Terminal Sedation: Ethical And Legal Concerns

Jennifer Pauline Starr

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A. INTRODUCTION

Leo Olztik was an 88-year-old man with dementia, congestive heart failure, and kidney problems when his wife and son found him jumping out of bed and ripping off his clothes.1 His family brought him to the hospital, which placed him in the hospice unit, where he passed away comfortably after eight days, in a sedated state induced by an IV drip of morphine and a strong sedative.2 After three days of failed efforts to ease Mr. Olztik’s agitation with oral medication, the doctors ordered that the drugs be administered through an IV.3 The doctors knew that the drugs would decrease his heart rate and slow his breathing. On the sixth day, Mrs. Olztik and her children met with doctors and nurses to discuss their options.4 Ultimately the family decided that it was best to continue the sedation without artificial nutrition and hydration because they felt that it would burden his system.5

The form of care Mr. Olztik received is called terminal sedation. The name is misleading, as it is not intended to cause death; it is intended to relieve suffering and distress that may be present during the final days of life.6 This paper argues that terminal sedation is a legal form of care necessary for use as a last resort when all other forms of providing comfort in the final days have failed. Terminal sedation is controversial.

Opponents and critics of terminal sedation believe that terminal sedation that involves

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2 Id.
3 Id.
4 Id.
5 Id.
discontinuation of feeding is indistinguishable from euthanasia. Distinguishing between legal treatment withdrawal and palliative care on the one hand, and illegal euthanasia on the other hand has become an increasing challenge. Adding to the complexity is that four states, Oregon, Washington, Vermont, and Montana, have legalized physician-assisted suicide, which involves a physician facilitating a patient’s death by providing a patient the means, a prescription, and information on the lethal dose while aware that the patient intends to end his life. In sum, it is legal to honor a competent patient’s request to withdraw or withhold life-sustaining treatment. It is illegal to connect an IV to a person to infuse drugs intended to hasten death. It is legal to connect an IV to a person with the intent to relieve pain, and to increase the dose enough to induce a sedated state, even if death is foreseeable. And so the question becomes on which side of the line is terminal sedation that involves withholding nutrition and hydration.

The Supreme Court of the United States unanimously upheld the power of a state to criminalize physician-assisted suicide and held that there is no fundamental right to hasten one’s own death. The Supreme Court has never directly addressed the issue of terminal sedation.

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7 Id.
10 Patient Choice and Control at End of Life Act, 18 V.S.A. Ch. 113 (2013).
13 If the patient is incompetent, a surrogate decision-maker should be identified. A patient who is incompetent may have a surrogate decision-maker who will advance their position on life-sustaining treatment. See Alan Meisel, Lois Snyder & Timothy Quill, Seven Legal Barriers to End-of-Life Care, 284 JAMA 2495, 2496 (2000).
14 “Life-sustaining treatment is any treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.” Am. Med. Assoc., Opinion 2.20-Withholding or Withdrawing Life-Sustaining Medical Treatment, AMA CODE OF ETHICS, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion220.page.
15 Quill, supra note 12, at 59 (A patient with the capacity to make decisions or a surrogate decision-maker must consent prior to initiation).
the companion cases *Washington v. Glucksberg*\(^{17}\) and *Vacco v. Quill*\(^{18}\) the concurring opinions of Justices O'Connor, Ginsburg, Breyer, Souter, and Stevens indicate support of terminal sedation. The majority opinions, written by Chief Justice Rehnquist, affirmed the Court’s assumption that the Due Process Clause protects the right to refuse unwanted medical treatment and indicate approval of the principle of double effect applied in the context of palliation. This paper argues that terminal sedation comprises palliation that can be justified pursuant to the principle of double effect.

This paper will address the topic of terminal sedation by discussing the legal support of the practice and the ethical controversy. The question that underlies the controversy is whether terminal sedation is distinct from euthanasia or euthanasia in disguise. The paper begins by surveying the different forms of terminal sedation and explicating the important basic definitions at the heart of the differences among euthanasia, physician-assisted suicide, and terminal sedation. The discussion of the background law focuses on three important Supreme Court decisions. The controversy is not just one among scholars but also a moral and ethical dilemma that physicians, nurses, patients, and their families face.

Terminal sedation is distinct from euthanasia and is the best option for some classes of patients to allow for equal opportunity to a painless death.

**B. TERMINAL SEDATION**

Terminal sedation is the induction of an unconscious state to relieve otherwise intractable distress, frequently accompanied by the withdrawal and withholding of life-sustaining interventions.\(^{19}\) Terminal sedation is also commonly referred to as sedation, palliative sedation,

\(^{17}\) *Glucksberg*, 521 U.S. 702.

\(^{18}\) *Quill*, 521 U.S. 793.

end-of-life-sedation, and total sedation. Terminal sedation is a form of palliative care. The World Health Organization (WHO) defines palliative care as “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.” The intent of terminal sedation is not to end the patient’s life, but to relieve pain and suffering despite the possibility that death may result. Terminal sedation is used as a last resort when alternative means of relieving symptoms have been ineffective or have intolerable adverse effects.

