THE HOUR OF DEATH: A CASE FOR A CLOSER LOOK AT PALLIATIVE SEDATION

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Palliative sedation is the practice of administering sedatives to terminally ill patients to relieve refractory suffering. This intervention provides compassionate relief when all other available measures fail to alleviate severe distress. And yet, the practice has also been described as "slow euthanasia" and is susceptible to abuse, raising serious ethical and legal concerns. The ethical practice of palliative sedation, directed toward the alleviation of suffering rather than to cause death, is inadequately considered in law and in legal scholarship and this Article seeks to remedy that lacuna.

In this Article, I explain the practice of palliative sedation, drawing on clinical literature to describe its definition, prevalence, and medical indication. I then explore assessments of its ethical use, guided by the principles of double effect and proportionality. I also raise the concern that palliative sedation may be practiced as a form of covert euthanasia, if improperly understood and misapplied. Building on these foundational principles, I analyze the inadequate legal distinction in American law between palliative sedation and euthanasia or physician-assisted suicide. I argue that the blurred line is amplified by the law regarding the refusal or withdrawal of nutrition and hydration.

To address these concerns, I propose further study and the development of legal reforms, especially in states seeking to promote the dignity of human life. Such reforms include enacting laws that define palliative sedation and distinguish it from physician-assisted suicide or euthanasia based on objective criteria; enhancing informed consent

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laws for the administration of palliative sedation; and developing advanced directive language that contemplates palliative sedation and its appropriate use. I also recommend reforms of the legal regulation of clinical practice, including mandatory medical training for those prescribing palliative sedation, to ensure that all persons experiencing intractable pain at the end of life receive informed, ethical, and expert care.

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INTRODUCTION

Since I am coming to that holy room,
Where, with thy choir of saints for evermore,
I shall be made thy music; as I come
I tune the instrument here at the door,
And what I must do then, think here before.
Whilst my physicians by their love are grown
Cosmographers, and I their map, who lie
Flat on this bed, that by them may be shown
That this is my south-west discovery,
Per fretum febris*, by these straits to die,*
I joy, that in these straits I see my west;
For, though their currents yield return to none,
What shall my west hurt me? As west and east
In all flat maps (and I am one) are one,
So death doth touch the resurrection.[1]

Many authors of classic literature use the "hour of death"—one often associated with a unique and intense suffering—as a narrative catalyst to explore the human condition. For example, in *Hymn to God, My God, in My Sickness*, penned by John Donne during a fever likely induced by typhus, the English poet, believing his death was near, depicts his physicians as "[c]osmographers" tasked with mapping the observable universe, his body. They witness the processes of his dying while he is pausing at the threshold of death, preparing to encounter the living God. To onlookers, he is prone in bed, "*per fretum febris*," passing helplessly, and perhaps in agony, through the "straits of fever." Yet inwardly he is active, tuning his soul as an instrument and ordering his whole self to its ultimate end. His gaze rests on his final destination where suffering will be no more.

Other works depict this deeply human moment. In Tolstoy's *The Death of Ivan Ilyich*, the title character's prolonged, severe suffering and confrontation with his mortality reveals the superficiality of his former life and prompts a search for transcendent meaning, in which he ultimately experiences reconciliation and love.[2] In Willa Cather's novella

1 John Donne, *Hymn to God, My God, In My Sickness*, POETRY FOUNDATION, https://www.poetryfoundation.org/poems/44114/hymn-to-god-my-god-in-my-sickness [https://perma.cc/7KJ3-NACJ] (last visited Feb. 28, 2026).

2 LEO TOLSTOY, THE DEATH OF IVAN ILYICH (Richard Pevear & Larissa Volokhonsky trans., Vintage Books 2009) (1886). The interested reader is encouraged to view two very fine film adaptations of Tolstoy's novella: IKIRU, Amazon Prime (Toho 1952), directed by Akira Kurosawa, and LIVING, HBO Max (Number 9 Films, et al. 2022), screenplay by Kazuo Ishiguro.

of the missionary priests of the American Southwest, *Death Comes for the Archbishop*, the author depicts the death scene of a dying priest.[3] "In those days," she writes, "death had a solemn social importance. It was not regarded as a moment when certain bodily organs ceased to function, but as a dramatic climax, a moment when the soul made its entrance into the next world, passing in full consciousness through a lowly door to an unimaginable scene."[4]

In each of these cases, consciousness at the threshold of death is constitutive of the dying person's final passage as a fully human experience rather than a mere biological event. But for many today, the "hour of death" may no longer be marked by awareness of deep suffering or a dramatic climax but instead appear as a gentle drift into a serene, final repose. The advent of medical technologies has institutionalized the process of dying.[5] Even while the number of deaths at home has risen in recent decades, most patients die in an institution such as a hospital, nursing facility, or hospice facility.[6] The development of palliative and hospice care has transformed the experience of suffering and led to a welcome focus on comfort, when hope of cure has passed, and on the relief of pain and other distressing symptoms. Indeed, many dying patients no longer face death consciously at all. Palliative sedation, the administration of sedatives to relieve intractable suffering in terminally ill patients, has become increasingly common.[7] But this practice, while necessary in some cases to alleviate unbearable distress when other interventions fail, raises profound ethical and legal questions.

It is the primary task of this Article to inquire into one of the most concerning questions raised by the growing use of palliative sedation, i.e., the risk that it will devolve into euthanasia[8] or physician-assisted

3 WILLA CATHER, DEATH COMES FOR THE ARCHBISHOP 170 (Modern Library 1984) (1927).

4 *Id.*

5 ATUL GAWANDE, BEING MORTAL: MEDICINE AND WHAT MATTERS IN THE END 6 (2014) ("Modern scientific capability has profoundly altered the course of human life. People live longer and better than at any other time in history. But scientific advances have turned the processes of aging and dying into medical experiences, matters to be managed by health care professionals.").

6 Sarah H. Cross & Haider J. Warraich, *Changes in the Place of Death in the United States*, 381 NEW ENG. J. MED. 2369, 2370 fig. 1 (2019).

7 *See infra* Part I.

8 Voluntary euthanasia is an act or omission which intends to bring about the death of a patient, upon his or her request. Involuntary euthanasia is an act or omission which intends to bring about the death of a patient, without his or her request. In either case, a third party (typically the physician) provides the means of causing death and directly administers such means. *See* JOHN KEOWN, EUTHANASIA, ETHICS AND PUBLIC POLICY: AN ARGUMENT AGAINST LEGALISATION 15 (2d ed. 2018).

suicide.[9] A preliminary clarifying point: Authentic palliative *care* is an essential tool to address suffering and may even serve as a deterrent to requests for physician-assisted suicide or euthanasia,[10] even when the patient is not experiencing intractable pain. When considering the motivations for a person to contemplate ending his life, a common assumption is that such a decision is motivated by unbearable suffering or agony.[11] However, research indicates that the most frequently cited reasons for requesting physician-assisted suicide do not include intractable pain. For example, in 2023, according to a study commissioned by the state of Washington (which permits physician-assisted suicide), the most common concerns articulated by those seeking death are: concern with decreased ability to engage in activities that make life enjoyable (eighty-three percent), fear of losing autonomy (eighty-one percent), loss of dignity (fifty-seven percent), and concern of being a burden on family or caregivers (fifty-one percent).[12] In contrast, forty-one percent reported concern about inadequate pain control.[13] Similarly, in the most recent summary report on Oregon's Death with Dignity Act, only thirty-seven percent of patients report inadequate pain control as a motivating end of life concern.[14] Palliative care, ordered toward pain management and often combined with occupational, psychosocial, and spiritual therapies, addresses these actual patient concerns, thereby reducing the allure of physician-assisted suicide. Conversely, the legalization of physician-assisted suicide may lead to the decrease in palliative care, effective pain management, and use of

9 Physician-assisted suicide "occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act" (typically through the prescription or provision of a drug which one self-administers). *Opinion 5.7: Physician-Assisted Suicide*, AMA CODE OF MED. ETHICS, https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-assisted-suicide [https://perma.cc/PKL4-CFLK] (last visited Feb. 28, 2026); *see* Jonathan Treem, *Medical Aid in Dying: Ethical and Practical Issues*, 14 J. ADV. PRAC. ONCOL. 207, 207 (2023). The AMA's Opinions constitute applications of its more general Principles of Medical Ethics to concrete issues or practices. *See* Frank A. Riddick, Jr., *The Code of Medical Ethics of the American Medical Association*, OCHSNER J., Spring 2003, at 6, 6.

10 *See* Nathan I. Cherny & Russell K. Portenoy, *Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment*, 10 J. PALLIAT. CARE, no. 2, 1994, at 31, 36 (observing that "[n]o patient should have to ask to be killed because of persistently unrelieved pain").

11 *See, e.g.*, *About Death with Dignity*, DEATH WITH DIGNITY, https://deathwithdignity.org/about/ [https://perma.cc/W8DS-8V79] (last visited Feb. 28, 2026) (The organization's mission is motivated by the concern that "some people die in horrible ways as their terminal illness overtakes them.").

12 UMAIR SHAH, WASH. STATE DEP'T OF HEALTH, REPORT TO THE LEGISLATURE: 2023 DEATH WITH DIGNITY 7 tbl. 6 (2024).

13 *Id.*

14 CTR. FOR HEALTH STAT., OR. HEALTH AUTH., OREGON DEATH WITH DIGNITY ACT: 2025 DATA SUMMARY 16 tbl. 1 (2025).

hospice care.[15] In addition to deterring resort to assisted suicide, access to palliative care, including sedation, can also properly deter physicians and patients from seeking nonbeneficial "care and treatments when they are medically inappropriate."[16] Thus, the ethical practice of palliative care is vitally important for providing care for the sick and dying.

But it does raise profound ethical questions. Beyond the risk of covert euthanasia, addressed in this Article, there are many concerning dimensions of the use of palliative sedation at the end of life. These are beyond the scope of this Article, but it is illuminating to sketch them out here to appreciate the myriad ethical and legal complexities raised by the practice of palliative sedation. For example, because it may reduce or eliminate consciousness, palliative sedation may preclude the opportunity for patients to communicate with family and to confront death with full awareness—potentially depriving patients and their family of opportunities for reconciliation or closure, and preventing patients from personal or spiritual preparation for death.[17] A resurgence in contemporary literature on the *ars moriendi*, the art of dying, has emerged to guide dying persons and their families and healthcare practitioners to better confront and navigate the complexities of death, including facing one's final moments consciously.[18]

Another ethical concern is that the use of palliative sedation risks violating the principle of informed consent, which requires that before receiving (or forgoing) a treatment or procedure, the patient receives

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15 *See, e.g.*, Jennifer Ballentine, Cordt Kassner & Ira Byock, *Physician-Assisted Death Does Not Improve End-of-Life Care*, 19 J. PALLIAT. MED. 479, 479 (2016); Terry O'Neill, *Canada's Assisted Suicide Law Undercuts Palliative Care, Experts Say*, CATH. SUN (May 18, 2022), https://www.catholicsun.org/2022/05/18/canadas-assisted-suicide-law-undercuts-palliative-care-experts-say/ [https://perma.cc/3EP5-JU6Y].

16 George P. Smith, II, *Refractory Pain, Existential Suffering, and Palliative Care: Releasing an Unbearable Lightness of Being*, 20 CORN. J.L. & PUB. POL'Y 469, 473 (2011).

17 For example, Pope John Paul II addressed the practice of palliative sedation in 1995, stating that it is licit to relieve pain, even when the result is decreased consciousness and a shortening of life, "if no other means exist, and if, in the given circumstances, this does not prevent the carrying out of other religious and moral duties." JOHN PAUL II, EVANGELIUM VITAE (1995), ¶ 65 (quoting Pius XII, Supreme Pontiff, Cath. Church, Address to an International Group of Physicians (Feb. 24, 1957)). But he continued, "'it is not right to deprive the dying person of consciousness without a serious reason': as they approach death people ought to be able to satisfy their moral and family duties, and above all they ought to be able to prepare in a fully conscious way for their definitive meeting with God." *Id.* (footnote omitted) (quoting Pius XII, *supra*). *See also* U.S. CONF. OF CATH. BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES ¶ 63 (7th ed. 2025).

18 *See, e.g.*, CHARLES CAMOSY, LIVING AND DYING WELL: A CATHOLIC PLAN FOR RESISTING PHYSICIAN-ASSISTED KILLING (2025); L.S. DUGDALE, THE LOST ART OF DYING: REVIVING FORGOTTEN WISDOM (2020); THE ART OF DYING: A NEW ANNOTATED TRANSLATION (Columba Thomas trans., The Nat'l Cath. Bioethics Ctr. 2021) (ca. 1465); IRA BYOCK, DYING WELL: PEACE AND POSSIBILITIES AT THE END OF LIFE (1997).

adequate information (diagnosis, proposed treatment, benefits, risks, and alternatives), has decisionmaking capacity, and makes the choice voluntarily, free from coercion or undue influence.[19] Many patients at the end of life may lack full medical decisional capacity, calling into question whether they can appreciate the nature of the palliative sedation decision and fully participate in it. The practice of palliative sedation poses further challenges as, even if the patient consents fully to the initial administration of sedation, his unconsciousness renders him incapable of continued consent. For this reason, some clinicians recommend the use of intermittent sedation, intended as a respite from pain but discontinued from time to time, preserving the possibility of continued communication, to both ensure that pain or suffering is actually being ameliorated and to maintain the patient's "interactive capability."[20]

If the patient is unable to participate in his own decisionmaking, surrogate or substituted decisionmaking raises other concerns. In some states, heightened evidentiary or procedural requirements apply for healthcare decisions made by third parties, such as requiring clear and convincing evidence of the patient's wishes regarding the withdrawal of life-sustaining treatment when no formal advance directive exists.[21] However, state laws lack comparable requirements for when a third party opts to choose palliative sedation for a patient. Moreover, the potential for conflicts of interest in surrogate decisionmaking is high. The surrogate's values (including financial or personal interests) may conflict with the patient's known wishes or best interests and the healthcare practitioner's recommendations.[22] The significant concerns about a patient's diminished autonomy during this time caution for *more* safeguards, rather than less, to prevent abuse and coercion, and to promote thoughtful, thorough, and informed decisionmaking.[23]

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19 *See* Alexander Morgan Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 370–71 (1974); TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 122 (8th ed. 2019); Ronald Munson, *Organ Transplantation*, *in* THE OXFORD HANDBOOK OF BIOETHICS 216, 217–28 (Bonnie Steinbock ed., 2007).

20 Molly L. Olsen, Keith M. Swetz & Paul S. Mueller, *Ethical Decision Making with End-of-Life Care: Palliative Sedation and Withholding or Withdrawing Life-Sustaining Treatments*, 85 MAYO CLINIC PROC. 949, 950 (2010).

21 *See, e.g.*, Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990) (upholding a Missouri law which required clear and convincing evidence of an incompetent's wishes as to the withdrawal of life-sustaining treatment).

22 *See, e.g.*, Alexander K. Smith, Bernard Lo & Rebecca Sudore, *When Previously Expressed Wishes Conflict with Best Interests*, 173 JAMA INTERN. MED. 1241, 1243 (2013).

