETHICS 66, 77 (2012).
[24] *Id*.
[25] Quill, B. Lo, and D. W. Brock, *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, 2099 (1997).
[26] *Id.*

Orentlicher states, "the sedation step and the withholding of nutrition and hydration step are viewed as a total package."[27]

Therefore, while it is clearly possible that physician may sedate a terminally ill patient and subsequently provide artificial nutrition and hydration until the illness runs its course, the bulk of the commentary seems to agree that terminal sedation includes more than mere sedation until death occurs as a result of the underlying ailment. Apparently, terminal sedation also involves, at least a majority of the time if not always, the withholding of artificial nutrition and hydration once the patient is unconscious. Furthermore, it is this second part of the procedure which seems to be the most problematic when trying to distinguish terminal sedation from euthanasia. Thus, for the remainder of this paper, when speaking of "terminal sedation," it will be understood as encompassing two steps: (1) sedation, through the administration of certain drugs, to the point of unconsciousness, and (2) withholding artificial nutrition and hydration.

III. The Law and Terminal Sedation: *Quill, Glucksberg,* and *Cruzan*'s Right to Refuse Treatment

Given that terminal sedation, due to the second step of terminal sedation – withholding artificial nutrition and hydration – is at the very least comparable to euthanasia, which is illegal in almost every State, one must observe the law itself and whether or not it has addressed terminal sedation and/or spoken of its legality.

The first mention of terminal sedation, at the Supreme Court level, occurred in two cases decided in the same year: *Vacco v. Quill* and *Washington v. Glucksberg*. First, in *Quill*, the law being challenged was a New York (NY) law that prohibited assisting suicide. The issue in that

[27] David Orentlicher, *The Supreme Court and Terminal Sedation: Rejecting Assisted Suicide, Embracing Euthanasia*, 24 HASTINGS CONST. L.Q. 947, 955 (1997).

case was whether the NY law prohibiting assisting suicide violated the Equal Protection Clause of the Fourteenth Amendment. The Court held that it did not.[28] In *Quill*, however, the Court went to great lengths to legally legitimize "the distinction between assisting suicide and withdrawing life-sustaining treatment," which, the Court argued, is "a distinction widely recognized and endorsed in the medical profession and in our legal traditions."[29] This distinction, the Court continued,

> …Comports with fundamental legal principles of causation and intent. First, when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease…but if a patient ingests lethal medication prescribed by a physician, he is killed by the medication…Furthermore, a physician who withdraws, or honors a patient's refusal to begin, life-sustaining treatment purposefully intends, or may so intend, only to respect his patient's wishes and "to cease doing useless…or degrading things to the patient when [the patient] no longer stands to benefit from them." *The same is true when a doctor provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's intent is, or may be, only to ease the patient's pain*. A doctor who assists a suicide, however, "must…intend primarily that the patient be made dead."[30]

Arguably the court drew a very fine line in distinguishing between assisting suicide and withdrawing life-sustaining treatment. And the Court made a very similar distinction, as the section in italics shows, between assisting suicide and providing "aggressive palliative care [that]…may hasten a patient's death." However, while the line may be very fine, the fact of that matter is that it had to be drawn. And as the Court also pointed out, "The law has long used actors' intent or purpose to distinguish between two acts that may have the same result."[31]

Next, in *Glucksberg*, the Washington law in question was, like the law in *Quill*, one that

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[28] Vacco v. Quill, 521 U.S. 793, 797 (1997).
[29] *Id.* at 800.
[30] *Id.* at 801-802 (emphasis added).
[31] *Id.* at 802.

prohibited causing or aiding a suicide. And, again like in *Quill*, the issue was whether or not such a law violates the Fourteenth Amendment. The Court held in this case that it did not.[32] Justice Rehnquist wrote the opinion in both *Glucksberg* and *Quill*, and drew many of the same distinctions in each opinion. First, the distinction between physician-assisted suicide and the withdrawing of life-sustaining treatment, and second, the distinction between physician-assisted suicide and the providing of aggressive palliative care that may hasten a patient's death.[33] Also, in Justice O'Connor's concurring opinion, she seemingly takes it a step further when she mentions that her approval of those state laws prohibiting physician-assisted suicide is, at least partially, because these laws "permitted adequate pain medication for terminally ill patients, including medication 'to alleviate…suffering, even to the point of causing unconsciousness and hastening death. According to O'Connor, as long as they do not impede patients' access to palliative care, laws against physician assisted-suicide are permissible."[34]