In advanced stages of terminal illness, patients may experience symptoms that are considered refractory symptoms; those that are not responsive to traditional pain management treatments, such as: extreme pain, respiratory distress, persistent vomiting, agitation, restlessness, and myoclonus. Refractory symptoms have a negative effect on a patient’s functioning, increase as the patient gets closer to death, and interfere with a peaceful dying process. Terminal sedation is appropriate for terminally ill patients as a last resort when other aggressive, symptom-specific palliative methods have been ineffective for reducing refractory suffering. Terminal sedation is justified when: (1) alternative means of relieving the symptoms are ineffective or have intolerable adverse effects; (2) the goal or intention is to relieve symptoms.

23 Quill et al., supra note 19; Lo & Rubenfeld, supra note 21, at 1812.
24 Id. at 1811.
25 Claessens, Menten, Schotsmans & Broeckaert, supra note 20, at 311.
26 Id.
not shorten life; and (3) the patient is at the point of death, in a dying state, or close to death.\(^{27}\)

There is opposition to terminal sedation when it is combined with the withdrawing or withholding of artificial nutrition and hydration.\(^{28}\) Also controversial is the use of terminal sedation to treat existential or spiritual suffering as opposed to refractory physical suffering.\(^{29}\) These controversies will be discussed below.

The use of a variety of terminology to describe the practice of terminal sedation and the lack of a universally agreed upon definition make researching and analyzing data on terminal sedation in clinical practice difficult.\(^{30}\) Terms are used synonymously despite having different meanings and the variability in classifying and defining terminal sedation creates confusion in clinical and research areas.\(^{31}\) The wide variation obscures the frequency of terminal sedation and the fundamental differences in how sedation of dying patients is used in clinical settings.\(^{32}\)

The term "terminal sedation" was first introduced in 1991.\(^{33}\) The term was immediately controversial due to the negative connotation and the possibility of misinterpretation that the name implies; that the primary aim is termination of life rather than symptom alleviation.\(^{34}\) One form of terminal sedation involves the slow drip of morphine; leading to another unfortunate label, "slow euthanasia."\(^{35}\) The usage was short-lived and is currently rarely used in the

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27 Lo & Rubenfeld, supra note 21, at 1812.
28 Id.
29 Id.
32 Id. at 207; M. Maltoni et al., Palliative Sedation Therapy Does Not Hasten Death: Results from a Prospective Multicenter Study, 20 ANNALS ONCOLOGY 1163 (2009).
34 Morita, Tsuneto & Shima, supra note 20.
Another term that has been used is "total sedation" which suggests sedation until total loss of consciousness or total relief of suffering. A commonly used term is "palliative sedation." Some prefer to use more descriptive terminology. The terms "continuous deep sedation," "palliative sedation to unconsciousness," "continuous deep sedation until death," and "continuous sedation until death" have emerged. The most common terms that are used are "terminal sedation" and "palliative sedation."

In addition to the variation in terminology used, there is disparity in the definitions. The challenges in achieving a universally accepted definition may account for the lack of conceptual clarity. Two core factors are incorporated into most definitions: (1) the presence of severe distress refractory to standard palliative treatment and (2) the use of sedative medication with the primary intent to relieve distress by reducing consciousness. A proposed definition for "palliative sedation therapy" is "the use of sedative medications to relieve intolerable and refractory distress by the reduction of patient consciousness."

Rather than using a standard definition, some prefer to describe the practice. However, when individual researchers or clinicians use descriptive language and then slap on a label, the description may not match the definition that another clinician or researcher used under the same label, and the confusion continues to grow. One group of authors accepts terminal sedation to mean what they describe as "sedation of the imminently dying." Terminal sedation is also used

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36 Evangelia S. Papavasiliou et al., supra note 30, at 693.
37 Morita, Tsuneto & Shima, supra note 20 at 451.
38 Id.
39 Id.
40 Evangelia S. Papavasiliou et al., supra note 30, at 692.
41 Morita, Tsuneto & Shima, supra note 20 at 448.
42 Id. at 452.
to describe a practice described as "sedation toward death." They describe "sedation of the imminently dying" as a practice in which: (1) the patient is within "hours, days, or at most a few weeks from death;" (2) the patient has severe symptoms that are refractory to standard palliative care; (3) the physician has tried all other possibilities; (4) there is a "dose-dependent side effect of sedation that is a foreseen but unintended consequence of trying to relieve the patient's symptoms;" and (5) this therapy may be combined with the withholding or withdrawing of life-sustaining treatments that are ineffective or disproportionately burdensome. The practice of "sedation toward death" is a practice in which (1) the patient does not need to be imminently dying; (2) the refractory symptoms are the consciousness that one is not dead yet; (3) the physician selects to render the patient unconscious as a means of treating the refractory symptom; and (4) other life-sustaining treatments are withdrawn to hasten death. The second definition is not describing terminal sedation. The second definition is more akin to euthanasia and is not an acceptable definition of terminal sedation.