23 *See generally* Lydia S. Dugdale, Barron H. Lerner & Daniel Callahan, *Pros and Cons of Physician Aid in Dying*, 92 YALE J. BIOL. & MED. 747, 748–49 (2019) (noting that advocates

Despite the numerous concerns attending palliative sedation, this Article focuses on the most fundamental of them, that is the distinction between its ethical use and intentional killing, whether physician-assisted suicide or euthanasia.[24] The practice of palliative sedation, while the subject of extensive discussion in clinical and ethical literature, has received little attention in recent American legal scholarship and is inadequately regulated in U.S. law.[25]

The Article is organized as follows. In Part I, I provide an overview of palliative sedation, drawing on clinical literature to describe its definition, types, prevalence, and medical indication. In Part II, I explore prevalent assessments of its ethical use, guided by the principle of double effect. This principle, with origins in Catholic moral theology, provides a framework to evaluate the liceity of actions, such as palliative sedation, that have both good and bad effects (here, the relief of suffering and the possibility of hastened death). As explained in Part II, despite its theological origins, the principle is widely accepted by major medical organizations and has been invoked in U.S. Supreme Court rulings. Because of this broad medical and legal endorsement, it serves as a practical, mainstream ethical standard—even for those who do not share its original religious roots. Part II will also discuss the ways in which palliative sedation may violate the boundaries of the principle of double effect and may become, either unintentionally or covertly, physician-assisted suicide or euthanasia.

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of physician-assisted suicide propose permissive laws that contain safeguards to prevent abuse and coercion).

24 This author holds the view that physician-assisted suicide and euthanasia constitute impermissible intentional killing of innocent human life and ought to be prohibited by law, and this Article proceeds on those presumptions. Human life possesses inherent, inviolable dignity, not contingent on quality, productivity, or personal choice. The moral and jurisprudential claims are not defended here, as that would require a separate, more extensive treatment. Moreover, the position is already well argued by others. *See, e.g.*, JOHN PAUL II, *supra* note 17 ¶ 57; LEON R. KASS, LIFE, LIBERTY AND THE DEFENSE OF DIGNITY: THE CHALLENGE FOR BIOETHICS 234–44 (2002); KEOWN, *supra* note 8, at 38–40. The Supreme Court has recognized the reasonableness of opposition to physician-assisted suicide and euthanasia and acknowledged that such reasons constitute legitimate state interests. *See* Washington v. Glucksberg, 521 U.S. 702, 728–33 (1997). Although many scholars consider these practices permissible (even praiseworthy), they remain highly controversial. It is therefore valuable to present a contrary perspective in the scholarly literature.

25 *See, e.g.*, Rob McStay, *Terminal Sedation: Palliative Care for Intractable Pain, Post* Glucksberg *and* Quill, 29 AM. J.L. & MED. 45 (2003); David Orentlicher, *The Supreme Court and Terminal Sedation: Rejecting Assisted Suicide, Embracing Euthanasia*, 24 HASTINGS CONST. L.Q. 947 (1997); Norman L. Cantor, *Twenty-Five Years after* Quinlan*: A Review of the Jurisprudence of Death and Dying*, 29 J.L. MED. & ETHICS 182 (2001); Richard Liu, Thaddeus Mason Pope & April Xiaoyi Xu, *Deep and Continuous Palliative Sedation Without Artificial Nutrition and Hydration: An International Review*, 35 IND. INT'L & COMPAR. L. REV. 67 (2025).

Building on these foundational principles, in Part III, I analyze the inadequate legal distinction in American law between palliative sedation and euthanasia or physician-assisted suicide. I argue that the blurred line between the two practices is evident in Supreme Court precedents and is further facilitated by the law regarding the refusal or withdrawal of nutrition and hydration. Part III also highlights the inadequate distinction between physician-assisted suicide and palliative sedation found in state statutes and suggests current statutory language does not promote ethical practice.

Part IV concludes by identifying proposals to address these concerns. In particular, I propose the development of state law reforms focused on defining the ethical practice of palliative sedation itself, and in conjunction with the withdrawal or withholding of life-sustaining treatment, to clarify its proper use and to ensure that it does not become by intent or practice a backdoor to euthanasia or physician-assisted suicide. Part IV also highlights the need for additional legal scholarship to address the importance of enhanced informed consent laws for the administration of palliative sedation, the development of advanced directive language that contemplates palliative sedation and its appropriate use, and mandatory medical training for those prescribing palliative sedation to ensure that all persons experiencing intractable pain at the end of life receive informed and ethical care.

I. PALLIATIVE SEDATION: TERMINOLOGY

The alleviation of suffering is a fundamental goal of the practice of medicine. The "duty to relieve pain and suffering is central to the physician's role as healer and is an obligation physicians have to their patients."[26] The ancient Hippocratic Oath provided that "[w]ith regard to healing the sick . . . I will take care that they suffer no hurt or damage. . . . Whatsoever house I may enter, my visit shall be for the convenience and advantage of the patient."[27] Palliative care is the

26 *Opinion 5.6: Sedation to Unconsciousness in End-of-Life Care*, AMA CODE OF MED. ETHICS, https://code-medical-ethics.ama-assn.org/ethics-opinions/sedation-unconsciousness-end-life-care [https://perma.cc/F6AX-HDLY] (last visited Feb. 28, 2026).

27 Massimo Valentino & Pietro Pavlica, *Medical Ethics*, 19 J. ULTRASOUND 73, 75 (2016). In some faith traditions, such as in Christianity, the duty to relieve suffering has a further, transcendent dimension that transforms both the sufferer and the comforter. The practice of *misericordia*—literally the suffering heart—is demonstrated by the parable of the Good Samaritan, the one who acts to alleviate suffering *and* who makes his neighbor's suffering his own. *Luke* 10:25–37. *See generally* John O'Callaghan, *Healing and Culture*, CHURCH LIFE J. (Mar. 7, 2016), https://churchlifejournal.nd.edu/articles/healing-and-culture/ [https://perma.cc/9P2R-N2PS]. This duty is also reflected in secular bioethical principles such as nonmaleficence, the obligation to "abstain from causing harm," and beneficence,

branch of medicine ordered toward the relief of pain and suffering, and hospice and palliative medicine constitutes a board-certified subspecialty.[28] According to the National Coalition for Hospice and Palliative Care, palliative care focuses on:

> expert assessment and management of pain and other symptoms, assessment and support of caregiver needs, and coordination of care. Palliative care attends to the physical, functional, psychological, practical, and spiritual consequences of a serious illness. It is a person- and family-centered approach to care, providing people living with serious illness relief from the symptoms and stress of an illness.[29]

While the alleviation of suffering is integral to all medical care, it takes on special meaning when all hope of cure or rehabilitation is gone. The goals of medicine then shift from curative to wholly palliative.[30] As captured in literature and poetry, patients at the end of life often experience unique and profound suffering, which varies widely in nature and severity. As Justice O'Connor described in her concurrence in *Washington v. Glucksberg*, the case in which the Supreme Court held that a law prohibiting physician-assisted suicide did not violate the Due Process Clause of the Fourteenth Amendment,[31] "Death will be different for each of us. For many, the last days will be spent in physical pain and perhaps the despair that accompanies physical deterioration and a loss of control of basic bodily and mental functions. Some will seek medication to alleviate that pain and other symptoms."[32]

Palliative care employs various interventions to ensure comfort, preserve dignity, and enhance quality of life at the end of life. Among these, the practice of palliative sedation has emerged as an option for managing symptoms that resist conventional treatment and cause

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the obligation to "act for the benefit of others." BEAUCHAMP & CHILDRESS, *supra* note 19, at 155, 217–18 (8th ed. 2019).

28 *See Internal Medicine & Subspecialty Policies*, ABIM, https://www.abim.org/certification/policies/internal-medicine-subspecialty-policies/hospice-and-palliative-medicine/ [https://perma.cc/3RGL-HL7J] (last visited Feb. 28, 2026). The history of palliative care and the origins of the hospice movement are beyond this Article's scope. Interested readers may wish to explore further resources, such as these seminal works: DAVID CLARK, TO COMFORT ALWAYS: A HISTORY OF PALLIATIVE MEDICINE SINCE THE NINETEENTH CENTURY (2016); ELISABETH KÜBLER-ROSS, ON DEATH AND DYING (1969); Cicely Saunders, *Hospice*, 1 MORTALITY 317 (1996).

29 NAT'L CONSENSUS PROJECT FOR QUALITY PALLIATIVE CARE, CLINICAL PRACTICE GUIDELINES FOR QUALITY PALLIATIVE CARE, at i (4th ed. 2018).

30 Some hospice palliative care programs permit or encourage the continuation of curative care or provide "bridge care" between curative care and hospice care. *See, e.g.*, *The Bridge Program*, OUR HOSPICE, https://www.ourhospice.org/bridge-program/ [https://perma.cc/FA35-RXLG] (last visited Mar. 19, 2026).

31 Washington v. Glucksberg, 521 U.S. 702, 735 (1997).

32 *Id.* at 736 (O'Connor, J., concurring).

significant distress.[33] But what constitutes the practice of palliative sedation is not well defined and is subject to controversy.[34] The term can be understood first by examining the ordinary meaning of its component terms. The term "palliative" refers to treatments that alleviate "the symptoms of a disease or condition without dealing with the underlying cause."[35] That is, palliative care focuses on symptom relief and management rather than treatment of the underlying illness or achievement of a cure. "Sedation," in a medical context, involves the use of medications to perform the "action of allaying, assuaging, making calm or quiet."[36] Sedation, therefore, does not necessarily mean that the patient will be rendered unconscious; the level of sedation can be tailored to the patient's needs, ranging from mild relaxation to deep states of reduced or eliminated awareness. Thus, at a minimum, palliative sedation involves administering medications[37] to calm a patient and relieve distressing symptoms and promoting patient comfort. So described, this practice is consistent with the physician's fundamental duty to seek to relieve a patient's suffering.[38]

A. Definition and Types of Sedation

However, the definition of palliative sedation lacks a univocal reference point due to the widespread use of variable and inconsistent

33 *See* Patricia Claessens, Johan Menten, Paul Schotsmans & Bert Broeckaert, *Palliative Sedation: A Review of the Research Literature*, 36 J. PAIN & SYMPTOM MGMT. 310, 311 (2008).

34 *See id.*

35 *Palliative*, OXFORD ENGLISH DICTIONARY (3d ed. 2005).

36 *Sedation*, OXFORD ENGLISH DICTIONARY (2d ed. 1989).

37 Although historically physicians used opioids and barbiturates for pain management and sedation, they have significant side effects. *See* Cherny & Portenoy, *supra* note 10, at 35 (noting "side effects such as myoclonus or agitated delirium," as well as "inadequate sedation"). Medical professionals now favor benzodiazepines, such as midazolam, for sedation due to their "short duration, rapid onset, and availability of subcutaneous route." Tatsuya Morita, Satoshi Inoue & Satoshi Chihara, *Sedation for Symptom Control in Japan: The Importance of Intermittent Use and Communication with Family Members*, 12 J. PAIN & SYMPTOM MGMT. 32, 37 (1996); *see also* N.I. Cherny, ESMO Guidelines Working Grp., *ESMO Clinical Practice Guidelines for the Management of Refractory Symptoms at the End of Life and the Use of Palliative Sedation*, 25 ANN. ONCOL. (SUPP. 3) iii143, iii147 tbl. 2 (2014) (listing pharmacology, dosage, and adverse effects for medications used for sedation in palliative care); Bert Broeckaert & Juan Manuel Nuñez Olarte, *Sedation in Palliative Care: Facts and Concepts*, *in* THE ETHICS OF PALLIATIVE CARE: EUROPEAN PERSPECTIVES 166, 174–75 (Henk ten Have & David Clark eds., 2002) (describing literature reviews of drugs used and summarizing information).

38 According to the American Medical Association, the practice of palliative sedation is squarely within the duty of the physician to relieve suffering. AMA CODE OF MED. ETHICS, *supra* note 26; *see also* Cherny & Portenoy, *supra* note 10, at 36 ("The relief of intolerable symptoms in patients with far advanced cancer and other terminal diseases is a moral imperative.").

terminology and the disputed and subjective nature of the indications calling for its use.[39] In 1991, the term used in clinical literature to describe the emerging practice of drug-induced sedation for pain control at the end of life was "terminal sedation."[40] Within the decade, some expressed concern that the use of the modifier, "terminal," could be taken to imply the termination of life, rather than the use of palliative sedation in cases of terminal illness.[41] In 2000, medical ethicist Bert Broeckaert proposed the term "palliative sedation" to address such perceived problems with the original phrasing, and especially to avoid connotations of euthanasia.[42] Broeckaert defined palliative sedation as "the intentional administration of sedative drugs in dosages and combinations required to reduce the consciousness of a terminal patient as much as needed to adequately relieve one or more refractory symptoms."[43] Later, Dutch researcher Judith Rietjens and colleagues described the term as "the administration of drugs to keep the patient in deep sedation or coma until death, without giving artificial nutrition or hydration,"[44] expanding the scope of the practice encompassed by the term.

Professional organizations each also adopt slightly different definitions. For example, the American Academy of Hospice and Palliative

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39 *See* Claessens et al., *supra* note 33, at 311; *see also* Columba Thomas, Yesne Alici, William Breitbart, Eduardo Bruera, Liz Blackler & Daniel P. Sulmasy, *Addressing Challenges with Sedation in End-of-Life Care*, 67 J. PAIN & SYMPTOM MGMT. 346, 347 (2024) ("Data regarding real-life practices of sedation in end-of-life care are largely from outside the United States, heterogeneous, and challenging to interpret because of variability in definitions used and approaches described.").

40 Robert E. Enck, *Drug-Induced Terminal Sedation for Symptom Control*, AM. J. HOSP. & PALLIAT. CARE, Sep./Oct. 1991, at 3, 5 (calling for further study of the appropriateness of the practice).

41 Bert Broeckaert, *Palliative Sedation: Ethical Aspects*, *in* BETWEEN TECHNOLOGY AND HUMANITY: THE IMPACT OF TECHNOLOGY ON HEALTH CARE ETHICS 239, 242 (Chris Gastmans ed., 2002) (finding that the phrase "terminal sedation" contributes to the conflation of the palliative practice with euthanasia).

42 *See* Bert Broeckaert, Abstract, *Palliative Sedation Defined or Why and When Sedation Is Not Euthanasia*, 20 J. PAIN & SYMPTOM MGMT. (ABSTRACTS) S58 (2000); *see also* Broeckaert, *supra* note 41, at 241 (discussing use of the phrase "terminal sedation" and opposition to such terminology and describing international discussions on the ethics of palliative sedation).

43 Broeckaert, *supra* note 42, at S58. In a 2011 article, Broeckaert stated that he would add "as much *and as long* as necessary," to emphasize that in some cases a temporary use of sedation is sufficient. Bert Broeckaert, *Palliative Sedation, Physician-Assisted Suicide, and Euthanasia: "Same, Same but Different"?*, AM. J. BIOETH., June 2011, at 62, 63.

44 Judith A.C. Rietjens, Johannes J.M. van Delden, Agnes van der Heide, Astrid M. Vrakking, Bregje D. Onwuteaka-Philipsen, Paul J. van der Maas & Gerrit van der Wal, *Terminal Sedation and Euthanasia: A Comparison of Clinical Practices*, 166 ARCH. INTERN. MED. 749, 750 (2006). For a discussion of the complications of concurrent withholding or withdrawing of nutrition and hydration, see *infra* Section II.D.

Medicine (AAHPM) defines palliative sedation as "the intentional lowering of awareness towards, and including, unconsciousness for patients with severe and refractory symptoms."[45] The European Association for Palliative Care (EAPC) states that palliative sedation "aims to relieve refractory suffering through the monitored proportional use of medications intended to reduce consciousness in patients with life-limiting disease."[46] The National Hospice and Palliative Care Organization (NHPCO) defines it as "the lowering of patient consciousness using medications for the express purpose of limiting patient awareness of suffering that is *intractable* and *intolerable*" and limits its use to patients who are imminently dying.[47]

As can be seen from these representative examples from the clinical and organizational literature, the definition of "palliative sedation" and its indications vary widely. Broeckaert's 2000 definition focuses on the reduction of consciousness only as necessary to control refractory symptoms in terminal patients.[48] In such a practice, the dosage must be monitored carefully and titrated to continue to achieve symptom control.[49] In contrast, Rietjens's description emphasizes the preservation of deep sedation or coma until death in combination with the omission of artificial nutrition or hydration.[50] The AAHPM defines the practice as "the intentional lowering of awareness," including to unconsciousness, for severe symptoms, and recognizes that "patients receiving palliative sedation are typically close to death," but does not necessarily limit it to end of life situations.[51] Similarly, the EAPC framework contains "no specific period of remaining life expectancy."[52] In contrast, NHPCO narrows its application to "imminently dying" patients.[53]

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45 *Palliative Sedation*, AAHPM (2014), https://aahpm.org/advocacy/where-we-stand/palliative-sedation/ [https://perma.cc/EWN3-YKRZ].