In these two cases, it is clear to some, such as Rob McStay, that Supreme Court "tacitly endorsed terminal sedation as an alternative to physician-assisted suicide."[35] However, there are those who argue that the Supreme Court, in making such an endorsement, was very unaware of what it was actually endorsing. Some even claim that, in distinguishing between the intent of (1) a physician who is assisting a patient's suicide and (2) a physician who is sedating a patient – i.e., providing aggressive palliative care – to the point of unconsciousness or even hastening death, the Supreme Court did not endorse terminal sedation at all. Those making such arguments

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32 Washington v. Glucksberg, 521 U.S. 702, 705-706 (1997).

33 Vacco v. Quill, 521 U.S. 793, 801-802 (1997) (emphasis added).

34 Rebecca Dresser, *The Supreme Court and End-of-Life Care: Principled Distinctions or Slippery Slope?*, *in* LAW AT THE END OF LIFE: THE SUPREME COURT AND ASSISTED SUICIDE 83, 86 (Carl E. Schneider ed., 2000) (quoting 117 S. Ct. at 2303 (O'Connor, J., concurring)).

35 Rob McStay, *Terminal Sedation: Palliative Care for Intractable Pain, Post Glucksberg and Quill*, 29 AM. J.L. & MED. 45, 45 (2003).

rely on the fact that the Supreme Court made no mention of the second step of the terminal sedation procedure: withholding of artificial nutrition and hydration. Specifically,

> Rehnquist did not have the special TS [terminal sedation] procedure in mind when he discussed palliative care…If Rehnquist had been trying to defend TS on 'double effect' grounds, one would have expected him to explain how a medical practice which combines sedating a patient to unconsciousness *and* the withholding of ANH [artificial nutrition and hydration] could be reconciled with the PDE [principal of double effect]. But Rehnquist did not do this.[36]

Furthermore, in the same article, Kamisar states "much of what I have said about…Justice Rehnquist's opinion applies to Justice O'Connor's concurring opinion [in *Quill*]…Although she talks about the availability of palliative care to relieve suffering, 'even to the point of causing unconsciousness and hastening death,' she says nothing about the 'withholding ANH' component."[37]

For the moment let us assume that Kamisar is correct; that, while endorsing the use of aggressive palliative care to alleviate extreme pain and suffering, even when it may hasten death, the Supreme Court did not therefore approve of terminal sedation because it made no explicit mention of, and therefore did not explicitly approve of the second step that comprises the practice – withholding artificial nutrition and hydration. What does this mean, then, for terminal sedation? Does this second step, as David Orentlicher argues, make the practice indistinguishable from euthanasia? Is terminal sedation, therefore, a form of criminal homicide?

While it may be true, as Kamisar points out, that the Supreme Court made no mention of withholding artificial nutrition and hydration in either *Quill* or *Glucksberg*, that does not change the fact that it **did** mention and explicitly approve of the withdrawing and subsequent

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[36] Yale Kamisar, *Are the Distinctions Drawn in the Debate About End-of-Life Decision Making 'Principled'? If Not, How Much Does It Matter?*, 40 J.L. MED. & ETHICS 66, 78 (2012).
[37] *Id.*

withholding of artificial nutrition and hydration in *Cruzan v. Director, Missouri Department of Health*. In that case, the Court "considered whether Nancy Beth Cruzan, who had been severely injured in an automobile accident and was in a persistent vegetative state, 'had a right under the…Constitution which would require the hospital to withdraw life-sustaining treatment.'"[38] The Court concluded, "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions."[39] Therefore, "for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse life-sustaining hydration and nutrition."[40] Thus, in that case, after providing clear and convincing evidence that Nancy would have wanted the artificial nutrition and hydration removed were she competent enough to make that choice, Nancy's co-guardian parents were able to order the removal of Nancy's artificial nutrition and hydration.