Another term used is "proportionate palliative sedation" where the sedation is systematically increased until sufficient relief of suffering is achieved and the patient may only be rendered unconscious because lesser doses did not provide sufficient relief. "Palliative sedation to unconsciousness" is a practice in which the goal from the beginning is to achieve unconsciousness and often nutrition and hydration are withheld. These two described practices seem to be similar to "sedation towards death" and "sedation of the imminently dying" but they have less description. It is difficult to discern if they are the same practice or different forms of the practice.

44 Id.
45 Id.
46 Id.
47 Quill, supra note 12, at 59.
48 Id.
For purposes of this paper, the term “terminal sedation” will be used. The analysis will consider terminal sedation of the terminally ill, terminal sedation of the terminally ill accompanied by the withdrawal of artificial nutrition and hydration, and terminal sedation of the terminally ill combined with the withholding of artificial nutrition and hydration.

C. PHYSICIAN-ASSISTED SUICIDE AND EUTHENASIA

In both physician-assisted suicide and euthanasia, the primary intention is to cause the patient’s death. However, euthanasia is illegal in every state whereas physician-assisted suicide is legal in Oregon⁴⁹, Washington⁵⁰, Vermont⁵¹, and Montana.⁵²

Physician-assisted suicide refers to a physician providing a patient with the medical means, by writing a prescription for a drug, and providing the patient with the knowledge of the lethal dose.⁵³ The physician assists by providing the patient with the means, but the patient is the one who takes the action, taking the medication, to end his own life.⁵⁴ The physician is not the one ending the patient’s life, but is still held legally and morally responsible as an accomplice.⁵⁵ Patients who choose the option of physician-assisted suicide are “motivated primarily by loss of autonomy, loss of control of their bodily functions, decreased ability to enjoy life, and tiredness of dying.”⁵⁶

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⁵¹ Patient Choice and Control at End of Life Act, 18 V.S.A. Ch. 113 (2013).
⁵⁴ Quill, supra note 12, at 59.
⁵⁵ Id.
Euthanasia involves the physician administering the agent that will end the patient's life. A physician is directly responsible for ending the patient's life. "Euthanasia is fundamentally incompatible with the physician's role as healer." The physician's intent is causing the patient's death. The patient's death results from the administration of the agent. Although there is an agent administered in the practice of terminal sedation, the intent is not to cause to the patient's death, only to relieve the patient's suffering. Patients requesting euthanasia typically do so as a result of a perceived loss of dignity at the end of life; terminal sedation is typically used to address severe physiological symptoms in dying patients.

D. RIGHT TO DIE JURISPRUDENCE SUPPORTS TERMINAL SEDATION

The Supreme Court has unanimously ruled that there is no constitutional right to physician-assisted suicide. Although the Supreme Court has never explicitly addressed terminal sedation, examination of three "right to die" cases suggests that a ban on terminal sedation would be unconstitutional.

I. CRUZAN V. DIRECTOR, MISSOURI DEPARTMENT OF HEALTH

Nancy Cruzan was in a persistent vegetative state caused by injuries that she sustained in an automobile accident. Nancy was unaware, unresponsive, unable to communicate, and was kept alive by the artificial feeding and hydration tube inserted in her abdomen. She could have remained in this state for many years. Prior to the accident, during a conversation with a friend/roommate, Nancy purportedly said that if she were unable to live at least halfway

58 Id.
59 Judith A.C. Rietjens et al., Terminal Sedation and Euthanasia: A Comparison of Clinical Practices, 166 ARCHIVES INTERNAL MED. 749, 753.
normally, she would not want to continue living. Her co-guardian parents sought to discontinue
the artificial nutrition and hydration that was sustaining her. The hospital refused to do so
without a court order.

The trial court authorized the removal of the life-sustaining treatment upon concluding
that a person in Nancy’s position had a fundamental right to refuse or direct the withdrawal of
the life-sustaining treatment. The trial court found the conversation with her friend to be
sufficient evidence of Nancy’s intent to no longer stay in her current state, and granted the
removal of the feeding tube. The Supreme Court of Missouri overturned the trial court ruling
and held that a showing of Nancy’s intent by clear and convincing evidence was required and
found that the evidence presented did not meet that standard.

The U.S. Supreme Court granted certiorari and in a five to four decision, affirmed the
Supreme Court of Missouri ruling. Chief Justice Rehnquist wrote for the majority. The Court
first focused on the common-law doctrine of battery and informed consent. The right to
freedom from unwanted touching and bodily integrity body are “embodied in the requirement
that informed consent is generally required for medical treatment.” The Court went on to say,
“[t]he logical corollary of the doctrine of informed consent is that the patient generally has a
right not to consent, that is, to refuse treatment.” The Court “assumed” the “United States
Constitution would grant a competent person a constitutionally protected right to refuse
lifesaving hydration and nutrition.”