46 Séverine M. Surges et al., *Revised European Association for Palliative Care (EAPC) Recommended Framework on Palliative Sedation: An International Delphi Study*, 38 PALLIAT. MED. 213, 221 tbl. 4 (2024) (emphasis omitted).

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

48 Broeckaert, *supra* note 42, at S58.

49 *See* Cherny & Portenoy, *supra* note 10, at 36 (indicating that sedation requires monitoring to ensure administration conforms to the goal of care).

50 *See* Rietjens et al., *supra* note 44, at 750.

51 AAHPM, *supra* note 45.

52 Surges et al., *supra* note 46, at 219.

53 Kirk & Mahon, *supra* note 47, at 915 (emphasis omitted).

Moreover, different studies may use the term, "palliative sedation," to refer to distinct types of sedation.[54] For example, "heavy sedation" leads to unconsciousness, whereas "mild" or "conscious" sedation may preserve the ability of patients to communicate.[55] "Emergency sedation" provides "urgent relief of overwhelming symptoms in dying patients . . . [such as] massive haemorrhage, asphyxiation, severe terminal dyspnoea, or overwhelming pain crisis."[56] With "proportional sedation," "sedatives are progressively increased according to the level of symptom palliation achieved: unconsciousness is only induced if palliation of suffering is not possible."[57] "Rapid deep sedation," in contrast, refers to the rapid increase of sedatives "until the patient is unconscious and then they are often maintained at that level until death."[58]

Terminology choices, such as "terminal sedation" or "palliative sedation," may reflect differing normative perspectives. Indiscriminate usage blurs these distinctions. For example, Daniel Sulmasy and Lynn Jansen note that "terminal sedation" can refer to either "sedation of the imminently dying" or "sedation toward death" depending on whether hastened death is the goal.[59] The first, "sedation of the imminently dying," involves sedation to alleviate severe refractory symptoms in patients near death.[60] Hastened death is not the goal but is a possible side effect. This type of sedation may be accompanied by the "withholding or withdrawing of life-sustaining treatments" where they would be "ineffective or disproportionately burdensome."[61] In contrast, "sedation toward death" is used regardless of whether death is imminent.[62] The refractory symptom may simply be the "consciousness that one is not yet dead."[63] The hastening of death is the intended goal,

54 *See, e.g.*, Tatsuya Morita, Kengo Imai, Masanori Mori, Naosuke Yokomichi & Satoru Tsuneto, *Defining "Continuous Deep Sedation" Using Treatment Protocol: A Proposal Article*, PALLIAT. MED. REPS., Jan.–Dec. 2022, at 8, 9–10 (providing a framework of four types of sedative use based on treatment goal, rapidity of dose titration, and planned duration of treatment).

55 H. Christof Muller-Busch, Inge Andres & Thomas Jehser, *Sedation in Palliative Care–A Critical Analysis of 7 Years Experience*, 2 BMC PALLIAT. CARE art. no. 2, at 1, 2, 8 (2003); *see also* Cherny, *supra* note 37, at iii144; Josep Porta Sales, *Sedation and Terminal Care*, 8 EUR. J. PALLIAT. CARE 97, 98 (2001).

56 Cherny, *supra* note 37, at iii148.

57 Morita et al., *supra* note 54, at 9.

58 *Id.*

59 Lynn A. Jansen & Daniel P. Sulmasy, *Sedation, Alimentation, Hydration, and Equivocation: Careful Conversation About Care at the End of Life*, 136 ANN. INTERN. MED. 845, 845 (2002) (emphasis omitted).

60 *See id.*

61 *Id.*

62 *Id.*

63 *Id.*

and "life-sustaining [measures] are withdrawn to hasten death" (whether or not they would be effective or helpful).[64]

The various and inconsistent definitions make it difficult to draw clinically significant conclusions from research and clinical studies as they may be distinguished temporally, by dose titration, by the level of the patient's consciousness, or the conditions under which sedation is used. They also make it difficult to make ethical judgments about the practice.

B. Incidence of Use

The exact frequency of administration of palliative sedation is unknown, in part due to the absence of a uniform definition.[65] Its reported uses range from rare to prevalent. For instance, the American Medical Association Code of Medical Ethics describes palliative sedation as "an intervention of last resort."[66] Dr. Ira Byock, in his seminal book on palliative care, *Dying Well: Peace and Possibilities at the End of Life*, relates that "[C]omfort is *always* possible. Although . . . it is considered from time to time, over the past ten years, as I have helped care for hundreds of hospice patients in Missoula, I have needed to resort to full sedation utilizing an infusion of barbiturate only once."[67] In contrast, some studies indicate its use may be or has become far more prevalent; one review of the literature reported use of palliative sedation ranged between one percent and fifty-two percent of terminally ill patients. [68] One medical expert posited that of the two million deaths that occur every year "in medical settings, . . . 85 percent to 90 percent of those are preceded by decisions to withhold or end life support. The vast majority involve sedation."[69] A recent international review estimated that twelve percent to eighteen percent of patients globally receive continuous palliative sedation until death.[70] The EAPC reports that it "is estimated that palliative sedation precedes 10%–18% of deaths of palliative care patients in Europe, although its use is known to vary considerably across cultures and countries, and even between

64 *Id.*

65 *See* Claessens et al., *supra* note 33, at 328. Other explanations for variation include different settings of palliative sedation, accepted indications for its use, and methodology of the prevalence study. *See id.*

66 AMA CODE OF MED. ETHICS, *supra* note 26.

67 BYOCK, *supra* note 18, at 215.

68 Kirk & Mahon, *supra* note 47, at 920; *see also* Claessens et al., *supra* note 33, at 325.

69 Denise Grady, *Medical and Ethical Questions Raised on Deaths of Critically Ill Patients*, N.Y. TIMES (July 20, 2006), https://www.nytimes.com/2006/07/20/health/20ethics.html [https://perma.cc/9BZ3-GLNX].

70 Liu, Pope & Xu, *supra* note 25, at 73.

institutions."[71] Some types, such as mild or intermittent sedation, are more prevalent than others.[72] Additionally, limited knowledge and insufficient clinical expertise may contribute to disparities in reported use, with some evidence suggesting that "good clinical palliative care decreases the need for palliative sedation significantly."[73]

C. Limitation to "Terminal" Patients

As noted, according to many formulations of the term, the appropriate use of palliative sedation is limited to "terminal" patients. Limiting palliative sedation to those facing terminal conditions recognizes the significant risks of the practice, which include diminishing the capacity of the patient to communicate and increasing the risk of a hastened death.[74] Dr. Nathan Cherny, an oncologist and palliative care specialist and one of the earliest to write about the use of sedation to manage refractory symptoms, noted that sedation's "loss of interactional function" makes it unsuitable for routine chronic pain management.[75] But, as Dr. Cherny also noted, at the end of life, the "goals of care may shift and the relief of suffering may predominate over all other considerations."[76]

According to Broeckaert, "terminal" refers to one who is imminently dying or "with a very limited life expectancy—either days or weeks."[77] The nearness of death, however, is difficult to predict with accuracy.[78] NHPCO defines "imminent death" as "a prognosis of death

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71 Surges et al., *supra* note 46, at 214.

72 *See* Claessens et al., *supra* note 33, at 328.

73 Bert Broeckaert, Patricia Claessens, Paul Schotsmans & Johan Menten, Letter, *What's in a Name? Palliative Sedation in Belgium. Reply to Chambaere et al.*, 41 J. PAIN & SYMPTOM MGMT. e2, e3 (2011).

74 Henk ten Have & Jos V.M. Welie, *Palliative Sedation Versus Euthanasia: An Ethical Assessment*, 47 J. PAIN & SYMPTOM MGMT. 123, 128 (2014). Whether sedation alone in fact hastens or causes death in terminally ill patients is debated in the literature and varies in clinical practice. *See, e.g.*, Marco Maltoni, Emanuela Scarpi, Marta Rosati, Stefania Derni, Laura Fabbri, Francesca Martini, Dino Amadori & Oriana Nanni, *Palliative Sedation in End-of-Life Care and Survival: A Systematic Review*, 30 J. CLIN. ONCOL. 1378, 1381 (2012) ("[I]n the context of specialist palliative care and when correctly used for symptom relief, it is not associated with shortening of life."); Cherny, *supra* note 37, at iii144 (finding that "neither the administration of palliative sedation nor the degree of sedation hastens death in otherwise terminally ill patients"); In Cheol Hwang, *Current Status and Future Directions of Research on Palliative Sedation*, 25 J. HOSPICE & PALLIATIVE CARE 193, 193–94 (2022).

75 Cherny & Portenoy, *supra* note 10, at 31.

76 *Id.*

77 Broeckaert & Nuñez Olarte, *supra* note 37, at 171. *But see* Jeffrey T. Berger, *Rethinking Guidelines for the Use of Palliative Sedation*, HASTINGS CTR. REP., May–June 2010, at 32, 36–37 (calling for adjusting the guidelines for the use of sedation to unconsciousness so that it is not limited to cases of imminent death).

78 *See* ten Have & Welie, *supra* note 74, at 128.

within 14 days,"[79] while the American Medical Association (AMA) limits its palliative sedation to "patients in the final stages of terminal illness," without specifying a timeframe.[80] The AAHPM associates refractory symptoms "with very advanced terminal illness," reserving palliative sedation for "extreme situations," but does not exclude the possibility that it would be employed for a nonterminal patient.[81]

As will be explored further in Part II, whether the practice of palliative sedation is reserved to the terminally ill raises ethical issues, especially when a patient sedated to unconsciousness is deprived of life-sustaining care, such as artificial nutrition and hydration.[82] If the patient is not imminently dying, forgoing such care would likely cause death. Even in the case of the imminently dying, the phrase, "refusal of hydration and nutrition," can refer to practices with different ethical implications.[83] For example, it can refer to the refusal of *artificial* nutrition and hydration in cases in which such sustenance is unable to accomplish its proper object of nourishing the patient, or it can refer to voluntarily stopping eating and drinking (VSED) for the purpose of ending one's life.[84] Vague definitions and improper distinctions risk misleading physicians in two directions—either encouraging participation "in practices that oppose their moral commitments" such as physician-assisted suicide[85] or deterring them from providing ethical care based on an unfounded fear of hastening death.

D. Use to Relieve "Refractory" Symptoms

Palliative sedation is often defined as a vital option for addressing "refractory" symptoms, that is those that resist conventional treatment and cause significant distress. This presents another interpretative challenge. The intent to relieve refractory pain distinguishes palliative sedation from other—often temporary—applications of sedative medications for other indications, such as inducing restorative sleep,

79 Kirk & Mahon, *supra* note 47, at 916.

80 AMA CODE OF MED. ETHICS, *supra* note 26.

81 AAHPM, *supra* note 45.

82 *See* discussion *infra* Part II; *infra* Section II.D.

83 Jansen & Sulmasy, *supra* note 59, at 845.

84 *Id.* at 845–46; *see also* William Cardinal Levada, *Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration*, VATICAN: ROMAN CURIA (Aug. 1, 2007), https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_risposte-usa_en.html [https://perma.cc/Y2WS-HULQ] (stating that artificial nutrition and hydration constitutes an "ordinary and proportionate means of preserving life," and is therefore obligatory for as long as it demonstrably serves its proper purpose of nourishing and hydrating the patient); U.S. CONF. OF CATH. BISHOPS, *supra* note 17, at 27 ¶ 60.

85 Jansen & Sulmasy, *supra* note 59, at 848–49.

preparing patients for medical procedures and surgeries (in conjunction with anesthetics), treating anxiety disorders, or relaxing muscles.[86] NHPCO describes refractory symptoms as "suffering that 'cannot be adequately controlled despite aggressive efforts to identify [. . .] tolerable therapy that does not compromise consciousness.'"[87] Refractory symptoms are distinct from "difficult" symptoms, i.e., those that could "potentially respond within a tolerable time frame" and "yield adequate relief and preserved consciousness without excessive adverse effects."[88]

Determining the nature and extent of pain is patient-specific and what constitutes exhaustive "aggressive efforts" to remedy pain may be subject to situational or environmental subjectivity, such as available clinical resources. A rural hospital with limited resources may differ in options compared to an urban research hospital with a dedicated palliative care team.[89] Additionally, it may be convenient for nonmedical reasons to describe any symptoms which necessitate intensive resources as refractory. Fixed budgets and economic pressures could incentivize sedation over more resource-intensive care options. After all, sedation at the end of life may prove more cost-effective than a "comprehensive package of physical therapy, nursing care, spiritual support, and various carefully titrated pharmacological forms of symptom relief."[90] Such financial considerations could influence clinical decisionmaking, prioritizing cost containment over the needs of patients at the end of life.[91]

E. What is Pain?

Another definitional debate is what constitutes the type of "pain" justifying palliative sedation. According to a systematic review, the most common symptoms requiring sedation are delirium, dyspnea (i.e., breathlessness), and psychological distress.[92] Some scholars contend

86 *See* AMA CODE OF MED. ETHICS, *supra* note 26.

87 Kirk & Mahon, *supra* note 47, at 917 (quoting Cherny & Portenoy, *supra* note 10, at 31 (describing refractory pain as symptoms that "cannot be adequately controlled despite aggressive efforts to identify a tolerable therapy that does not compromise consciousness")) (quote corrected).

88 Cherny & Portenoy, *supra* note 10, at 32, 32–34 (describing the challenges of distinguishing difficult from refractory symptoms).

89 *See* ten Have & Welie, *supra* note 74, at 130 (noting that refractoriness is dependent on the quality of care). Cherny recommends if "local expertise is limited, telephone consultation with experts in palliative medicine is strongly encouraged." Cherny, *supra* note 37, at iii145.

90 ten Have & Welie, *supra* note 74, at 130.

91 *See id.* (noting that "the financial objectives of the new for-profit hospice industry are frequently at odds with the goal of compassionate service to the dying").

92 Maltoni et al., *supra* note 74, at 1381 fig. 2.

that palliative sedation is only justified by physical suffering, such as delirium or dyspnea.[93] These experts posit that it is inappropriate to resort to palliative sedation to respond to "psycho-existential suffering, such as loss of autonomy, dependency, feelings of meaninglessness, and burden on others."[94] Such existential pain, they argue, is harder to quantify and "the severity of distress may be highly fluid and idiosyncratic."[95] Further, these scholars stress that such suffering is addressed more properly through counseling or spiritual accompaniment. According to medical doctor and bioethicist Daniel Sulmasy, sedation for existential suffering "denies medicine's restorative goals" by rendering a patient unconscious and thus unable to experience "spiritual and existential restoration and growth," something a patient must be conscious to do.[96] Others contend that sedation to unconsciousness is unethical in the context of existential suffering on the basis that such patients may not be imminently dying, and thus the intended use of sedation in such cases is actually to cause death.[97] Or, it is argued that use of sedation to unconsciousness is not proportional to treat existential suffering alone.[98]

In contrast, other scholars argue that, at least in the case of the imminently dying, there is no justification for restricting the use of palliative sedation to physical symptoms alone.[99] Broeckaert, for example, "see[s] no reason why people should be ethically required to participate consciously in their own process of dying," noting that there are "many people who hope, not before they have reached a respectable age, to die peacefully in their sleep."[100] He cautions, however, that

93 *See* Claessens et al., *supra* note 33, at 325.