Since the Supreme Court was willing to assume that the Constitution would grant someone like Nancy Cruzan, were she competent to make the decision, a constitutionally protected right to refuse life-sustaining hydration and nutrition, it stands to reason that the Court would allow a competent yet suffering terminally ill patient the same right. This is especially true after the patient has been terminally sedated; for it is at that time that the artificial nutrition and hydration becomes a form of life-sustaining treatment because once the patient is unconscious (until death) he or she is longer able to feed him or herself. Furthermore, in the case of Nancy Cruzan, while it is true that she was in a persistent vegetative state, she was neither terminal, nor suffering. Nancy could have lived several more years had the hospital continued to

[38] Washington v. Glucksberg, 521 U.S. 702, 724 (1997) (quoting Cruzan v. Dir., Missouri Dep't of Health, 497 U.S. 261, 269 (1990)).
[39] Cruzan v. Dir., Missouri Dep't of Health, 497 U.S. 261, 278 (1990).
[40] *Id.* at 279.

provide her with artificial nutrition and hydration. Also, there was really no indication that Nancy was suffering before the artificial nutrition and hydration was removed. Thus, the withholding of artificial nutrition and hydration is arguably more appropriate in the context of someone who is terminally ill and whose death will be a very painful one, for their life-span is considerably shorter than what Cruzan's would have been and it is a lifespan riddled with pain.

In sum, "Ethically and legally, the right of competent, informed patients to refuse life-prolonging interventions, including artificial nutrition and hydration, [was]…firmly established [in *Cruzan*]."[41] Thus, while it Kamisar and others are correct in pointing out the Supreme Court made no mention of the second step of terminal sedation – withholding artificial nutrition and hydration – in either *Quill* or *Glucksberg*, it is also true that the Court did explicitly mention this aspect of terminal sedation in *Cruzan*, and in doing so explicitly approved of the practice's second step.

However, let us take this one step further, because despite the fact that, as illustrated above, the Supreme Court has both mentioned and approved of each of the two steps comprising terminal sedation – (1) sedation, through the administration of certain drugs, to the point of unconsciousness, and (2) withholding artificial nutrition and hydration – there are still those who believe that it is no different from euthanasia. And they have a point; in none of those cases was "the legality of terminal sedation…directly before the Court."[42] Therefore, because the Supreme Court has never used the words "terminal sedation," and because the Court has never considered the legality of the two steps comprising terminal sedation **when done in conjunction with one**

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[41] Quill, B. Lo, and D. W. Brock, *Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia*, 278 JAMA 2099, 2100 (1997).

[42] Rob McStay, *Terminal Sedation: Palliative Care for Intractable Pain, Post Glucksberg and Quill*, 29 AM. J.L. & MED. 45, 53 (2003).

another, let us assume that the Supreme Court has never actually approved of terminal sedation. Is it because, like some argue, the **combination** of sedation and withholding artificial nutrition and hydration amounts to euthanasia, something that the Court openly rejects?

IV. Terminal Sedation vs. Euthanasia: The Principle of Double Effect as the Distinguishing Factor

Before comparing terminal sedation to euthanasia, and in doing so deciding whether or not the comparison has merit, one must first define "euthanasia." "Euthanasia, translated literally, simply means a 'good death.' The term has traditionally been used to refer to the hastening of a *suffering* person's death or 'mercy killing.'"[43] Also, it is clear that one of the reasons "terminal sedation remains controversial [is because]…like…euthanasia, the final actors are the clinicians, not the patient."[44] So, based on that alone it would seem that the comparison is at least warranted. However, there are those who go a step further and claim that there is virtually no difference between terminal sedation and euthanasia. For example, David Orentlicher argues

> In many cases, terminal sedation amounts to euthanasia because the sedated patient often dies from the combination of two intentional acts by the physician – the induction of…unconsciousness and the withholding of food and water. Without these two acts, the patient would live longer before eventually succumbing to illness. In other words…we have a situation in which a patient's life is ended by the active intervention of a physician."[45]

There is no doubt that Orentlicher and the like make a very persuasive argument. Provided with

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[43] MARGARET C. JASPER, THE RIGHT TO DIE, 39 (2nd ed. 2000).