63 Id.
64 Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988).
65 Id.
66 Id. at 426.
67 Cruzan, 497 U.S. at 279.
68 Id. at 269.
69 Id.
70 Id.
71 Id.
The Court went on to consider whether the United States Constitution forbid Missouri's establishment of a heightened evidentiary requirement as to the incompetent patient's wishes regarding the withdrawal of life-sustaining treatment. The majority held that Missouri could guard against potential abuses in this situation by requiring the surrogate to show "clear and convincing" evidence of an incompetent patient's wishes as to the withdrawal of life-sustaining treatment. The State could impose a heightened standard of proof to advance the important State interests in (1) protecting and preserving human life; (2) safeguarding the "personal element" of the choice between life and death; (3) maintaining procedural safeguards to ensure accurate fact-finding in potentially adversarial proceedings; and (4) refusing to "make judgments about the 'quality of life that a particular individual may enjoy.'" The case was sent back to the trial court.

The trial court concluded that the evidence met the clear and convincing standard and once again determined that Nancy would not wish to be maintained in her current state and the feeding tube was removed.

II. WASHINGTON V. GLUCKSBERG

In Washington v. Glucksberg, the Court addressed the constitutionality of Washington's assisted suicide ban. Plaintiffs argued that there is a liberty interest protected by the Fourteenth Amendment that extends to the personal choice of a mentally competent, terminally ill adult to seek physician-assisted suicide. The Ninth-Circuit Court of Appeals held that "a liberty interest exists in the choice of how and when one dies, and that the provision of the Washington statute banning assisted suicide, as applied to competent, terminally ill adults who wish to hasten
their deaths by obtaining medication prescribed by their doctors, violates the Due Process Clause.\textsuperscript{77}

The majority opinion, written by Chief Justice Rehnquist, answered the more general question of "whether the 'liberty' interest specially protected by the Due Process Clause includes a right to commit suicide which itself includes a right to assistance in doing so."\textsuperscript{78} The Court held that the right to physician-assisted suicide is not a fundamental liberty interest protected by the Due Process Clause.\textsuperscript{79} To find such a right, the Court would "have to reverse centuries of legal doctrine and practice, and strike down the considered policy of almost every state."\textsuperscript{80} Because there was no fundamental constitutional right to assisted suicide, Washington had to demonstrate that the ban on assisted suicide was only "rationally related to legitimate government interests."\textsuperscript{81} The Court concluded that the ban was rationally related to the legitimate governmental interests in: preservation of life, prevention of suicide, protecting the integrity and ethics of the medical profession, and protecting vulnerable groups.\textsuperscript{82} The Court also pointed out the State's legitimate concern that assisted suicide could lead to voluntary and involuntary euthanasia.\textsuperscript{83}

Justice Steven's concurred in the judgment. In the concurrence, Justice Steven's stated "I do not however, foreclose the possibility that an individual plaintiff seeking to hasten her death, or a doctor whose assistance was sought, could prevail on a more particularized challenge."\textsuperscript{84}

Interestingly, in a footnote at the end of the majority opinion, Chief Justice Rehnquist cited Justice Steven's statement and acknowledged, "Our opinion does not absolutely foreclose such a

\textsuperscript{77} Compassion in Dying v. Washington, 79 F.3d 790, 838 (9th Cir. 1996).
\textsuperscript{78} Glucksberg, 521 U.S. at 723.
\textsuperscript{79} Id. at 728.
\textsuperscript{80} Id. at 723.
\textsuperscript{81} Id. at 728.
\textsuperscript{82} Id. at 728-732.
\textsuperscript{83} Id. at 732.
\textsuperscript{84} Id. at 750 (Stevens, J., concurring in the judgment).
claim." He went on to say that the "claim would have to be quite different from the ones advanced by respondents here." This leaves open the possibility that a particular patient's interests with case-specific circumstances might outweigh the State's interests and prevail.

Although the Court unanimously held that there is no right to commit suicide, the concurring opinions of Justices O'Connor, Breyer, Ginsberg, Stevens, and Souter indicate a position that there is a right to adequate pain management and treatment.

Justice O'Connor explained that she joined the Court's majority opinion because she agreed that there is no generalized right to commit suicide and the State's interests are sufficiently weighty to justify the ban on assisted suicide. She indicates that state legislatures are the proper forum to "strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State's interests in protecting those who might seek to end life mistakenly or under pressure." Justice O'Connor explains that the Court did not need to address the narrower question whether patients have a "constitutionally cognizable interest in obtaining relief from the suffering that they may experience in the last days of their lives" because "there is no dispute that dying patients in Washington and New York can obtain palliative care, even when doing so would hasten their death." Justice O'Connor's concurring opinion suggests her belief that there is a right to avoid great suffering.

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85 Id. at 735, n. 24.
86 Id.
87 Id. at 736 (O'Connor, J., concurring).
88 Id.
89 Id.
90 Id. at 738.
Justice Stevens concurred in the judgment. He agreed with the distinctions the majority noted in causation and intent between terminating life-support and assisting in suicide. Justice Stevens explained that the Court holding that Washington’s statute was not unconstitutional “on its face” did not foreclose the possibility that some applications of the statute might be invalid. He also addressed the statute in *Vacco v. Quill* and stated that the holding “does not foreclose the possibility that some applications of the New York statute may impose an intolerable intrusion on the patient’s freedom.