94 Tatsuya Morita, *Palliative Sedation to Relieve Psycho-Existential Suffering of Terminally Ill Cancer Patients*, 28 J. PAIN & SYMPTOM MGMT. 445, 446 (2004). For a different taxonomy of types of suffering, see Lynn A. Jansen & Daniel P. Sulmasy, *Proportionality, Terminal Suffering and the Restorative Goals of Medicine*, 23 THEOR. MED. & BIOETH. 321, 322 (2002) (distinguishing "neuro-cognitive" suffering from "agent-narrative" suffering).

95 Cherny & Portenoy, *supra* note 10, at 34. *See also* Smith, *supra* note 16, at 473 (describing various types of pain and the interplay between existential and physical pain).

96 BIOS CENTRE, *Prof Daniel Sulmasy on "Continuous Deep Sedation in Palliative Care"*, at 48:44 (YouTube, Mar. 20, 2025), https://www.youtube.com/watch?app=desktop&v=S9BX7yC5Md8&sttick=0 [https://perma.cc/MT8H-G7JN].

97 *See* ten Have & Welie, *supra* note 74, at 132.

98 *See* Jansen & Sulmasy, *supra* note 59, at 847.

99 *See, e.g.*, Morita, *supra* note 94, at 449 (concluding that "palliative sedation for psycho-existential suffering could be ethically permissible in exceptional cases, if the proportionality and autonomy principle is applied").

100 Broeckaert, *supra* note 41, at 247; *see also* Laura Gilbertson, Julian Savulescu, Justin Oakley & Dominic Wilkinson, *Expanded Terminal Sedation in End-of-Life Care*, 49 J. MED. ETHICS 252 (2023) (arguing for expanded use of terminal sedation beyond traditional limits); Smith, *supra* note 16, at 480–88 (arguing that the palliative management of existential pain

"sedation cannot be a convenient solution which merely camouflages the lack of adequate psychological and spiritual counseling."[101] ten Have and Welie further argue that restricting sedation to physiological pain "introduces a reductionist understanding of palliative care."[102] They claim the decisive factor should not be the nature of the pain, but the refractoriness of the suffering.[103] As with the definition itself, guidelines promulgated by various professional societies reflect the lack of consensus regarding the nature of pain which indicates the use of palliative sedation. For example, under the EAPC's revised framework the term suffering "is used to encompass distressing physical and psychological symptoms as well as states of existential suffering," and thus permits palliative sedation for refractory existential suffering.[104] The AMA recommends its use for "severe pain *or other distressing clinical symptoms* that do not respond to aggressive, symptom-specific palliation."[105] And, NHPCO stated its ethics committee was "unable to reach agreement on a recommendation regarding this practice."[106]

The widespread terminological confusion outlined in Part I creates significant challenges for clinicians, patients, and families at the bedside.[107] Simply renaming the practice from "terminal sedation" to "palliative sedation" did little to "change the experience of those at the bedside who saw the patient being sedated and, without ever regaining consciousness, expire not very long thereafter."[108] This terminological confusion is compounded by substantial variation in the clinical criteria justifying sedation, in its administration, and, as discussed in Part III, in the law's persistent vagueness.[109] Together, these factors raise the risk that palliative sedation may unintentionally cross into euthanasia or serve as a covert means of facilitating physician-assisted suicide or euthanasia where they are prohibited. Conversely, the same uncertainties may deter clinicians and patients from pursuing legitimate, necessary palliative care out of ethical or legal concerns. Despite these difficulties, a clear and precise understanding of palliative

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has been neglected and calling for further study as to whether terminal sedation is valid for "nonterminal psychiatric illness").

101 Broeckaert, *supra* note 41, at 247.

102 ten Have & Welie, *supra* note 74, at 129.

103 *Id.* at 130.

104 Surges et al., *supra* note 46, at 219.

105 AMA CODE OF MED. ETHICS, *supra* note 26 (emphasis added).

106 Kirk & Mahon, *supra* note 47, at 916.

107 *See, e.g.*, Lauren Vogel, News, *Framework Urges Physicians to Proceed with Caution on Palliative Sedation*, 183 CAN. MED. ASS'N J. 174, 174 (2011) (noting that forty-eight percent of medical specialists in Quebec thought palliative sedation "can be likened to a form of euthanasia").

108 ten Have & Welie, *supra* note 74, at 125.

109 *See infra* Part III.

sedation remains essential to appreciating the bioethical principles that justify its use—a task taken up in Part II.

II. PALLIATIVE SEDATION OR INTENTIONAL KILLING? THE PRINCIPLE OF DOUBLE EFFECT

As described in Part I, a typical definition of palliative sedation is the administration of sedative medications to alleviate refractory suffering in terminally ill patients. This practice is ordered toward relief from suffering. In contrast, physician-assisted suicide entails the deliberate provision of lethal medication by a physician to a competent patient for self-administration, with the explicit intent of causing the patient's death. Euthanasia is an act or omission which intends to bring about the death of a patient, whether upon his or her request (voluntary) or not (involuntary). Euthanasia and physician-assisted suicide are morally fraught not only because they intentionally end human life, but also because they fundamentally contradict medicine's healing mission, undermine human dignity, disincentivize effective alternatives, risk dangerous expansions especially for vulnerable persons, and erode societal values that affirm life in all its stages.[110] Nevertheless, at the time of writing, they are legally permitted in specific regions, such as physician-assisted suicide in thirteen U.S. states and the District of Columbia[111] and euthanasia in countries like Canada[112] and the Netherlands.[113] It is essential for physicians to differentiate physician-assisted suicide and euthanasia from the ethical practice of palliative sedation to preserve the sanctity of human life, to follow the bioethical injunction to "do no harm," and to provide genuine, compassionate palliative care.

A. The Principle of Double Effect

So long as the use of palliative sedation is directed toward relieving suffering, and not causing death, the practice is widely regarded as

110 *See supra* note 24; *see also* Vacco v. Quill, 521 U.S. 793, 808–09 (1997) (listing legitimate state interests in prohibiting assisted suicide, such as those listed); Washington v. Glucksberg, 521 U.S. 702, 728–35 (1997) (listing legitimate state interests). For an account of public bioethics based on an anthropology of human embodiment and defense of the protection of life at all stages, see O. CARTER SNEAD, WHAT IT MEANS TO BE HUMAN: THE CASE FOR THE BODY IN PUBLIC BIOETHICS (2020).

111 *See infra* note 262.

112 *See* Isabel Grant, *Legislated Ableism: Bill C-7 and the Rapid Expansion of Medical Assistance in Dying in Canada*, 15 MCGILL J.L. & HEALTH 259, 270-82 (2024) (summarizing brief history of MAiD in Canada).

113 *See* KEOWN, *supra* note 8 at 91 (Part III includes a chronological account of the Dutch experience.).

ethically appropriate under the principle of double effect, a moral reasoning framework used to evaluate actions with both good and bad effects. The first formulation of the principle of double effect is attributed to medieval theologian Thomas Aquinas,[114] and Roman Catholic moral theologians further developed and applied it.[115] But its application does not depend upon a particular theological framework and it is used widely in medical ethics "particularly to govern medical decisions whose outcomes include shortening a patient's life."[116] In fact, the major professional societies in the United States rely on the principle of double effect in their statements supporting the practice of palliative sedation,[117] and it has been invoked by the United States Supreme Court, as explained below in Section III.A.[118]

A typical formulation of the principle of double effect is that:

> A person may licitly perform an action that he foresees will produce a good and a bad effect provided that four conditions are verified at one and the same time: 1) that the action in itself from its very object be good or at least indifferent; 2) that the good effect and not the evil effect be intended; 3) that the good effect be not produced by means of the evil effect; 4) that there be a proportionately grave reason for permitting the evil effect.[119]

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114 *See* THOMAS AQUINAS, SUMMA THEOLOGICA, pt. II-II, q. 64, art. 7 (Fathers of the English Dominican Province trans., R & T. Washbourne, Ltd., 2d rev. ed. 1918) (c. 1270) Here, Aquinas considers an act with good and bad effects in his justification of killing in self-defense. Some scholars contest whether the principle of double effect is fairly attributed to Aquinas. *See, e.g.*, G.E.M. ANSCOMBE, *Action, Intention and 'Double Effect,' in* HUMAN LIFE, ACTION AND ETHICS: ESSAYS BY G.E.M. ANSCOMBE 207, 225 (Mary Geach & Luke Gormally eds., 2005).

115 *See e.g.*, Joseph T. Mangan, *An Historical Analysis of the Principle of Double Effect*, 10 THEOLOGICAL STUD. 41, 42 (1949) ("[B]efore the time of St. Thomas Aquinas there is no indication of a definitely formulated principle of the double effect."); Columba Thomas, *Double Effect Reconsidered: A Thomistic Reappraisal of Contemporary Accounts*, 89 THOMIST: 493, 493 (2025).

116 Joseph Boyle, *Medical Ethics and Double Effect: The Case of Terminal Sedation*, 25 THEOR. MED. & BIOETH. 51, 51 (2004).

117 *See, e.g.*, Kirk & Mahon, *supra* note 47, at 916 ("Properly administered, palliative sedation of patients who are imminently dying is not the proximate cause of patient death, nor is death a means to achieve symptom relief in palliative sedation. As such, palliative sedation is categorically distinct from euthanasia and assisted suicide."); AMA CODE OF MED. ETHICS, *supra* note 26 (providing that "[s]edation to unconsciousness must never be used to intentionally cause a patient's death"); AAHPM, *supra* note 45 (providing that "[p]ractitioners who use palliative sedation should be clear in their intent to palliate symptoms and to not shorten survival").

118 *See infra* Section III.A.

119 Mangan, *supra* note 115, at 43*; see also* Thomas, *supra* note 115, at 523 (proposal of revised criteria for double effect reasoning to comport more closely with the thought of Aquinas). Note that Sulmasy expands the conditions of the rule of double effect, which he

We may apply the principle of double effect to palliative sedation as follows. The proper use of palliative sedation consists of a physician administering sedative drugs which may produce a good effect (the relief of refractory symptoms) and a bad effect (the hastening of death).[120] This action, the administration of sedative drugs, is at least indifferent (i.e., it is not intrinsically evil to provide sedative drugs to a patient to relieve pain). The good effect, the relief of pain, is intended. The bad effect, the hastening of death, is not intended. The good effect is not produced by means of the potential bad effect, that is hastened death does not produce symptom relief. Rather it is the sedation, proportionately titrated to symptom control, which relieves the refractory suffering. While sedation may foreseeably hasten death, such as by lessening respiration, this is an unintended side effect, not the means to achieve relief. The proportionality criterion for permitting the evil effect is met, as there is a grave reason, namely a dying patient is suffering otherwise refractory pain (which is not reasonably or more simply addressable by alternative analgesic means).

In contrast, physician-assisted suicide or euthanasia does not satisfy the principle of double effect. In such practices, the provision or administering of a *lethal* prescription (rather than a proportional one) does not have two effects, but rather only one: death. And the physician undertakes this action with the explicit intention of causing death. That the physician's motivation may be to relieve suffering changes nothing about the end or goal of the act. Even if we were to describe the action as having two effects—death and the relief of suffering—in these cases the evil effect (death) is not merely a foreseen possible effect but rather constitutes the direct means to achieve the relief of suffering. Unlike palliative sedation, where death may occur naturally due to the progression of the underlying terminal illness, physician-assisted suicide involves a deliberate act to end a life.

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believes are assumed by those who apply the principle, such as that all reasonable alternatives have been exhausted before employing an action which has two effects (one bad and one good). *See* BIOS CENTRE, *supra* note 96, at 28:36–29:22. There are many debates within moral philosophy regarding the contours of the principle of double effect, such as the justification for the distinction of what is intended and what is accepted as a foreseen but unintended side effect. *See* Boyle, *supra* note 116, at 55–57 (proposing such a justification); *see also* Stephen L. Brock, *The Specification of Action in St. Thomas: Nonmotivating Conditions in the Object of Intention*, 83 THOMIST 321 (2019). Such debates are beyond the scope of this Article.

120 *See* BIOS CENTRE, *supra* note 96, at 33:40–34:20 (explaining the application of the principle of double effect in the use of palliative sedation). Note that Sulmasy also explains that while the intentional sedation of a patient in order to relieve suffering is not justified by the principle of double effect (because the intended means, the sedation, has only one effect), it is justified by the principle of parsimony, i.e., not using more therapy than is necessary. *See id.* at 39:40–40:49.

Two concepts bear additional explanation, given clinical complexities: intention and proportionality.

B. Intention

The second criterion of the principle of double effect (i.e., "that the good effect and not the evil effect be intended") is often relied upon to the exclusion of the first (or the two are conflated). Properly, the principle of double effect requires *both* that the objective end or object of the act itself be good (or at least indifferent) *and* that the subjective end or intention of the agent performing the act is toward the good effect. By relying heavily on the physician's intention to relieve suffering (rather than to cause death), applications of the principle of double effect in ethical or legal contexts risk subordinating the intrinsic nature of the intervention—administering sedatives that may hasten death—to a subjective motive-based analysis. Such an approach threatens to render the doctrine overly permissive or impossible to prove from an empirical or prosecutorial standpoint.[121] In fact, intent may sometimes be "difficult even for the acting person to articulate accurately and reflectively."[122] The ethical determination should not hinge solely on a "clean" subjective intent; rather, it should also evaluate the act itself, chiefly as demonstrated by the legitimacy of the palliative justification and the proportional administration of medications to achieve that end. In the settings of professional ethics or law, one scholar suggests that "notations on the patient's chart and in the recorded dosages and titration of analgesics" may provide evidence of intent.[123] Others recommend that specific treatment protocols can demonstrate proper intent. For example, Morita observes that a "proportional sedation" protocol is more likely to preserve patient consciousness than a "deep sedation" protocol.[124] For this reason, Morita suggests that treatment goal, rather than expressed physician intention, is a more accurate indicator of the intended type of sedation.[125]

Focusing on the treatment goal ensures that the first criterion is not overlooked. The focus is not merely on the subjective intent of the physician-actor but rather on the "*act* that materializes this

121 *See* Thomas et al., *supra* note 39, at 347 ("An obvious barrier to empirical research on sedation practices in end-of-life care is the challenge of determining these related elements [including intention], especially if not clearly communicated.").

122 Boyle, *supra* note 116, at 58.

123 *Id.* at 51–52*; see also* ten Have & Welie, *supra* note 74, at 125.

124 *See* Morita et al., *supra* note 54, at 9 (citing Kengo Imai et al., *Efficacy of Proportional Sedation and Deep Sedation Defined by Sedation Protocols: A Multicenter, Prospective, Observational Comparative Study*, 62 J. PAIN & SYMPTOM MGMT. 1165, 1165–74 (2021)).

125 *See id.* at 10.

intention."[126] For example, Broeckaert argues that the action that demonstrates proper intention is the *proportional* administration of medication because "sedation is all about symptom control and thus proportionality is its key ingredient."[127] Similarly, Jansen and Sulmasy contend that the goals of the physician "are set by the structure of his actions."[128] They explain that "if the physician acts to end his patient's life as a means of relieving her suffering, then although he may believe that he intended only to relieve her suffering, it will remain true that he also intended the means that brought about this end."[129]

C. Proportionality

In bioethics, the principle of proportionality is a balancing test which weighs the potential good (e.g., therapeutic benefit, improved quality of life) against the potential harm (e.g., side effects or risks) to ensure the intervention is fitting, or proportionate, to the patient's condition and goals.[130] The principle of double effect employs the concept of proportionality differently. First, proportionality is not applied in isolation from the other criteria, and so the morality of the act is not reduced to a balancing test in which the goods and harms are commensurable. Rather proportionality is one criterion requiring a grave reason for risking an evil effect when the other criteria are already present. The dominant view is that palliative sedation must therefore be an intervention of last resort for the treatment for refractory symptoms.[131] Others stress that it is the context of imminent death that provides the proportionally grave reason.[132] In any case, proportionality alone does not justify use without the other criteria being satisfied.