[44] Quill, B. Lo, and D. W. Brock, *Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia*, 278 JAMA 2099, 2100 (1997).

[45] David Orentlicher, *The Supreme Court and Terminal Sedation: Rejecting Assisted Suicide, Embracing Euthanasia*, 24 HASTINGS CONST. L.Q. 947, 956 (1997).

nothing but the above excerpt, it would seem that terminal sedation and euthanasia are virtually identical, which in turn means that terminal sedation – like euthanasia – is illegal in almost every state (the only exceptions being those three states with Death with Dignity Acts). How then, is one supposed to distinguish between the two, so that terminal sedation may remain as a legal option for suffering, terminally ill patients? The answer lies in the intent of the physician. More specifically, the answer lies in the principle of double effect.

According to the principle of double effect, "consequences that would be wrong if caused intentionally become acceptable, even when foreseen, if the actions creating those consequences were intended for a morally permissible purpose."[46] The principle can be illustrated as such:

> I perform action A. By performing A, I intend outcome X. A and X themselves are morally praiseworthy, or…morally neutral. By doing A, I know that I…risk accomplishing outcome Y. I do not intend Y. There is no alternative action to accomplish X that would not risk causing Y in the process. The principle of double effect states that even if Y is morally bad, it may be acceptable to do A in order to accomplish X. The essence of the principle is that it is acceptable to do A if Y is a *foreseen but unintended consequence* of an otherwise justifiable act.[47]

Also, "the unintended but foreseen bad effect must also be proportional to the intended good effect."[48] Put another way,

> The traditional rule of double effect specifies that an action with 2 possible effects, one good and one bad, is morally permitted if the action: (1) is not itself immoral, (2) is undertaken only with the intention of achieving the possible good effect, without intending the possible bad effect even though it may be foreseen, (3) does not bring about the possible good

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[46] Rob McStay, *Terminal Sedation: Palliative Care for Intractable Pain, Post Glucksberg and Quill*, 29 AM. J.L. & MED. 45, 53 (2003).

[47] Howard Brody, *Physician-Assisted Suicide in the Court: Moral Equivalence, Double Effect and Clinical Practice*, *in* LAW AT THE END OF LIFE: THE SUPREME COURT AND ASSISTED SUICIDE 101, 105 (Carl E. Schneider ed., 2000).

[48] Quill, B. Lo, and D. W. Brock, *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, 2101 (1997).

> effect by means of the possible bad effect, and (4) is undertaken for a proportionately grave reason.[49]

In the context of terminal sedation, this means that "a physician may administer pain medication to a patient, knowing that [the] medication may hasten the patient's death, so long as the intent of the physician is solely to relieve the patient's pain."[50] However, the administering of pain medication, even when done solely with the intent to relieve the patient's suffering, is not the only step comprising terminal sedation. Again, the second, much more problematic step involves withholding artificial nutrition and hydration once the patient is unconscious.

According to some, it is this second step that informs the real intent of the physician performing terminal sedation. Put another way, the withholding of artificial nutrition and hydration illustrates that the actual intent of the physician is to cause or at least hasten the patient's death, as opposed to relieve the patient's suffering. Furthermore, those making this argument also claim that, in conjunction with the simple existence of the principle of double effect, there also exists some "informal presumption in favor a benign intent, as opposed to an intent to cause or hasten death."[51] When the reality of the situation is that "although the overarching intention of the sedation is to relieve the patient's suffering, the additional step of withholding fluids and nutrition is not needed to relieve pain, but is typically taken to hasten the patient's…death."[52]

This, when taken at face value, makes a very strong case for the essential equivalence of terminal sedation with euthanasia. For if the intent is not to hasten death, but rather to alleviate

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[49] Daniel P. Sulmasy, *The Rule of Double Effect: Clearing up the Double Talk*, 159 ARCHIVES INTERNAL MED. 545, 545 (1999).

[50] McStay, *Terminal Sedation: Palliative Care for Intractable Pain*, *supra* note 46.

[51] McStay, *Terminal Sedation: Palliative Care for Intractable Pain*, *supra* note 46, at 55.