Justice Souter concurred in the judgment. Justice Souter analogized the physician-assisted suicide cases and the abortion cases. Even though the State had a legitimate interest in discouraging abortion and the decision to have an abortion can be made irresponsibly and under the influence of others, the Court recognized a woman’s right to a physician’s assistance. “Without physician assistance in abortion, the woman’s right would have too often amounted to nothing more than a right to self-mutilation, and without a physician to assist in the suicide of the dying, a patient’s right will often be confined to crude methods of causing death.” He also points out a reason that physician’s assistance would fall into accepted traditional methods of care would be the Court’s recognition in *Roe v. Wade*, that the physician “is not just a mechanic of the human body whose services have no bearing on a person’s moral choice, but one who does more than treat symptoms, one who ministers to the patient.”

91 *Id.* at 751 (Stevens, J., concurring in the judgments).
92 *Id.* at 739.
93 *Id.* at 751-752.
94 *Id.* at 778 (Souter, J., concurring in the judgment).
95 *Id.*
96 *Id.* at 779.
Justice Ginsburg wrote a very brief concurrence stating that she concurred with the judgments for substantially the same reasons as Justice O’Connor. 97

Justice Breyer concurred in the judgment and agreed with the distinction between physician assisted suicide and withdrawal of life support. 98 His concurring opinion indicates that he a ban on terminal sedation unconstitutional. He agrees with Justice O’Connor that a successful claim would have to deal with avoidance of severe physical pain (connected with death) and neither New York nor Washington force a dying person to undergo such pain as neither of the laws “prohibit doctors from providing patients with drugs sufficient to control pain despite the risk that those drugs themselves will kill.” 99 If there were a “state law to prevent the provision of palliative care, including the administration of drugs as needed to avoid pain at the end of life ... the Court might have to revisit its conclusions.” 100 Justice Breyer’s concurrence further supports the presumption that a state would not be able to ban the practice of terminal sedation.

III. VACCO V. QUILL

In Vacco v. Quill, the Supreme Court addressed the New York ban on assisted suicide. 101 The plaintiffs in that case argued that the New York ban on assisted suicide violated the Equal Protection Clause of the Fourteenth Amendment. 102 The basis of the plaintiffs’ argument was that New York law permits a competent person to refuse life-sustaining medical treatment and physician-assisted suicide is essentially the same as refusing life-sustaining treatment; thus,

97 Id. at 789 (Ginsburg, J., concurring).
98 Glucksberg 789-790.
99 Id. at 791 (Breyer, J., concurring in the judgments).
100 Id. at 792.
prohibiting physician-assisted suicide violated the Equal Protection Clause.\textsuperscript{103} The District Court rejected the argument and stated that New York had legitimate interests in preserving life and protecting vulnerable persons.\textsuperscript{104} The Court of Appeals for the Second Circuit reversed on the basis that those on life support at the final stages of life could hasten their death by removing the support whereas similarly situated people, who were not on life-sustaining treatment, were not allowed to hasten their death.\textsuperscript{105} The Court of Appeals found no rational relationship between the ban and a legitimate state interest.\textsuperscript{106}

Chief Justice Rehnquist wrote the majority opinion, joined by Justices O'Connor, Scalia, Kennedy, and Thomas. The Supreme Court reaffirmed the position that there is a constitutionally protected liberty interest in refusing unwanted medical treatment and emphasized that it is based on the traditional rights to bodily integrity and freedom from unwanted touching and denied the proposition that there is a right to hasten death.\textsuperscript{107}

Chief Justice Rehnquist's opinion drew a distinction between assisted suicide and withdrawing life sustaining treatments. "This Court has recognized, at least implicitly, the distinction between letting a patient die and making that patient die."\textsuperscript{108} The majority opinion stated that the "distinction comports with fundamental legal principles of causation and intent."\textsuperscript{109} "The law has long used actors' intent or purpose to distinguish between two acts that may have the same result."\textsuperscript{110} "When a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication

\begin{itemize}
\item \textsuperscript{103} Id.
\item \textsuperscript{104} Id.
\item \textsuperscript{105} Quill v. Vacco, 80 F.3d 716 (2nd Cir. 1996).
\item \textsuperscript{106} Id. at 731.
\item \textsuperscript{107} Vacco v. Quill, 521 U.S. 793, 807 (1997).
\item \textsuperscript{108} Id. at 807.
\item \textsuperscript{109} Id. at 801.
\item \textsuperscript{110} Id. at 802.
\end{itemize}
prescribed by a physician, he is killed by that medication.” The majority stated that a physician only intends to honor a patient’s wish to cease or not to begin life-sustaining treatment whereas a physician assisting a suicide “must, necessarily and indubitably, intend primarily that the patient be made dead.” The Court stated that the intent of the physician in the scenario of removing life-sustaining treatment is the same as the intent “when a doctor provides aggressive palliative care.” In a footnote in the Majority opinion, “Just as a State may prohibit assisting suicide while permitting patients to refuse unwanted lifesaving treatment, it may permit palliative care related to that refusal, which may have the foreseen but unintended “double effect” of hastening the patient’s death.”