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126 Bert Broeckaert, Letter, *Response to Morita et al., Re:* Continuous Deep Sedation, PALLIAT. MED. REPS., Jan.–Dec. 2022, at 96, 96.

127 *Id.*

128 Jansen & Sulmasy, *supra* note 59, at 847.

129 *Id.*

130 *See* BEAUCHAMP AND CHILDRESS, *supra* note 19, at 167. *But see* JOHN PAUL II, VERITATIS SPLENDOR ¶¶ 75–76 (1993) (rejecting proportionalism and consequentialism without reference to the objective moral act).

131 *See* ten Have & Welie, *supra* note 74, at 130. However, some express concern even in such circumstances, arguing that "the administration of narcotics for the sole purpose of depriving the dying person of a conscious end is a truly deplorable practice." *Id.* (quoting PONTIFICAL COUNCIL FOR PASTORAL ASSISTANCE, CHARTER FOR HEALTH CARE WORKERS ¶ 124, at 109 (Vatican trans., 1995)). *But see* Berger, *supra* note 77, at 35 (arguing that "[t]here is no sound ethical basis for restricting the use of sedation based on 'refractory symptom' [or] 'last resort' criteria in situations in which its use will not shorten survival").

132 *See* Boyle, *supra* note 116, at 55 (noting that in cases of terminal sedation, proportionality is "easily met" because the "need for palliation of some dying patients is substantial").

Proportionality has a second application in the principle of double effect in that it may demonstrate the first criterion of the principle of double effect: The object of the act is determined by what the agent does. A dosage calibrated to symptom relief constitutes an act of sedation; while a dosage in excess of what symptom relief requires changes the object of the act itself, from palliation to something that can no longer be described as such. The dosage of sedatives must correspond only to that needed to control the symptoms, and the depth and duration of unconsciousness will be proportional accordingly.[133] "The goal of palliative sedation is not to induce coma or bring the patient into deep sleep but to relieve the symptoms."[134] Clinicians should therefore monitor and titrate sedatives to ensure the dosage used is the minimum amount necessary for symptom control.[135] To do otherwise risks "losing trace of this crucial notion of adequacy or proportionality."[136] As Broeckaert states, "Whoever is knowingly and willingly giving more than is needed to relieve the refractory symptom is not doing sedation anymore, but performing euthanasia when this overdosing shortens the life of the patient."[137] Broeckaert also clarifies that a lack of proportional dosing could indicate that the practitioner does not know what he or she is doing, in which case it would constitute medical malpractice.[138] In either case, "neither of these scenarios is a case of adequate palliative sedation."[139] Based on this sense of proportionality, some clinicians recommend the use of intermittent sedation to preserve the possibility of continued communication, to ensure that pain or suffering is actually being ameliorated, and to maintain the patient's "interactive capability."[140]

The principle of double effect thus provides a clear moral framework. The requirement of a proportionally grave reason for permitting the evil effect of hastened death is satisfied by the clinical reality of imminent death and refractory suffering that cannot otherwise be

133 *See* ten Have & Welie, *supra* note 74, at 130.

134 *Id.*

135 *See* Cherny & Portenoy, *supra* note 10, at 36 (indicating that sedation requires monitoring to ensure administration conforms to the goal of care); Cantor, *supra* note 25, at 187 ("To avoid any suggestion of criminality, care providers are expected to use sedative dosages commensurate with keeping the patient unconscious, but not with killing the patient."); Maltoni et al., *supra* note 74, at 1381 ("As agents to control symptoms, not to shorten life, sedatives should be provided in doses that are titrated against the response to achieve relief of symptoms.").

136 Bert Broeckaert, Palliative Sedation Defined or Why and When Palliative Sedation Is Not Euthanasia 2 (Jan., 2000) (unpublished manuscript) (on file with author).

137 *Id.*

138 Broeckaert, *supra* note 41, at 246.

139 *Id.*

140 *See* Olsen, Swetz & Mueller, *supra* note 20, at 950.

controlled. Palliative sedation also satisfies the first three criteria if it is practiced proportionally and is ordered toward symptom relief even if there is a possibility of hastened death. In contrast, even if the fourth criterion is met and the physician's intent is compassionate, because euthanasia and physician-assisted suicide aim at death as the object and intention of the act, they fail to satisfy the first and third criteria of the principle of double effect. Proportionality thus plays an integral role in the ethical practice of palliative sedation. If it deviates from strict proportionality, most obviously where dosages are disproportionate to symptom severity, the object of the act is transformed, and what presents itself as a compassionate intervention becomes in Sulmasy's apt phrase "slow euthanasia."[141] Maintaining this distinction is therefore essential to ensuring that palliative sedation remains a therapeutic intervention for authentic palliative care at the end of life, and if consistently observed, may guide both legal frameworks and clinical practice.

D. Withholding or Withdrawing of Life-Sustaining Interventions

The ethical assessment of palliative sedation is further complicated when the practice is combined, as it often is,[142] with the withholding or withdrawing of life-sustaining interventions, such as nutrition and hydration. Many scholars take the position that "the discontinuation of hydration and nutrition is not an essential element to the administration of sedation in the management of refractory symptoms," and that the decision to sedate and the decision to discontinue nutrition and hydration are separate, and should be assessed ethically as such.[143] For example, Broeckaert asserts that the withholding or withdrawing of "hydration and nutrition is not an intrinsic part of sedation or the treatment of refractory symptoms."[144] While this may be accurate, the likelihood of co-occurrence of these practices in clinical settings presents a distinct ethical challenge. The frequent combination of palliative sedation, intended to alleviate suffering, with decisions that may cause the patient's death, should prompt more rigorous scrutiny of moral responsibility.[145]

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141 BIOS CENTRE, *supra* note 96, at 52:32.

142 *See* Liu, Pope & Xu, *supra* note 25, at 69 ("Deep and continuous palliative sedation combined with withholding or withdrawal of artificial nutrition and hydration . . . is a medical process *regularly used* in end-of-life care as a means of alleviating suffering." (emphasis added)).

143 Cherny, *supra* note 37, at iii146, iii149.

144 Broeckaert, *supra* note 41, at 248 (emphasis omitted).

145 *See* Broeckaert, *supra* note 136 (arguing that sedation combined with the withdrawal of hydration and nutrition "is not just sedation" and it "would be totally unfair and confusing to suggest here that you are only sedating").

Numerous clinical scenarios involve the interplay of palliative sedation and decisions regarding the withholding or withdrawal of nutrition and hydration. When a patient is sedated to the point of unconsciousness, the ability to consume food and water is compromised, even if he was previously capable of doing so and continues to be capable of receiving and processing nutrients. Or, in cases where a patient is already receiving artificial nutrition and hydration, a decision must be made whether to continue this intervention once the patient is unconscious. In cases where death is imminent, providing or continuing artificial nutrition and hydration may no longer accomplish its proper object of nourishing the patient, as the body's ability to process nutrients diminishes as death approaches. Withholding or withdrawing artificial nutrition and hydration in such circumstances may not actually hasten death, which is already rapidly approaching.[146] Each of these cases raises critical ethical and clinical questions: Should artificial nutrition and hydration be initiated or maintained for such patients? If not, should attempts at natural nutrition and hydration still be made? What criteria are necessary to answer these questions? These questions necessitate careful consideration of clinical, ethical, and patient-specific factors to ensure that the practice of palliative sedation does not become the setting for intentional killing.[147]

Forgoing nutrition and hydration likely hastens death for patients who are not imminently dying, but some jurisdictions or professional guidelines permit palliative sedation in those circumstances, raising serious questions about the ethical permissibility of palliative sedation in such contexts. When a physician initiates palliative sedation and subsequently withholds nutrition and hydration where it is not otherwise harmful or medically inappropriate, the goal is no longer purely palliative. The means employed are intended to hasten death. In all such cases, there is a risk that the concurrent use of palliative sedation and the withholding or withdrawal of nutrition and hydration could be used as a surreptitious, "back door" form of euthanasia, particularly when involving non-imminently dying patients. And even if not covert, inadvertent euthanasia might result instead. Broeckaert describes an illustrative case:

> Imagine the case of a patient that is still drinking and even eating naturally and normally before deep and continuous sedation is started. Since it will become impossible for a patient to eat and drink naturally once sedation starts, the food

146 *See* ten Have & Welie, *supra* note 74, at 131–32 (citing research that shows "when the life expectancy is less than two weeks, forgoing AN&H [artificial nutrition and hydration] does not hasten death," *id.* at 131).

147 A comprehensive ethical framework for addressing these questions can be found in U.S. CONF. OF CATH. BISHOPS, *supra* note 17, ¶ 58.

> and more importantly the fluid intake of this patient will drop off dramatically (to nothing), at least when this induced impossibility to eat and drink as before is not compensated with artificial nutrition and hydration. In cases like this, one could speak of induced or artificial de-hydration, a preventable dehydration that is clearly hastening death, at least in patients who are not imminently dying.[148]

The moral and practical outcome—the deliberate ending of a human life—mirrors that of providing a lethal dosage of sedation, which constitutes euthanasia or assisted suicide.

If a patient *voluntarily* ceases to eat or drink, the patient may be motivated by a desire to end life due to unbearable suffering. If the patient does so first and the physician *then* provides sedation to mitigate the distress of dehydration or starvation, knowing that death will occur rapidly, the physician may have the subjective intent to alleviate suffering, but the act of sedation is no longer ordered merely toward symptom relief but toward hastening death, facilitating directly the patient's intent to die. Jansen and Sulmasy describe such an example in which a brain cancer patient ("Bill"), with worsening symptoms but who is not yet imminently dying, asks his physician for help in ending his life:

> Bill's physician responds that it is against the law for him to assist in suicide, but he informs Bill of his right to refuse food and fluids. If Bill chooses this route, his physician says that he will support the decision and do everything possible to ensure that Bill's death is comfortable. Three days later, Bill stops eating and drinking. One week later, he becomes severely agitated. Bill's physician prescribes sedation medication to ensure his comfort. Bill dies 2 days later.[149]

Jansen and Sulmasy assert that it is not the rule of double effect that aids in assessing this case, but rather the principle of collaboration (also referred to as cooperation or complicity).[150] They explain that voluntarily stopping eating and drinking may be an instance of suicide.[151] Thus, they argue that the doctor acted wrongly to advise the patient that refusing food and water was permissible.[152] Jansen and Sulmasy do not further analyze whether the doctor should have provided

148 Broeckaert, *supra* note 41, at 249 (emphasis omitted).

149 Jansen & Sulmasy, *supra* note 59, at 846.

150 *See id.* at 848.

151 *Id.*

152 *Id.* Note that Jansen and Sulmasy say this is so, even if the patient has a legal right to refuse food and water. *Id.* They go further to state that the "physician should not even mention this practice to his patient because, by doing so, the patient may be tempted or influenced to choose it." *Id.*

sedation to address the patient's suffering, but the same principle of collaboration would hold. When combined with palliative sedation, particularly to manage symptoms of thirst or hunger, providing medical support for this decision may constitute assistance in suicide.

In their influential article exploring the ethical dimensions of palliative care options for the dying, Drs. Timothy Quill, Bernard Lo, and Dan Brock reasoned that the combination of terminal sedation and the withholding of nutrition and hydration does not readily satisfy the principle of double effect.[153] They admit that even if the intention motivating sedation is to relieve suffering, "the additional step of withholding fluids and nutrition is not needed to relieve pain, but is typically taken to hasten the patient's wished-for death."[154] In such cases, they stated, it "seems implausible to claim that death is unintended."[155] But rather than concluding that the combined use of sedation with the withholding of nutrition and hydration is therefore ethically impermissible, they argued that ethical judgments should instead rely on the principle of autonomy and furthering the patient's voluntary and informed decisionmaking.[156] Furthermore, they asserted that the principle of proportionality, applied independently of the principle of double effect, can be employed, in some circumstances, to justify all forms of hastening death, whether terminal sedation, physician-assisted suicide, or voluntary euthanasia.[157]

Going further, philosopher Samuel Lipuma argues that a particular form of palliative sedation (described by him as "continuous sedation until death" to include the cessation of nutrition and hydration) is equivalent to physician-assisted suicide or euthanasia.[158] Lipuma asserts this is so because, according to him, death should not be defined merely biologically but rather that "[t]o have one's consciousness permanently eliminated is to die. It is a death of higher brain functioning."[159] He claims that higher brain functioning is the "most

153 *See* Timothy E. Quill, Bernard Lo & Dan 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). Quill et al. also critique any ethical distinction of terminal sedation from physician-assisted suicide or voluntary euthanasia based on whether the action is active or passive, claiming the distinction does not comport with experience or reason. *See id.* at 2102. However, the principle of double effect does not rely on the active/passive distinction but rather on the moral quality of the action and the intention.

154 *Id.* at 2101.

155 *Id.*

156 *See id.* at 2102.

157 *See id.* at 2102–03.

158 Samuel H. Lipuma, *Continuous Sedation Until Death as Physician-Assisted Suicide/Euthanasia: A Conceptual Analysis*, 38 J. MED. & PHIL. 190, 190, 190–92 (2013).

159 *Id.* at 195.

meaningful aspect of being human" and that a permanent loss of it is equivalent to death.[160] Since the intent of sedation, Lipuma claims, is to permanently eliminate consciousness (the equivalent of death), it cannot be meaningfully distinguished from physician-assisted suicide or euthanasia.[161] Responding to the objection that sedation may be reversible and therefore does not constitute a permanent loss of higher brain functioning, Lipuma asserts that such potential has no relevance to distinguishing "successful" continuous sedation until death, i.e., sedation which results in death, from physician-assisted suicide or euthanasia.[162] In response to the objection that the intent of sedation is to manage or relieve pain, rather than to cause death, Lipuma emphasizes that where the intent is to eliminate consciousness, that is synonymous with the intent to cause death, as they are functionally equivalent.[163] Like Quill et al., Lipuma claims that continuous sedation to death is "morally justifiable because it rests on the principles of respect for patient autonomy, mercy, compassion, and physician nonabandonment."[164]

The foregoing description of the ethical principles guiding palliative sedation, though not comprehensive in capturing its complexities, delineates fundamental tenets essential for informing the development of laws and regulations that ensure ethical medical practice.[165] And, as will be discussed below, contemporary legal frameworks inadequately and imprecisely capture the ethical practice of palliative sedation such that it poses significant risks, on its own and particularly in cases involving the withholding or withdrawal of nutrition and hydration, carrying all the tendencies to abuse and coercion that does legalized assisted suicide and euthanasia.[166]

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160 *Id.* at 198.

161 *See id.* at 200.

162 *Id.* Putting aside whether palliative sedation is ever or always permanent, if the definition of brain death is expanded to encompass the loss of consciousness through palliative sedation, and the *ethical* practice of palliative sedation is equated to euthanasia, this could open the door for more direct forms of euthanasia or physician-assisted suicide to be accepted under an equal protection analysis, as was argued by right-to-die proponents in *Vacco*. *See* discussion *infra* Section III.A. Also, given recent attention to the abuse of brain death criteria to harvest organs, this should give great pause to equating the administration of sedation with causing death. *See, e.g.*, Brian M. Rosenthal, *Doctors Were Preparing to Remove Their Organs. Then They Woke Up.*, N.Y. TIMES (Dec. 16, 2025), https://www.nytimes.com/2025/06/06/us/kentucky-organ-donations.html [https://perma.cc/BH98-DKRW].

163 *See* Lipuma, *supra* note 158, at 200–01.

164 *Id.* at 201.

165 The clinical and philosophical literature on the principle of double effect is extensive. *See, e.g.*, Jansen & Sulmasy, *supra* note 59, at 846–47 (collecting cites).