[52] Yale Kamisar, *Are the Distinctions Drawn in the Debate About End-of-Life Decision Making 'Principled'? If Not, How Much Does It Matter?*, 40 J.L. MED. & ETHICS 66, 77 (2012).

extreme pain, then why would the common practice, following the induction of an unconscious state, be to withhold artificial nutrition and hydration? However, this argument makes the same assumption that it indirectly accuses those advocates of double effect of making; namely, it assumes that the intent of the physician can be accurately made based on his or actions, when the reality of the situation is that "it is questionable whether such judgments on the physician's mental state can or will be made accurately in a clinical setting."[53] The argument assumes that the only reason a doctor would withhold artificial nutrition and hydration is to hasten death, and this is simply not the case. It is very possible that a physician may withhold artificial nutrition and hydration merely with the intent to honor a patient's wishes. And while this may bear at most a small resemblance to euthanasia, or possibly even physician-assisted suicide, the fact of the matter is that this is perfectly legal.

First, the Supreme Court stated explicitly in *Quill*,

> *A physician who withdraws, or honors a patient's refusal to begin, life-sustaining treatment purposefully intends, or may so intend, only to respect his patient's wishes* and…The same is true when a doctor provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's intent is, or may be, only to ease the patient's pain. A doctor who assists a suicide, however, "must…intend primarily that the patient be made dead.[54]

Thus, not only is it possible for a physician to intend only to respect a patient's wishes when withdrawing or withholding artificial nutrition and hydration, but the Supreme states outright (by comparing it to the use of aggressive palliative care) that this specific combination of intent and action, or lack thereof, is permissible. Furthermore, in *Cruzan*, the Court stated, "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted

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[53] Rebecca Dresser, *The Supreme Court and End-of-Life Care: Principled Distinctions or Slippery Slope?*, *in* LAW AT THE END OF LIFE: THE SUPREME COURT AND ASSISTED SUICIDE 83, 89 (Carl E. Schneider ed., 2000).

[54] Vacco v. Quill, 521 U.S. 793, 801-802 (1997) (emphasis added).

medical treatment may be inferred from our prior decisions."[55] Therefore, "for purposes of this case, we assume the United States Constitution would grant a competent person a constitutionally protected right to refuse life-sustaining hydration and nutrition."[56]

Also, it is well within a patient's right to, when capable, "voluntarily stop eating and drinking (VSED)."[57] According to Quill, Lo, and Brock, "With VSED, a patient who is otherwise physically capable of taking nourishment makes an active decision to discontinue all oral intake and then is gradually 'allowed to die,' primarily of dehydration or some intervening complication [as opposed to the patient's illness]."[58] Also, it is interesting to note, "Many patients lose their appetites and stop eating and drinking in the final stages of many illnesses."[59] So, it would seem that if a patient, when fully capable, is allowed to (1) refuse life-sustaining medical treatment, or (2) to voluntarily stop eating and drinking and essentially "allowed to die,"[60] it would stand to reason that when it comes to terminal sedation, a may patient may elect to have artificial nutrition and hydration withheld once they are unconscious. And, as is the case when a patient either refuses life-sustaining medical treatment or voluntarily stops eating and drinking, it is well within a physician's right to respect that decision and essentially "allow…[the patient] to die"[61] on his or her own terms.

However, when a conscious patient, who will remain that way, decides to either refuse life-sustaining medical treatment or voluntarily stop eating and drinking, he or she also has the

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55 Cruzan v. Dir., Missouri Dep't of Heath, 497 U.S. 261, 278 (1990).

56 *Id.* at 279.

57 Quill, B. Lo, and D. W. Brock, *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, 2099 (1997).

58 *Id.*

59 *Id.* at 2100.

60 *Id.* at 2099.

61 *Id.*

option of changing his or her mind and subsequently informing the physician as such. A patient who has been terminally sedated, on the other hand, will be unable to do so due to their being unconscious. Yet, this is something that can be easily rectified if the physician simply informs the patient of this downside. As long as the patient is adequately informed, there is no reason to believe that the law would allow patients to refuse life-sustaining treatment or essentially starve themselves while conscious, but not allow those same patients to explicitly approve of the withholding of artificial nutrition and hydration once he or she is unconscious. Furthermore, one of the "main disadvantages of VSED…[is] that it may last for weeks and may initially increase suffering because the patient may experience thirst and hunger."[62] When a patient is terminally sedated, however, this is not the case. The patient's suffering will not be increased due to thirst and hunger simply because the patient is unconscious.