In a brief concurring opinion, Justice Souter stated “The reasons that led me to conclude in Glucksberg that the prohibition on assisted suicide is not arbitrary under the due process standard also support the distinction between assistance to suicide, which is banned, and practices such as termination of life support and death-hastening pain medication, which are permitted.”

E. ETHICAL CONSIDERATIONS

There are aspects of terminal sedation that people find to be problematic. It is argued that terminal sedation is indistinguishable from euthanasia; that the practice is euthanasia in disguise. Terminal sedation is not euthanasia. The main distinction is the physician’s intent to relieve suffering and not to cause death. Euthanasia involves the physician administering an agent intended to facilitate death. Terminal sedation involves the physician administering an agent intended to sedate the patient and relieve intractable suffering. When terminal sedation is

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111 Id. at 801.
112 Id. at 801-802.
113 Id. at 802.
114 Id. at 807, n. 11.
115 Id. at 809-810 (Souter, J., concurring in the judgment).
combined with the withholding or withdrawing of life-sustaining treatment, specifically artificial nutrition and hydration. The issue is more problematic regarding terminal sedation combined with withholding or withdrawing life sustaining treatment, specifically artificial nutrition and hydration, the intent distinction becomes more problematic. However, terminal sedation involves the sedation of the patient to relieve suffering. Withholding or withdrawing of treatment is a separate practice. As such, even though they may be used together, the decision to use terminal sedation and the decision to withdraw or withhold nutrition and hydration must be evaluated separately. Terminal sedation combined with withholding and withdrawing life-sustaining treatment is ethically permissible.

I. THE PRINCIPLE OF DOUBLE EFFECT

In order for a physician to engage in terminal sedation, the physician must administer the sedating medication with the intent to relieve pain and suffering, not to cause death, even though death is a foreseeable risk. This is known as the principle of double effect. The principle of double effect provides guidelines to aid in deciding if a course of action is ethically permissible. The principle is a common justification for why terminal sedation is treated as morally distinct from euthanasia. Under this rule, a foreseeable bad outcome is acceptable if it is unintended and outweighed by an intentional good. The principle of double effect has four conditions: (1) the nature of the act must be “good” or morally neutral; (2) the actor must intend the “good” effect, not the “bad” effect, but the “bad” effect may be foreseen; (3) the “bad” effect must not be a means to the good effect; and (4) there must be proportionality between the

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116 Timothy E. Quill, Rebecca Dresser & Dan W. Brock, The Rule of Double Effect – A Critique of its Role in End-of-Life Decision Making 337 NEW ENG. J. MED. 1768 (the principle of double effect was developed by Roman Catholic moral theologians and is applied to situations when it is impossible for a person to avoid all harmful actions).
118 Id.
119 Id.
intended “good” effect and the unintended but foreseen “bad” effect. Proportionality is determined based on the terminal condition of the patient, the urgent need to relieve suffering, and the consent of the patient or proxy. The first condition determines whether the act is ever permissible, the second and third conditions determine whether the potential harm is intentional or unintentional, and the fourth condition compares the net good and bad effects to determine which course produces an effect of proportionately greater value.

When applying the doctrine of double effect to terminal sedation, the “good” effect is relief of suffering and the “bad” effect is death. If one assumes that a physician administering sedative medicine to a patient to relieve pain is at least a “morally neutral” act and the situation is one where relief of suffering outweighs the possibility of death, the conditions required by the doctrine would be met if the physician administers the medication to the patient, intending only to relieve suffering by sedating the patient. This theory is best applied when the patient is terminally ill and does not have long to live because the further from death the patient is, the less likely it would be that death would be seen as the better outcome.

One criticism of the doctrine of double effect is the heavy reliance on intent of the physician, which can be difficult to judge. “The morality of everyday clinical practice depends heavily on the concept of intention, and clinicians have an unarticulated, intuitive grasp of the rule of double effect in almost all of their therapeutic interventions.” The physician’s intent may be inferred from the dose that is initially given and the process by which the dose is increased. In the medical field, proportionality requires that “the risk of causing harm bear a

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120 Quill, Dresser & Brock, supra note 115; Lo & Rubenfeld, supra note 21, at 1812.
121 Lo & Rubenfeld, supra note 21, at 1812.
122 Quill, Dresser & Brock, supra note 115, at 1770.
124 Lo & Rubenfeld, supra note 21, at 1812.
direct relationship to the danger and immediacy of the patient’s clinical situation and the expected benefit of the intervention.”\textsuperscript{125} If the initial dose is a lethal dose with no possibility for symptoms to be relieved without the patient’s death, this is closer to euthanasia and would not be considered an acceptable practice of terminal sedation. The dose should only be increased if the lower dose is ineffective.\textsuperscript{126} The notion of proportionality is crucial to differentiate palliative sedation from euthanasia.\textsuperscript{127}

Another criticism is that people are generally held accountable for consequences that they foresee and not merely for those that they intend and so the doctrine of double effect is inconsistent with societal norms regarding actions.\textsuperscript{128} The understanding of moral responsibility encourages people to act more carefully and holds people responsible for things under their control. Physician’s are often in the position of balancing risks and benefits. When a surgeon undergoes a risky surgery to remove a brain tumor in a difficult area of the brain, the physician knows that there is a chance that they can cause significant brain damage or death. However, the benefit of removing the brain tumor in most cases would significantly outweigh the possibility of death. In the medical field, foreseeable risks are common and physicians often have to weigh their duty to relieve suffering and their duty to do no harm. In most of these scenarios, there are foreseeable risks, but it is between the physician and the patient to determine the best course.