166 *See* Liu, Pope & Xu, *supra* note 25, at 148 (noting that where palliative sedation without artificial nutrition and hydration (which will hasten death) and euthanasia are allowed, there could be a situation in which palliative sedation "is allowed in the absence of

III. DISTINGUISHING PALLIATIVE SEDATION FROM INTENTIONAL KILLING IN LAW: LANDSCAPE AND CONFUSION

Far from being a medieval construct of interest only to philosophers and bioethicists, the principle of double effect has served as a cornerstone in legal frameworks governing practices of euthanasia and physician-assisted suicide, providing the basis for distinguishing palliative sedation—intended to relieve suffering in terminally ill patients—from criminal conduct. Application of the principle ensures that physicians will not be prosecuted criminally for the deaths of their palliative care patients and promotes ethical principles such as the dignity of human life and the protection of vulnerable populations from abuse or coercion. The principle of double effect has served as an important framework for differentiating palliative care from physician-assisted suicide in U.S. constitutional law, lower court caselaw, state statutes, and other regulatory contexts.[167] This Part will describe how existing legal frameworks incorporate the principle of double effect and will also examine how they often fall short in articulating it properly, leading to ambiguity and challenges in application.

A. The Principle of Double Effect at the Supreme Court

In *Washington v. Glucksberg* and *Vacco v. Quill*,[168] the Supreme Court rejected the assertion that the Fourteenth Amendment

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the safeguards usually associated with euthanasia"); *see also* Jocelyn Downie & Richard Liu, *The Legal Status of Deep and Continuous Palliative Sedation Without Artificial Nutrition and Hydration*, 12 MCGILL J.L. & HEALTH 29, 62 (2018) (arguing that palliative sedation without artificial nutrition and hydration (which will hasten death) should be lawful in Canada as long as it complies with the procedural safeguards of the Medical Assistance in Dying Act).

167 The principle of double effect is also employed in regulatory contexts such as the exclusion of assisted suicide from Medicare coverage. *See* 42 C.F.R. § 411.15(q) (2024) (providing that the exclusion "does not pertain to the withholding or withdrawing of medical treatment or care, nutrition or hydration or to the provision of a service for the purpose of alleviating pain or discomfort, even if the use may increase the risk of death, so long as the service is not furnished for the specific purpose of causing death"). Relatedly, several states specifically provide that a physician may use controlled substances for the relief of chronic intractable pain, for palliative care, or for end-of-life care, and exempt physicians from disciplinary action for assisted suicide or "mercy killing" in such cases relying on double effect reasoning. *See, e.g.*, ARK. CODE ANN. § 17-95-704 (2025); FLA. STAT. § 458.326 (2025); MO. REV. STAT. § 334.106 (2025); *see also* ARIZ. REV. STAT. ANN. § 32-3248.01 (2026); CAL. BUS. & PROF. CODE § 2241.5 (West 2026); TEX. OCC. CODE ANN. § 107.051 (West 2025).

168 Washington v. Glucksberg, 521 U.S. 702 (1997); Vacco v. Quill, 521 U.S. 793 (1997). Both cases resulted in unanimous 9-0 judgments upholding the constitutionality of state bans on physician-assisted suicide (reversing lower courts and affirming the states' prohibitions), but the decisions were effectively fractured along differing lines of reasoning. *See Glucksberg*, 521 U.S. at 735; *id.* at 738 (Stevens, J., concurring in judgments); *id.* at 752

protected a right to determine the moment and method of one's death.[169] The *Glucksberg* case involved a challenge to Washington State's felony prohibition on assisted suicide under the Due Process Clause.[170] Proponents of a "right to die" made two main arguments, both of which were rejected by the Court. First, they argued that a "right to die" was encompassed within the broad scope of liberty under the Fourteenth Amendment as articulated in *Planned Parenthood v. Casey*: "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life."[171] Instead of *Casey*'s sweeping interpretation of the scope of "liberty," the Court employed a more restrained methodology, requiring the purported right at stake to be carefully described and to be deeply rooted in the nation's history and tradition and essential to ordered liberty.[172] The Court reasoned that this approach to identifying unenumerated rights was necessary to avoid transforming "liberty" into judicial policy preferences.[173]

Applying this methodology, the Court described the right at stake as the "right to commit suicide which itself includes a right to assistance in doing so"[174] and then undertook a comprehensive survey of the nation's historical legal practice to determine whether it merited constitutional protection as a fundamental right.[175] While

(Souter, J., concurring in judgment); *id.* at 789 (Ginsburg, J., concurring in judgments); *id.* (Breyer, J., concurring in judgments); *Vacco*, 521 U.S. at 809. In each case, five Justices (Chief Justice Rehnquist and Justices O'Connor, Scalia, Kennedy, and Thomas) articulated the majority reasoning whereas the remaining four (Justices Stevens, Souter, Ginsburg, and Breyer) concurred only in the judgment, writing separate opinions that expressed narrower or more open-ended views, as will be described below. *See infra* notes 200–05 and accompanying text.

169 *Glucksberg*, 521 U.S. at 705–06; *Vacco*, 521 U.S. at 796–97.

170 *Glucksberg*, 521 U.S. at 707. The Washington statute under review provided that a "person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide." *Id.* (quoting WASH. REV. CODE. § 9A.36.060(1) (1994)). The Washington Natural Death Act provided, however, that the "'withholding or withdrawal of life-sustaining treatment' at a patient's direction 'shall not, for any purpose, constitute a suicide,'" *id.* (quoting WASH. REV. CODE § 70.122.070(1) (1994)), and that a physician's participation in such a decision "is immune from civil, criminal, or professional liability," *id.* at 707 n.2 (citing WASH. REV. CODE § 70.122.051 (1994)).

171 Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 851 (1992), *overruled by* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022); *see also* Brief for Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls, Thomas Scanlon, and Judith Jarvis Thompson as Amici Curiae in Support of Respondents at 8, *Glucksberg*, 521 U.S. 702 (No. 96-110) & *Vacco*, 521 U.S. 793 (No. 95-1858).

172 *See Glucksberg*, 521 U.S. at 721.

173 *Id.* at 720. This restrained approach to the Court's substantive due process jurisprudence was revived in *Dobbs*, 142 S. Ct. at 2242, suggesting a low likelihood that a federal "right to die" will be recognized by the Court as presently constituted.

174 *Glucksberg*, 521 U.S. at 723.

175 *Id.* at 723–28.

acknowledging that attitudes toward suicide had changed over the centuries, the Court found that the asserted right was not fundamental within the protection of the Due Process Clause as "our laws have consistently condemned, and continue to prohibit, assisting suicide."[176] The Court concluded that assisted-suicide bans are "longstanding expressions of the States' commitment to the protection and preservation of all human life."[177]

Second, the right-to-die advocates pointed to the 1990 decision, *Cruzan v. Director, Missouri Department of Health*, wherein the Court, for purposes of that case, had "assume[d] that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."[178] The right-to-die advocates argued that if the Constitution protected the right of competent persons to hasten their death in such a manner, it likewise guaranteed a right to die by ingesting a lethal dose of drugs.[179] The Court acknowledged that in *Cruzan* it had "assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment."[180] In rejecting the argument, however, the *Glucksberg* Court did not directly address any philosophical difference between killing and allowing to die.[181] Rather it rested on the historical distinction in legal treatment of the practices, noting that "[t]he decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection."[182] The Court further distinguished the historic origins of the putative right at stake in *Cruzan*. A right to refuse medical treatment rested not on "abstract concepts of personal autonomy," but rather on the well-established common law rule that forced or unwanted medical treatment constituted a battery.[183]

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176 *Id.* at 719.

177 *Id.* at 710.

178 Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 279–80 (1990) (holding that the Constitution permitted states to require clear and convincing evidence of an incompetent patient's wishes concerning the withdrawal of such treatment).

179 *Glucksberg*, 521 U.S. at 780 (Souter, J., concurring in judgment).

180 *Id.* at 720 (majority opinion); *see also Cruzan*, 497 U.S. at 269–78 (describing court's reliance on both the common law doctrine of informed consent and the right to privacy in "right to refuse" cases and stating that the "principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions").

181 *See, e.g.*, Daniel P. Sulmasy, *Killing and Allowing to Die: Another Look*, 26 J.L. MED. & ETHICS 55, 55 (1998).

182 *Glucksberg*, 521 U.S. at 725.

183 *Id.* The common law rule forms the basis of modern informed consent law. *See* Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body;

Having determined that the asserted right was not a fundamental one within the protection of the Due Process Clause, the Court determined that the State's ban needed only "be rationally related to legitimate government interests."[184] In upholding the law, the Court found that the state's prohibition furthered many legitimate state interests, including the preservation of human life and prevention of suicide, the promotion of "the integrity and ethics of the medical profession," the protection of groups vulnerable to abuse, neglect, and coercion, and the prevention of euthanasia.[185]

In *Vacco v. Quill*, the companion case to *Glucksberg*, the Court addressed the constitutionality of New York's prohibition on assisted suicide, this time in light of a challenge under the Equal Protection Clause of the Fourteenth Amendment.[186] Like the petitioners in *Glucksberg*, opponents of the state ban equated the right to refuse or withdraw life-sustaining treatment with physician-assisted suicide, arguing that both involve a competent adult choosing to end his life.[187] The Court of Appeals for the Second Circuit had agreed with the right-to-die advocates, reasoning that the law did not treat all competent persons at the end of life equally because "[t]he ending of life by [the withdrawal of life-support systems] is *nothing more nor less than assisted suicide*" and that no legitimate state interest justified the distinction.[188]

Since the Court had held in *Glucksberg* that no fundamental right was at stake, nor did the prohibition on assisted suicide involve a suspect classification, the Court in *Vacco* applied the rational basis test to New York's decision to distinguish the two practices,[189] noting that the distinction was "widely recognized and endorsed in the medical profession and in our legal traditions."[190] In this case, though, the Court directly addressed whether it was "rational" and "logical" for states to distinguish between the right to refuse treatment and physician-assisted suicide, finding the practices distinguishable based on key

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and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."), *abrogated on other grounds by*, Bing v. Thunig, 143 N.E. 2d 3, 8 (N.Y. 1957).

184 *Glucksberg*, 521 U.S. at 728.

185 *See id.* at 728 n.20, 728–35.

186 Vacco v. Quill, 521 U.S. 793, 797 (1997).

187 *Id.* at 798.

188 *Id.* (alterations in original) (citing Quill v. Vacco, 80 F.3d 716, 729 (2d Cir. 1996), *rev'd by*, *Vacco*, 521 U.S. 793).

189 *Id.* at 799.

190 *Id.* at 800 (footnote omitted); *see also* United States v. Skrmetti, 145 S. Ct. 1816, 1829, 1835 (2025) (holding that a law classifying drugs by medical use is subject only to rational basis review, and that a legislature may rationally permit the same drugs to be prescribed for some indicated uses but not others).

differences in causation and intent.[191] First, the Court reasoned that "when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology," whereas in assisted suicide, the patient is killed by the lethal dose of medication.[192] The Court invoked double effect principles in stating that "the law distinguishes actions taken 'because of' a given end from actions taken 'in spite of' their unintended but foreseen consequences."[193] Second, the intent of a physician who withdraws, or respects the decision of a patient to refuse, life-sustaining medical treatment, intends "only to respect his patient's wishes."[194]

The same holds true, the *Vacco* Court explained, in the case of a physician providing "aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain. A doctor who assists a suicide, however, 'must, necessarily and indubitably, intend primarily that the patient be made dead.'"[195] The right-to-die advocates characterized such palliative care as "induc[ing] barbiturate coma and then starv[ing] the person to death,"[196] again equating palliative sedation and physician-assisted suicide for purposes of equal protection. The Court rejected this argument, noting that the law has long used the principle of double effect to distinguish the two practices. "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."[197]

The concurring Justices in the two cases also directly addressed the practice of palliative sedation, also employing the principle of double effect to distinguish it from physician-assisted suicide. Justice O'Connor (joined for the most part by Justices Ginsburg and Breyer) filed a concurring opinion in both cases, addressing the right-to-die proponents' as-applied argument that terminally ill patients who are experiencing great suffering should be able to choose assisted

191 *Vacco*, 521 U.S. at 800–801.

192 *Id.* at 801.

193 *Id.* at 802–03 (quoting Pers. Adm'r of Mass. v. Feeney, 442 U.S. 256, 279 (1979)).

194 *Id.* at 801.

195 *Id.* at 802 (quoting *Assisted Suicide in the United States, Hearing Before the Subcomm. on the Const. of the H. Comm. on the Judiciary*, 104th Cong. 367 (1996) (testimony of Dr. Leon R. Kass)).

196 *Id.* at 807 n.11 (alteration in original) (quoting Brief for Respondents at 48–50, *Vacco*, 521 U.S. 793 (No. 95-1858)).

197 *Id.* at 808 n.11.

suicide.[198] Justice O'Connor saw no need to reach that question, stating that such patients have "no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death."[199]

In his concurrence, Justice Stevens went further and, while he concurred in the judgments of *Vacco* and *Glucksberg*, he did not foreclose the possibility that a future such plaintiff "could prevail in a more particularized challenge."[200] He reasoned that the line between palliative sedation and physician-assisted suicide blurs in terminal cases, where sedation may effectively hasten death, and there may not be "a significant difference between the intent of the physicians, the patients, or the families in the two situations."[201] Indeed, like the right-to-die advocates, Justice Stevens saw an equivalence of intent and causation in some cases of terminal sedation and physician-assisted suicide.[202]

Finally, Justice Souter wrote separately in *Glucksberg* to argue, in part, that the State's historical interest in preventing suicide had been substantially weakened by its own repudiation of that interest by permitting patients to withdraw or withhold life-sustaining treatments, including nutrition and hydration, and permitting physicians to administer terminal sedation—in both cases where it will hasten death.[203] Thus, he asserted, states had opened the door to equal protection claims of patients wishing to assert their bodily autonomy.[204] These concessions, he argued, would undermine the State's argument in preserving life, at least in certain extreme circumstances at the end-of-life.[205]

B. Evaluating the Court's Use of the Principle of Double Effect

These opinions warrant closer scrutiny regarding their engagement with the principle of double effect. The reservations posed by the concurring Justices point to weaknesses in the Court's analysis, which are most visible in its treatment of causation and intent in *Vacco*. For example, when the Court distinguished the right to refuse treatment

198 *See* Washington v. Glucksberg, 521 U.S. 702, 737 (O'Connor, J., concurring); *id.* at 789 (Ginsburg, J., concurring in judgments); *id.* (Breyer, J., concurring in judgments); *Vacco*, 521 U.S. at 809 (O'Connor, J., concurring).

199 *Glucksberg*, 521 U.S. at 737 (O'Connor, J., concurring); *see also id.* at 789–92 (Breyer, J., concurring in judgments).

200 *Id.* at 750 (Stevens, J., concurring in judgments).

201 *Id.*

202 *Id.* at 751.

203 *Id.* at 775–82 (Souter, J., concurring in judgment).

204 *Id.* at 781.