In sum, the Supreme Court, in both *Quill* and *Glucksberg*, explicitly approved of the principle of double effect. Furthermore, the Court stated that, because "the law has long used actors' intent or purpose to distinguish between two acts that may have the same result,"[63] it is permissible when to use the principle to justify both steps comprising terminal sedation. A physician may sedate a suffering, terminally ill patient to the point of unconsciousness, so long as his only intent is to relieve the patient's pain. This is permissible even if the sedation may hasten the patient's death, so long as that foreseen side effect is unintended. Similarly, a physician may withhold artificial nutrition and hydration from the patient once he or she is unconscious, so long as his only intent is to respect the patient's wishes. This is permissible even if withholding artificial nutrition and hydration may hasten a patient's death, so long as that outcome is unintended.

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[62] *Id.* at 2100.

[63] Vacco v. Quill, 521 U.S. 793, 802 (1997).

V. *Why* Terminal Sedation is a Necessary Option for Suffering, Terminally Ill Patients

Now we address what may be the most important question of this paper: From a moral standpoint, regardless of what is legal, should terminal sedation remain as an option for suffering, terminally ill patients? Yes, terminal sedation must remain available as a palliative option for suffering, terminally patients. First, we consider the alternatives. Specifically, we consider the alternative to double effect:

> The alternatives to double effect would be to either accept, or at least tolerate, a physician's [supposed] intent to hasten or cause death, or to forbid a physician from engaging in conduct that has the foreseeable effect of hastening death. The former…directly contradicts the law of almost every state, and the latter would likely leave some patients without the ability to obtain adequate pain relief.[64]

Neither of these options, from a moral standpoint, seems desirable. The first would have the effect of, in essence, legalizing, at least in this instance, the intent to kill or hasten death. The second would have the possible effect of leaving certain patients in a state of perpetual agony until their ailment finally robs them of their lives.

Next, we consider the alternative of sedating a patient to the point of unconsciousness until his or her death, but at the same time, once the patient is unconscious, providing the patient with artificial nutrition and hydration until the patient's illness inevitably runs its course. To some, this may seem like the least objectionable option. It reinforces the idea that a physician's intent is to alleviate pain as opposed to causing or hastening death, and allows the patient to die of their illness rather than starvation and dehydration. However, there are some patients who may disagree. For in this type of instance, some argue, "terminal sedation [then] has 'the

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[64] Rob McStay, *Terminal Sedation: Palliative Care for Intractable Pain, Post Glucksberg and Quill*, 29 AM. J.L. & MED. 45, 54 (2003).

dehumanizing effect of turning the patient into a decaying zombie.'"[65] For while the sedation itself may "ensure a painless death,"[66] prohibiting the withholding of artificial nutrition and hydration "may require patients to linger in a state that may profoundly compromise their dignity and…prevent patients from retaining some control over the timing and circumstances of their death, a control that may be critical to their psychological well-being."[67] And again, this argument assumes that the only reason a physician would withhold artificial nutrition and hydration is to hasten death, when the simple fact of the matter is that it is very possible for them to do so with only the intent to honor a patient's wishes. And as we saw in *Cruzan*, a patient has the option of refusing life-sustaining treatment, which includes artificial nutrition and hydration when the patient is unconscious and unable to feed his or herself.