II. TERMINAL SEDATION VS. EUTHANASIA

Terminal sedation is ethically different than euthanasia. The main distinctions focus on intention and proportionality. With euthanasia and physician-assisted suicide, the primary

\begin{thebibliography}{99}
\bibitem{125} Quill et al., \textit{supra} note 19.
\bibitem{126} Lo & Rubenfeld, \textit{supra} note 21, at 1812.
\bibitem{127} Claessens, Menten, Schotsmans & Broeckaert, \textit{supra} note 20, at 328.
\bibitem{128} Lo & Rubenfeld, \textit{supra} note 21, at 1813
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intention is to cause the patient’s death. On the other hand, terminal sedation requires that the primary intention be to alleviate the patient’s suffering.

David Orentlicher, one of the first legal commentators on terminal sedation, argues that at times, terminal sedation is “slow euthanasia” because the patient dies after a few hours or days rather than immediately. Orentlicher argues that when terminal sedation is accompanied by the withholding of nutrition and hydration, the patient dies as a result of active intervention on the part of the physician. “It is the physician-created state of consciousness that is responsible for the patient’s inability to eat, not the natural progression of the patient’s underlying disease.” Orentlicher urges that the principle of double effect, as applied to terminal sedation in addition to withholding nutrition and hydration, only justifies the act of sedation and not the withholding of nutrition and hydration because starving and dehydrating the patient does not relieve suffering, it brings on the patient’s death.

The decision to use terminal sedation must be made independent of the decision to reduce or withhold artificial nutrition and hydration. The main ethical issue is whether the patient or surrogate consented to the withholding of artificial nutrition and hydration, not what caused the patient not to eat. If a patient shows signs of imminent death before sedation, it seems unethical and irresponsible to hamper the natural dying process. In many cases it would also seem futile. In most situations, candidates for terminal sedation will be near death and the overriding goal of care is no longer to prolong survival, but to provide comfort and symptom

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129 Orentlicher, supra note 6.
130 Id. at 956.
131 Id. at 957.
132 Id.
133 Claessens, Menten, Schotsmans & Broeckaert, supra note 20, at 329.
relief. Case law supports the refusal of life-sustaining treatment, including the ability to forego hydration and nutrition. This right is likely not contingent upon whether the refusal is of artificial nutrition and hydration or the patient election to discontinue eating and drinking. The American Medical Association does not recognize an ethical distinction between withdrawing and withholding life-sustaining treatment. "Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care."

Withholding nutrition and hydration does not have to be supported by the principle of double effect. If a competent patient, or a surrogate decision maker gives informed consent to forego life-sustaining treatment, the physician must respect the patient’s wishes.

Orentlicher also argues that relying on physician intent to distinguish terminal sedation from euthanasia fails because the physician must intend for the patient to die considering no one can survive for very long without nutrition and hydration. Orentlicher distinguishes withholding from withdrawal of treatment. He argues withdrawal is distinguishable from euthanasia because the physician might reasonably believe that the patient will survive after discontinuation and thus only intends to free the patient from unwanted treatment. The argument is not a strong one because the physician who withholds nutrition and hydration is only respecting the patient’s decision to decline life-sustaining treatment. Physician intent is irrelevant to the issue of withdrawing or withholding nutrition and hydration; “the operative issue is whether it is within the individual patient’s ‘liberty interest’ in making this decision.”

137 Id.
138 Orentlicher, supra note 6, at 959.
139 Id. at 958.
140 George P. Smith II, supra note 116, at 504.
There is disagreement on the propriety of using terminal sedation when the patient is suffering from psychological or emotional distress. There is a perception that death is hastened because patients may live for many years with refractory depression. It can be difficult to distinguish and draw bright lines among the three major categories of symptoms identified in the dying process: physical, psychological, and existential suffering. Psychological symptoms include depression, anxiety, fear, and delirium. Existential suffering includes feelings of meaninglessness, hopelessness and grief.

Existential pain is more difficult to access because evaluation requires special training that a physician typically lacks and it also requires continual contact with patients' families. The American Medical Association does not approve of terminal sedation to treat primarily existential suffering. Terminal sedation should not be used on patients who are primarily experiencing psychological and existential suffering; there are other forms of treatment that would be more beneficial to the patient.

III. ADDITIONAL CONCERNS

A few weeks after Mr. Oltzik’s death, Mrs. Oltzik still felt a bit uneasy. She was very upset that she did not get the chance to say goodbye to her husband. Even so, she said that she could not think of any other way to handle her husband’s agitation and she does not regret the decision. It is common for the family to be involved in the decision making process.