205 *Id.* at 753.

from physician-assisted suicide on the grounds that death in the former is caused by the underlying disease rather than the physician's act, it overlooked that, in cases such as *Cruzan* itself, the patient may not die from an underlying terminal illness but from the deprivation of life-sustaining treatment.[206] This effectively bypasses the first criterion of the principle of double effect. When a patient refuses nutrition and hydration not because its provision can no longer nourish the patient but in order to hasten death, the object of the act is the patient's death. That object does not become good or morally indifferent by virtue of the physician's benign intent or the patient's expression of autonomy. As Justice Scalia observed in his *Cruzan* concurrence, "[s]tarving oneself to death is no different from putting a gun to one's temple as far as the common-law definition of suicide is concerned; the cause of death in both cases is the suicide's conscious decision to 'pu[t] an end to his own existence.'"[207]

The third criterion, which requires that the good effect not be produced by means of the evil effect, is violated as well. When nutrition and hydration are withdrawn from a patient who is not otherwise imminently dying, the intended good effect, such as relief from suffering or the burdens of continued treatment or honoring the patient's autonomy, cannot be separated from the evil effect. The patient does not die despite the withdrawal of nutrition and hydration; the patient dies because of it. The structure of the act is therefore one in which the evil effect is not merely foreseen but is causally determinative of the good effect, which is precisely what the third criterion prohibits. This is distinguishable from, for example, the administration of sedatives in doses calibrated to relieve pain, where death may be a foreseen consequence of an act directed at symptom relief. In the withdrawal of nutrition and hydration from a patient who would otherwise continue to live, the good effect, whatever it is taken to be, is reached only through and by means of the patient's death from starvation and dehydration.

The Court's failure to engage with either criterion reflects a broader problem in its reasoning: an implicit absolutization of patient autonomy which forecloses inquiry into whether the object of the chosen act is good or indifferent. A conception of autonomy that empowers the patient not only to choose among courses of action but to determine for himself the moral character of the object of his choice

206 *See* Robert Steinbrook, *Comatose Woman Dies After Artificial Feedings are Halted*, L.A. TIMES (Dec. 27, 1990, at 12:00 PT), https://www.latimes.com/archives/la-xpm-1990-12-27-mn-10204-story.html [https://perma.cc/4L4R-DKTZ] (noting that Nancy Cruzan's cause of death was "shock, due to dehydration, due to severe head injury").

207 Cruzan v. Dir., Mo. Dep't Health, 497 U.S. 261, 296–97 (1990) (Scalia, J., concurring) (second alteration in original) (quoting 4 WILLIAM BLACKSTONE, COMMENTARIES *189).

absolutizes autonomy in a way that renders the first criterion of the principle of double effect inoperative. The proper ethical question is not whether the patient has the legal freedom to refuse nutrition and hydration, but whether such a refusal is morally permissible and whether the physician is ethically entitled to cooperate in it.

Autonomy has never been treated as an absolute, even in constitutional law. The state's interests in the sanctity of life, the protection of vulnerable populations, and the prevention of suicide have been recognized as legitimate grounds for limiting bodily autonomy across a range of contexts, from compelled vaccinations,[208] to the protection of minors,[209] or to prevent a grave harm such as suicide.[210] The right to refuse life-sustaining treatment is not categorically different in kind from these other exercises of autonomy. The withholding or withdrawal of nutrition and hydration may indeed constitute suicide if it involves a deliberate choice to hasten death by forgoing essential sustenance.[211]

Nevertheless, U.S. jurisdictions do not criminalize the refusal of food and water, and in fact give it broad protection, treating such decisions as falling within the scope of individual autonomy, provided they are made competently and without coercion.[212] But this legal framing, allowing two forms of conduct (palliative sedation and the withdrawing or withholding of nutrition and hydration) as acceptable exceptions from the prohibition of assisted suicide, fails to respond to the serious ethical issues that arise when the practices are used in

208 Jacobson v. Massachusetts, 197 U.S. 11, 26 (1905) ("This court has more than once recognized it as a fundamental principle that 'persons and property are subjected to all kinds of restraints and burdens, in order to secure the general comfort, health, and prosperity of the state; of the perfect right of the legislature to do which no question ever was, or upon acknowledged general principles ever can be made, so far as natural persons are concerned.'" (quoting R.R. Co. v. Husen, 95 U.S. 465, 471 (1878)).

209 *See, e.g.*, Prince v. Massachusetts, 321 U.S. 158, 168–69 (1944); *see also* Jehovah's Witnesses in Wash. v. King Cnty. Hosp., 278 F. Supp. 488, 504 (W.D. Wash. 1967), *aff'd*, 390 U.S. 598 (1968) (mem.).

210 *See Glucksberg*, 521 U.S. at 742 (Stevens, J., concurring in judgments) ("[T]his common-law right to refuse treatment is neither absolute nor always sufficiently weighty to overcome valid countervailing state interests."); *Cruzan*, 497 U.S. at 296–98 (Scalia, J., concurring) (explaining reasons a State could treat a competent patient's refusal of nutrition and hydration as a suicide).

211 Refusing natural or artificial nutrition and hydration in such cases may be distinguished from ethical instances of forgoing or withdrawing nutrition and hydration such as when its provision no longer accomplishes its proper object of nourishing the patient. *See supra* note 84.

212 Liu, Pope & Xu, *supra* note 25, at 130 (acknowledging that U.S. law permits palliative sedation, combined with the withholding or withdrawing of nutrition and hydration, even where it is *certain* to cause death, "so long as the physician does not . . . intend to cause the patient's death").

tandem. The legal permissibility of each practice in isolation says nothing about the ethical character of their combination, and the Court's jurisprudence provides a thin framework for evaluating that combination. In *Cruzan*, the patient's expression of preference became the primary criterion of permissibility, displacing inquiry into the object of the act chosen.[213] In *Vacco*, the Court compounded this error by grounding the distinction between lawful withdrawal of treatment and unlawful assisted suicide in the subjective intent of the patient and physician, treating a benign purpose as sufficient to render the act morally and legally acceptable regardless of what the act itself accomplishes.[214] Together, these moves produce a framework in which moral analysis is conducted entirely at the level of subjective mental states. Despite the Court's careful historical methodology which rejected assisted suicide in *Glucksberg* and *Vacco*, it left intact an expansive scope of autonomy that threatens to undermine a careful application of the principle of double effect, blurring the distinction between palliative care and intentional life-ending conduct it sought to maintain.

In the immediate aftermath of the rulings, legal scholar David Orentlicher criticized the Court's double-effect reasoning, arguing that by distinguishing terminal sedation from physician-assisted suicide, the Court had effectively endorsed euthanasia.[215] Orentlicher's normative position is that physician-assisted suicide is an ethically superior alternative and he was therefore critical of the Court for failing to protect it while permitting terminal sedation, which he asserted "is at times essentially 'slow euthanasia.'"[216] This is so, Orentlicher claimed, on both grounds of causation and intent. First, in most cases of terminal sedation, a patient's death results from the combination of two steps: sedation *and* withholding of nutrition and hydration. Therefore, it is simply not the case, as the Court had claimed,[217] that the withholding or withdrawal of life-sustaining treatment is permissible because the patient dies from the underlying disease. Rather, Orentlicher claimed, it "is the physician-created state of diminished consciousness that is responsible for the patient's inability to eat, not the natural progression of the patient's underlying disease."[218]

Second, acknowledging that the principle of double effect may justify the initial sedation of the patient, where the physician *intends* to relieve the patient's suffering, Orentlicher argued that the principle does not justify the withholding or withdrawal of nutrition and

213 *See supra* notes 178–80 and accompanying text.
214 *See supra* note 194 and accompanying text.
215 *See* Orentlicher, *supra* note 25, at 948.
216 *Id.* at 955 (citation omitted).
217 Vacco v. Quill, 521 U.S. 793, 801 (1997).
218 Orentlicher, *supra* note 25, at 957.

hydration because "that step does nothing to relieve the patient's suffering, but rather serves only to bring on the patient's death."[219]

The Court's reliance on causation and intent to distinguish between treatment withdrawal versus assisted suicide and the practice of palliative sedation versus intentional killing was also misplaced, Orentlicher argued. Withdrawing a ventilator or feeding tube is an *active* decision that contributes to death, he argued, much like prescribing lethal medication.[220] Similarly, the intent to relieve suffering in terminal sedation often overlaps with an awareness that death will be hastened, mirroring the intent of a physician and the patient in euthanasia.[221] By endorsing terminal sedation, he claimed, making an argument parallel to Justice Souter's concurrence, the Court inadvertently acknowledged that some active interventions causing death can be permissible, ultimately weakening its case against assisted suicide.

The risks of "slow euthanasia" posed by the concurrent use of sedation and the withdrawal or withholding of life-sustaining treatment such as nutrition and hydration are acknowledged by other legal scholars. Some have insisted that the two practices must be evaluated separately and thus are justified under separate rationales. For example, Rob McStay acknowledged the potential conflation but argued that the two practices must be assessed separately, each justified by a distinct ethical doctrine: the principle of double effect in the case of palliative sedation, and respect for patient autonomy in the case of the withdrawal of life-sustaining measures.[222] He acknowledged that the convergence of these two practices "muddle[s]" the question of whether the physician could be criminally culpable.[223] Ultimately he argued that the patient's decision to forgo nutrition and hydration should not bear on the mental state of the physician.[224]

Others expressed more concern. For example, legal scholar Norman Cantor expressed skepticism that the concurring Justices in *Glucksberg* had in mind the concurrent withholding or withdrawal of life-sustaining treatments (such as nutrition and hydration) when they made favorable reference to palliative sedation.[225] But he noted that the "problematic aspect of terminal sedation surfaces if withholding artificial nutrition and hydration takes place at an earlier point in the

219 *Id.*; *see also* Quill, Lo & Brock, *supra* note 153, at 2101.

220 *See* Orentlicher, *supra* note 25, at 947 n.1; *cf.* Sulmasy, *supra* note 181, at 56 (arguing that the active/passive distinction is not helpful in distinguishing the difference between killing and allowing to die).

221 *See* Orentlicher, *supra* note 25, at 957–59.

222 *See* McStay, *supra* note 25, at 46.

223 *See id.* at 70.

224 *See id.*

225 Cantor, *supra* note 25, at 187.

dying process, say, many weeks before the patient would have normally died from the underlying disease."[226] While offering defenses of the combined practice, Cantor admitted that "the sequence of long-term terminal sedation followed by a withholding of artificial nutrition and hydration is legally uncharted territory."[227]

Orentlicher offered an explanatory diagnosis of the Court's endorsement of palliative sedation, suggesting that the Court embraced what amounts to "slow euthanasia" in response to the same moral sentiment that underlies right-to-die laws, namely the imperative to address severe suffering in dying patients.[228] He asserted that the "Court saw a right to terminal sedation as necessary to preserve a patient's right to refuse life-sustaining treatment"[229] because otherwise patients would have to choose between refusing such treatment and obtaining relief from suffering.[230] According to this perspective, terminal sedation, framed as palliative care, comports with traditional medical ethics and avoids the societal opprobrium of explicitly endorsing assisted suicide or euthanasia. But, Orentlicher warned, terminal sedation "poses the same risks of abuse" while serving fewer legitimate state goals when compared to assisted suicide.[231] For example, he claimed, assisted suicide allows patients greater autonomy, as they can choose the timing and manner of their death, often in a conscious state, surrounded by loved ones.[232] In contrast, terminal sedation typically renders patients unconscious, stripping them of agency and meaningful interaction in their final moments. Additionally, terminal sedation can prolong the dying process, potentially increasing distress for families, whereas assisted suicide offers a quicker, more controlled death.[233] Ultimately, Orentlicher claimed, the Supreme Court's rejection of assisted suicide while embracing terminal sedation created an incoherent and ethically problematic legal framework, one that he suggested will lay the groundwork for states to "gradually lift their prohibitions against physician-assisted suicide."[234]

226 *Id.*

227 *Id. See also* Liu, Pope & Xu, *supra* note 25, at 74 (acknowledging that the withholding of life-sustaining treatments during palliative sedation is "ethically tenuous").

228 Orentlicher, *supra* note 25, at 968.

229 *Id.* at 965–66.

230 *Id.* at 966.

231 *Id.* at 960.

232 *See id.* at 961.

233 *See id.*

234 *Id.* at 968.

C. State Courts' Use of the Principle of Double Effect

As these scholars warned, despite being rejected by the *Vacco* and *Glucksberg* Court, arguments that palliative sedation, under certain circumstances, can be equated to physician-assisted suicide or euthanasia continue to be advanced by advocates in support of equal protection claims, and these arguments have gained purchase with some judges. Most notably, the Montana Supreme Court's decision in *Baxter v. State* illustrates the doctrinal consequences that follow when the distinction between palliative care and intentional life-ending conduct is left without a rigorous ethical foundation.[235] The majority held, on statutory grounds, that patient consent is a defense to homicide charges for a physician who provides aid in dying to a mentally competent, terminally ill patient.[236] The court rejected the argument that such a result violated public policy, analogizing the provision of lethal medication to a physician's withdrawal of life-sustaining treatment.[237] Both, the court asserts, are expressions of "end-of-life autonomy."[238] In his concurrence, Justice Nelson would have grounded a right to physician-assisted suicide in the state constitution's guarantees of dignity and privacy.[239] In asserting this, he quoted the plaintiff's own description of palliative sedation combined with the withdrawal of nutrition and hydration as a prolonged lethal process that deprives the patient of agency, dignity, and consciousness.[240]

In *Myers v. Schneiderman*, the New York state high court held that the *state* constitution did not protect a constitutional right to "aid-in-dying," declining to equate the right to refuse life-sustaining treatment with physician-assisted suicide.[241] But Justice Rivera concurred, writing separately to express her view that a state could not constitutionally distinguish between physician-assisted suicide and palliative sedation in the specific context of a "mentally-competent, terminally-ill person [who] approaches the final stage of the dying process that is agonizingly painful and debilitating."[242] In such a case, she asserted, "the State cannot prevent the inevitable, and its interests do not outweigh either the individual's right to self-determination or the freedom to choose a death that comports with the individual's values and sense of

235 Baxter v. State, 224 P.3d 1211 (Mont. 2009).
236 *Id.* at 1222.
237 *See id.* at 1217–18.
238 *Id.* at 1217.
239 *Id.* at 1223 (Nelson, J., specially concurring).
240 *Id.* at 1232.
241 Myers v. Schneiderman, 85 N.E.3d 57, 60 (N.Y. 2017) (per curiam).
242 *Id.* at 66 (Rivera, J., concurring).

dignity."[243] Justice Rivera did not distinguish sedation from euthanasia by intent but rather viewed them as much more closely related:

> Terminal sedation is intended to initiate what must be described for what it is: a slow-acting lethal process. While it may fall under the umbrella of palliative care, terminal sedation is not solely a method of pain management but is instead a procedure that hastens the inevitable death of the patient. It places the patient in a condition where choosing to struggle against death is no longer possible. It facilitates the patient's choice to end life.[244]

Indeed, Justice Rivera reasoned that a focus on the physician's intent would be misplaced in a constitutional analysis which should instead require a court to weigh the individual patient's autonomous decision against the State's interest.[245] Echoing Justice Souter, she continued:

> Given that the State already permits a physician to take affirmative steps to comply with a patient's request to hasten death [(i.e., through the use of palliative sedation)], . . . the State's interests lack constitutional force for this specific subgroup of patients. . . . [T]he State may not unduly burden a terminally-ill patient's access to physician-prescribed medication that allows the patient in the last painful stage of life to achieve a peaceful death as the end draws near.[246]

Similarly, in *Kligler v. Attorney General*, the Supreme Judicial Court of Massachusetts held that physician-assisted suicide is not protected by the state Declaration of Rights.[247] Justice Cypher agreed that there was no such broad right but wrote separately to probe the limits of the decision.[248] She noted that both the U.S. Supreme Court and Massachusetts courts had authorized the removal of feeding tubes, the withdrawal of ventilators, and the discontinuation of life-sustaining medications, and argued that, for some patients, the constitutional protection of these practices is difficult to square with the criminalization of physician-assisted suicide.[249] She critiqued efforts to distinguish such practices based on causation, stating for example that "[t]o claim that the affirmative withdrawal of the [feeding] tube was not the proximate cause of the patient's death ignores logic."[250] Quoting Justice

243 *Id.*
244 *Id.* at 74 (citation omitted).
245 *Id.* at 73.
246 *Id.* at 66.
247 Kligler v. Att'y Gen., 198 N.E.3d 1229, 1261 (Mass. 2022).
248 *See id.* at 1262 (Cypher, J., concurring).
249 *Id.* at 1264–67.
250 *Id.* at 1264.