However, if there are those who still feel uncomfortable with terminal sedation, due to the second step, then as an alternative to simply prohibiting the practice, or even just the second step, it may be possible to add a step to the practice: informing the patient, before he or she is put under, that once he or she is unconscious artificial nutrition and hydration will be withheld. Then the patient is presented with an option. The patient will be able to either (1) verbally consent to the withholding of artificial nutrition and hydration after careful discussion of what exactly that will mean, or (2) state outright that he or she would rather be provided with artificial nutrition and hydration while unconscious and allow the disease to run its course. This leaves all of the power in the hands of the patient, meaning that the physician's only possible intention would be to honor the patient's wishes when withholding artificial nutrition and hydration once the patient is unconscious. Of course, this is just a suggestion, and it is an unnecessary one, for

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[65] Rebecca Dresser, *The Supreme Court and End-of-Life Care: Principled Distinctions or Slippery Slope?*, *in* LAW AT THE END OF LIFE: THE SUPREME COURT AND ASSISTED SUICIDE 83, 91 (Carl E. Schneider ed., 2000).
[66] *Id.* at 90.
[67] *Id.*

this paper has illustrated (several times) that the Court has, however indirectly, already approved of terminal sedation.

VI. Conclusion

Terminal sedation must be made available to suffering, terminally ill patients. And, as of right now, it is available to these patients. "Terminal sedation is already openly practiced by some palliative care and hospice groups in cases of unrelieved suffering, with a reported frequency from 0% to 44% of cases."[68] It must remain that way; for there is no doubt that at least some terminally ill patients suffer during their final days.

> One report suggested that more than 50% of patients with terminal cancer have physical suffering during the last days of their life controlled…only by sedation. Another report shows that 40% of all dying patients in the United States die in pain…the Institute of Medicine found that anywhere from 40% to 80% of patients with terminal illness report that their treatment for pain is inadequate and prolongs the very agony of death.[69]

However, while the Supreme Court has, as this paper has shown, addressed and approved both steps that comprise terminal sedation, it has never made specific mention of "terminal sedation" and what exactly it will entail in the context of the law. Or, as Yale Kamisar states,

> Some day the Court will have to focus on TS. When it does, will it uphold its legality? One may argue that TS is essentially an embellished form of forgoing ANH. After all, if patients so desire, they can have ANH withheld or withdrawn. So why should TS be prohibited? On the other hand, one may argue that the second component of TS – the withholding of ANH – colors the first component – sedation to the point of unconsciousness…[and] indicates that the overall purpose is not to relieve

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[68] Quill, B. Lo, and D. W. Brock, *Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia*, 278 JAMA 2099, 2100 (1997).

[69] George P. Smith, II, *Terminal Sedation as Palliative Care: Revalidating a Right to a Good Death*, 7 CAMBRIDGE Q. HEALTHCARE ETHICS 382, 384 (1998).

the pain, but to kill the patient.[70]

But again, this second argument assumes that a physician cannot, or would not withhold artificial nutrition and hydration for any other reason other than to hasten death. And as this paper as shown, this is not true. The law, specifically in *Cruzan*, allows patients to refuse life-sustaining treatment, and in the context of a patient who has been sedated to the point of unconsciousness, that life-sustaining treat includes artificial nutrition and hydration. A physician, in withholding artificial nutrition and hydration, may only have the intent of respecting a patient's wishes. Furthermore, the law, specifically in *Quill*, also approves of the principal of double effect, thus allowing physicians to legally sedate suffering, terminally ill patients to the point of unconsciousness, even if said sedation may foreseeably hasten death, so long as the physician's intention is to alleviate extreme pain.

Thus, terminal sedation is essentially legal, despite the fact that the phrase itself and what it entails has never actually been mentioned and/or addressed by the Supreme Court. And thank God for that, for the alternative is to subject suffering, terminally ill patients to a death that is comprised almost entirely of physical, and possibly mental and emotional pain and suffering. This is arguably even more inhuman than things such as euthanasia and physician-assisted suicide (and that is assuming that those two things are inhuman at all), which States such as New York and Washington – in *Quill* and *Glucksberg*, respectively – have taken great pains to outlaw. Or, if the States are to illegalize the practice of terminal sedation, they must then find some other way to provide suffering, terminally ill patients with some semblance of dignity, autonomy, and general control over their final days. One way is to follow the example of Oregon, Washington, and Vermont and implement a Death with Dignity Act, but that is a whole other question.

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[70] Yale Kamisar, *Are the Distinctions Drawn in the Debate About End-of-Life Decision Making "Principled"? If Not, How Much Does It Matter?*, 40 J.L. MED. & ETHICS 66, 78 (2012).