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141 Lo & Rubenfeld, supra note 21, at 1812.
142 Rady & Verheijde, supra note 31, at 206.
143 Id.
144 Id.
147 Id.
148 See generally Claessens, Menten, Schotsmans & Broeckaert, supra note 20, at 326.
Caregivers, family, and friends often have strong emotional reactions when a patient is experiencing severe distress; and it is important that the health care team provide emotional support and to ensure that the family and patient or surrogate have the opportunity to think through the complicated ethical issues. There should be a plan of care that includes opportunities for the family to say good-bye and for religious ceremonies or consultations with spiritual advisors.\textsuperscript{149} A study which reported on the experience of family members attitudes on terminal sedation, found that fear of shortening a loved one’s life, not being provided with enough information, and physicians and nurses who lacked sufficient compassion, contributed to dissatisfaction.\textsuperscript{150}

Clinicians are unlikely to be able to predict with sufficient accuracy the amount of time a patient will live.\textsuperscript{151} Additionally, there are arguments that terminal sedation hastens death by shortening the patient’s life. However, empirical studies have not shown an association between increases in doses of sedatives during the last hours of life and decreases in survival.\textsuperscript{152} There are numerous reports in the literature that state, directly or indirectly, that there is an absence of an impact of terminal sedation on survival duration.\textsuperscript{153}

When physicians are faced with a terminally ill patient with refractory symptoms, they face a dilemma because two ethical guidelines conflict: to relieve the patient’s suffering and not to cause the patient’s death.\textsuperscript{154} Studies have shown that more than half of physicians find the

\textsuperscript{149} Lo & Rubenfeld, supra note 21, at 1814.
\textsuperscript{150} Claessens, Menten, Schotsmans & Broeckaert, supra note 20, at 327 (citing Tatsuya Morita et al., Family Experience with Palliative Sedation Therapy for Terminally Ill Cancer Patients, 28 J. PAIN & SYMPTOM MGMT. 557 (2004)).
\textsuperscript{151} Id. at 210.
\textsuperscript{152} Lo & Rubenfeld, supra note 21, at 1815.
\textsuperscript{153} Maltoni et al., supra note 32.
\textsuperscript{154} Lo & Rubenfeld, supra note 21, at 1813.
decision making process very difficult. Proportionality can help the physician to overcome this dilemma and find the appropriate balance.

F. CONCLUSION

It is common for terminally ill patients to receive sedatives and for symptom relief to be achieved while the patient retain consciousness. However, sometimes normal palliative treatment is not enough to relieve the suffering and that is when terminal sedation becomes an option. Terminal sedation integrates 2 accepted clinical practices: (1) sedation to unconsciousness or a level that ensures escape from intolerable suffering, and (2) withholding life-sustaining therapy including food and fluids.

The Supreme Court has unanimously held that there is no constitutionally protected right to physician-assisted death. However, the concurring opinions may be read as a warning to states not to adopt statutes that would prohibit physicians from doing everything in their medical power to prevent suffering. The Court left the door open to challenges of physician-assisted suicide without a clear articulation as to the type of claim that would succeed. Justices O'Connor and Breyer indicated that patients in New York and Washington did not have barriers to obtaining pain relief at the end of life and if such barriers existed the analysis would be different. If a state were to ban the practice of terminal sedation, a claim that the ban is unconstitutional would likely fit the type of challenge that would succeed.

For the principle of double effect to apply, the conditions that must be met are (1) the action must be good or at least neutral; (2) the good effect and not the bad effect must be intended; (3) the good effect must not be produced by means of the bad effect; and (4) there must

155 Claessens, Menten, Schotmans & Broeckaert, supra note 20, at 328.
156 Lo & Rubenfeld, supra note 21, at 1811.
157 Meisel, Snyder & Quill, supra note 13, at 2499.
be proportionately grave reason for permitting the bad effect.\textsuperscript{159} Administering the medication is at least neutral. The good effect is pain relief and the bad effect is death. With terminal sedation, the physician is intending to provide pain relief to their patient. Death is foreseeable, but not intended. The effect of relieving the pain is not met by death; it is met by the medications. The patient living pain-free rather than suffering in the last days is sufficiently grave to risk the already imminent death. If you add the withholding or withdrawing of nutrition and hydration into the equation, and look at the sedation and the withholding/withdrawing as one continuous step, the principle of double effect no longer justifies the action.

Withholding or withdrawing nutrition and hydration is not a part of terminal sedation. The decision to withhold or withdraw nutrition needs to be considered separately from consideration of terminal sedation. "The liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual’s deeply personal decision to reject medical treatment, including the artificial delivery of food and water."\textsuperscript{160} A patient may decline artificial nutrition or hydration. As discussed above, the Supreme Court has implicitly approved the use of terminal sedation. Terminal sedation can be morally justified by the principle of double effect. Terminal sedation combined with the withholding or withdrawing of nutrition and hydration is legal and distinct from euthanasia.

\textsuperscript{159} Quill, Dresser & Brock, \textit{supra} note 115.
\textsuperscript{160} Cruzan 289 (O’Connor concurring).