Rivera, she concluded, "The difference, however, 'between injecting a drug that sedates a patient while simultaneously quickening death and prescribing lethal medication is not meaningful in the constitutional sense.'"[251]

Taken together, *Baxter, Myers*, and *Kligler* illustrate that arguments equating palliative sedation with physician-assisted suicide, arguments the *Glucksberg* and *Vacco* majorities declined to accept but which had purchase among the concurring Justices, continue to find receptive audiences on the bench.[252] The error underlying each of these decisions is the same: the conflation of foreseen consequences of an act with its object, treating the fact that palliative sedation may hasten death as sufficient to render it equivalent to the administration of a lethal dose. This is the confusion that a careful application of the principle of double effect prevents. An important criterion is not whether death may result but whether death is the means by which the therapeutic goal is achieved, and in proportionate palliative sedation, it is not. Without a rigorous application of that distinction, the line between palliative care and intentional life-ending conduct blurs, as these concurrences demonstrate. The persistence of these arguments in the courts therefore underscores the need for a more rigorous ethical and legal standard, one grounded in a careful application of all four criteria of the principle of double effect rather than in the subjective purposes of those who perform it.

D. State Statutory Law: Inadequate Incorporation of the Principle of Double Effect

Despite the fact that these arguments have not resulted in the *judicial* recognition of a constitutional right to die, the current state of U.S. statutory law fails to capture the important criteria of the principle of double effect and thus may effectively permit the use of palliative sedation in cases that go beyond its ethical boundaries, allowing it to function as an inadvertent or covert euthanasia. This is especially the case given the legal permissibility of withholding or withdrawing nutrition and hydration. Recall that the principle of double effect permits the administration of palliative sedation, even where it is foreseen that the evil effect of the hastening of death may occur. The ethical principle permits this under the following conditions: (1) The act itself is

251 *Id.* at 1265 (quoting Myers v. Schneiderman, 85 N.E.3d 57, 72–73 (N.Y. 2017) (Rivera, J., concurring)).

252 *See also* Morris v. Brandenburg, 356 P.3d 564, 575, 585 (N.M. Ct. App. 2015) (finding no constitutional right to physician-assisted suicide under the New Mexico Constitution, but noting that state law already permitted physicians to "support a patient's desire to shorten the dying process by removing life-sustaining nutrition, hydration, or mechanical life support, and by administering palliative sedation," *id.* at 575), *aff'd*, 376 P.3d 836 (2016).

good or neutral (the objective nature of the act can be demonstrated through proportional administration of medication), (2) the intent of the actor is to relieve suffering, (3) the relief of suffering is not obtained through death, and (4) a grave reason justifies the risk of death.

In criminal law, an element necessary to determining whether a defendant is legally responsible for a crime is mens rea, the concept of the guilty mind.[253] Criminally culpable states of mind include *intention*, but also include other standards such as knowledge, recklessness, and negligence.[254] Thus, if death is foreseeable, traditional principles of criminal law may hold persons accountable, even where they did not intend death.[255] Thus, to provide physicians with the *legal* protection afforded by the *ethical* principle of double effect, many state bans on assisted suicide exempt physicians who employ palliative sedation if the intent is to alleviate pain, rather than to cause death.[256] However, these

253 *See Mens Rea*, BLACK'S LAW DICTIONARY (12th ed. 2024).

254 *See* MODEL PENAL CODE § 210.1(1) (A.L.I. 2021); *cf.* Cantor, *supra* note 25, at 186 (noting that allowing a physician to administer palliative sedation, knowing it will hasten death, is "in tension with the traditional criminal law principle that to knowingly cause death is a form of unlawful homicide").

255 Cantor criticized the use of the doctrine of double effect in law, noting that generally "it is criminal homicide to knowingly cause death, even if the actor's motive or intention is to relieve suffering." Cantor, *supra* note 25, at 186. He argued that palliative sedation would be better supported by criminal law principles of recklessness which "allow a measure of medical risk-taking short of knowingly causing death." *Id.*

256 *See* ALA. CODE § 22-8B-6(3) (2026) (providing that nothing in the Alabama Assisted Suicide Ban Act shall prohibit a physician or health care provider from "[p]rescribing and administering palliative care or pain medication treatment options intended to relieve pain while the illness or condition of the patient follows its natural course"); ARK. CODE ANN. § 5-10-106(d)(2) (2025) (providing that the criminal offense of physician-assisted suicide does not prohibit a physician "from prescribing any drug, compound, or substance for the specific purpose of pain relief"); GA. CODE ANN. § 16-5-5(c)(1) (2025) (providing that the crime of assisted suicide does not apply to actions "calculated or intended to relieve or prevent such patient's pain or discomfort but are not calculated or intended to cause such patient's death, even if the medication or medical procedure may have the effect of hastening or increasing the risk of death"); IDAHO CODE § 18-4017(5)(a) (2025) (providing that a health care professional does not violate the statute "who administers, prescribes or dispenses medications or procedures to relieve another person's pain or discomfort, even if any such medication or procedure may hasten or increase the risk of death"); IND. CODE § 35-42-1-2.5(a)(1) (2025) (providing that the crime of assisted suicide does not apply to a "licensed health care provider who administers, prescribes, or dispenses medications or procedures to relieve a person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death"); IOWA CODE § 707A.3(1) (2025) (providing that a "licensed health care professional who administers, prescribes, or dispenses medications or who performs or prescribes procedures to relieve another person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death" does not commit the crime of assisted suicide); KAN. STAT. ANN. § 60-4403(a) (2025) (providing that a "licensed health care professional who administers, prescribes or dispenses medications or procedures to relieve another person's pain or discomfort" does not commit the crime

statutes suffer from many of the problems that flow from the lack of clear definition discussed in Part I and fail to capture all the criteria of

of assisted suicide); KY. REV. STAT. ANN. § 216.304(1) (West 2025) (providing that a "licensed health care professional who administers, prescribes, or dispenses medications or procedures to relieve another person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death" does not commit the crime of assisted suicide); LA. STAT. ANN. § 14:32.12(C)(2) (2025) (providing that criminal assistance to suicide does not apply to one who "[p]rescribes, dispenses, or administers any medication, treatment, or procedure if the intent is to relieve the patient's pain or suffering and not to cause death"); MD. CODE ANN., CRIM. LAW § 3-103(a) (LexisNexis 2025) (providing that a physician does not commit the crime of assisted suicide by "administering or prescribing a procedure or administering, prescribing, or dispensing a medication to relieve pain, even if the medication or procedure may hasten death or increase the risk of death"); MINN. STAT. § 609.215(3)(a) (2025) (providing that a health care provider "who administers, prescribes, or dispenses medications or procedures to relieve another person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death" does not criminally assist a suicide); OHIO REV. CODE ANN. § 3795.03(A) (LexisNexis 2026) (providing that the prohibition on assisted suicide does not prohibit the administration of medication for "the purpose of diminishing the patient's pain or discomfort and not for the purpose of postponing or causing the patient's death, even though the medical procedure, treatment, intervention, or other measure may appear to hasten or increase the risk of the patient's death"); OKLA. STAT. tit. 63, § 3141.4(A) (2026) (providing that a "licensed health care professional who administers, prescribes, or dispenses medications or procedures for the purpose of alleviating pain or discomfort, even if their use may increase the risk of death" does not violate the Assisted Suicide Prevention Act); 11 R.I. GEN. LAWS § 11-60-4(a) (2025) (providing that a "licensed health care professional who administers, prescribes, or dispenses medications or procedures to relieve another person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death," does not commit the crime of assisted suicide); S.C. CODE ANN. § 16-3-1090(c)(2) (2026) (providing that "administering, prescribing, or dispensing of medications or procedures, by or at the direction of a licensed health care professional, for the purpose of alleviating another person's pain or discomfort, even if the medication or procedure may increase the risk of death," does not constitute assisted suicide); S.D. CODIFIED LAWS § 34-12D-23 (2026) (providing that the administration of medication, even if it may hasten or risk death, does not constitute aiding or abetting suicide unless done "with a purpose to cause death"); TENN. CODE ANN. § 39-13-216(b)(2) (2025) (providing that it does not constitute the crime of assisting a suicide to "[p]rescribe, dispense, or administer medications or perform medical procedures calculated or intended to relieve another person's pain or discomfort but not calculated or intended to cause death, even if the medications or medical procedures may hasten or increase the risk of death"); UTAH CODE ANN. § 76-5-205(5)(a) (LexisNexis 2025) (providing that a practitioner does not criminally assist a suicide "if the practitioner provides medication or a procedure to treat an individual's illness or relieve an individual's pain or discomfort, regardless of whether the medication or procedure may hasten or increase the risk of death"); VA. CODE ANN. § 8.01-622.1(E)(i) (2025) (providing that the criminal prohibition on assisted suicide does not apply to a "licensed health care provider" who "administers, prescribes or dispenses medications or procedures to relieve another person's pain or discomfort and without intent to cause death, even if the medication or procedure may hasten or increase the risk of death"); W. VA. CONST. art. III, § 23 (providing that constitutional prohibition on assisted suicide and euthanasia does not prohibit "the administration or prescription of medication for the purpose of alleviating pain or discomfort while the patient's condition follows its natural course").

the principle of double effect outlined in Part II. A typical statute contains the following language: The crime of assisted suicide does not apply to a "licensed health care provider who administers, prescribes, or dispenses medications or procedures to relieve a person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death."[257]

Such statutes suffer from the following defects:

- They focus on the subjective intent or purpose of administration of the sedative medication, without reference to the first criterion, the objective nature of the act itself. Nor do they specify a means to demonstrate the first criterion is met, such as the role of proportionality.
- They do not specify *how* proper palliative intent may be demonstrated. For instance, if medical records or discussions indicate that sedation was used to "help the patient die comfortably," does this demonstrate use to relieve refractory symptoms or to hasten death?
- They do not require evidence of a grave reason to justify the risk, such as limiting sedation to when a patient is imminently dying, or limit its use to address refractory symptoms or physiological pain.[258]
- Many statutes also provide exemptions from the definition of assisted suicide for circumstances in which medical treatment (in many cases life-sustaining care such as nutrition and hydration) is withheld or withdrawn, thus raising the likelihood that the two practices will be used concurrently in nonterminal patients to cause death.[259] As explained, even where

257 IND. CODE § 35-42-1-2.5(a)(1) (2025).

258 While most professional medical organizations require the patient to be terminally ill, *see supra* Section I.B, most state laws do not require this, *see supra* note 256.

259 *See* ALA. CODE § 22-8B-6(2) (2026) (providing that nothing in the Alabama Assisted Suicide Ban Act shall prohibit a physician or health care provider from "[f]ollowing a patient's wishes or health care proxy's instructions to withhold or withdraw life-sustaining treatment or artificially provided nutritional hydration"); ARK. CODE ANN. § 5-10-106(d)(1) (2025) (providing that the criminal offense of physician-assisted suicide does not prohibit a "[p]hysician or healthcare provider from carrying out an advanced directive or living will"); *id.* § 20-6-311(a) ("A death that results from compliance with a physician order for life-sustaining treatment form does not constitute a suicide, homicide, or abuse, for any reason."); GA. CODE ANN. § 16-5-5(c)(2) (2025) (providing that the crime of assisted suicide does not apply to, "[p]ursuant to a patient's consent, any person discontinuing, withholding, or withdrawing medications, medical procedures, nourishment, or hydration"); IDAHO CODE § 18-4017(5)(b) (2025) (providing that a health care professional does not violate the statute who "withholds or withdraws treatment or procedures in compliance with a living will and durable power of attorney for health care, a health care directive, a physician orders for scope of treatment form or any other similar document"); IND. CODE § 35-42-1-2.5(a)(2) (2025) (providing that the crime of assisted suicide does not apply to the

"withholding or withdrawing of medical treatment or life-prolonging procedures by a licensed health care provider"); IOWA CODE § 707A.3(2) (2025) (providing that a "licensed health care professional who withholds or withdraws a life-sustaining procedure" does not commit the crime of assisted suicide); KAN. STAT. ANN. § 60-4403(b) (2025) (providing that a "licensed health care professional, family member or other legally authorized person who participates in the act of, or the decision making process which results in the withholding or withdrawal of a life-sustaining procedure" does not commit the crime of assisted suicide); KY. REV. STAT. ANN. § 216.304(2) (West 2025) (providing that a "licensed health care professional who withholds or withdraws a life-sustaining procedure" does not commit the crime of assisted suicide); LA. STAT. ANN. § 14:32.12(C)(1) (2025) (providing that criminal assistance to suicide does not apply to one who "[w]ithholds or withdraws medical treatment"); MD. CODE ANN., CRIM. LAW § 3-103(b) (LexisNexis 2025) (providing that a physician does not commit the crime of assisted suicide by "withholding or withdrawing a medically administered life-sustaining procedure"); MICH. COMP. LAWS § 750.329a(2) (2026) (providing that the crime of criminal assistance to a suicide "does not apply to withholding or withdrawing medical treatment"); MINN. STAT. § 609.215(3)(b) (2025) (providing that a health care provider "who withholds or withdraws a life-sustaining procedure" does not criminally assist a suicide); MISS. CODE ANN. § 41-41-227(2) (2024) (providing that "[d]eath resulting from the withholding or withdrawal of health care" does not "constitute a suicide or homicide"); MO. REV. STAT. § 404.845 (2026) (providing that when a "patient's death results from withholding or withdrawing life-sustaining treatment in accordance with the terms of the durable power of attorney for health care act, the death shall not constitute a suicide or homicide"); NEB. REV. STAT. ANN. § 20-412(1) (2026) (providing that "[d]eath resulting from the withholding or withdrawal of life-sustaining treatment" is not suicide or homicide); NEV. REV. STAT. § 449A.560(1)(a) (2025) (providing that withholding "emergency care or life-sustaining treatment" does not subject a health care provider to civil, criminal, or professional liability); N.H. REV. STAT. ANN. § 137-J:10(I) (2026) (providing that the "withholding or withdrawal of life-sustaining treatment pursuant to the provisions of this chapter shall at no time be construed as a suicide or murder for any legal purpose"); OHIO REV. CODE ANN. § 3795.03(C)–(D) (LexisNexis 2026) (providing that the prohibition on assisted suicide does not prohibit or affect the "withholding or withdrawal of life-sustaining treatment," *id.* § 3795.03(C)); OKLA. STAT. tit. 63, § 3141.4(B) (2026) (providing that a "licensed health care professional who withholds or withdraws a medically administered, life-sustaining procedure" does not violate the Assisted Suicide Prevention Act); 20 PA. CONS. STAT. § 5426 (2026) (providing that the "withholding or withdrawal of life-sustaining treatment from a principal or patient resulting in death . . . shall not . . . constitute suicide or homicide"); 11 R.I. GEN. LAWS § 11-60-4(b) (2025) (providing that a "licensed health care professional who withholds or withdraws a life-sustaining procedure" does not violate the prohibition on assisted suicide); S.C. CODE ANN. § 16-3-1090(c)(1) (2026) (providing that "withholding or withdrawing of a life sustaining procedure" does not constitute assisted suicide); TENN. CODE ANN. § 39-13-216(b)(1) (2025) (providing that it does not constitute the crime of assisting a suicide to "[w]ithhold or withdraw medical care"); TEX. HEALTH & SAFETY CODE ANN. § 166.047 (West 2025) (providing that a person does not assist suicide "by withholding or withdrawing life-sustaining treatment"); UTAH CODE ANN. § 76-5-205(1)(a)(i)(B) (LexisNexis 2025) (providing that aiding suicide does not include "the withholding or withdrawal of life sustaining treatment"); VA. CODE ANN. § 8.01-622.1(E)(ii) (2025) (providing that the criminal prohibition on assisted suicide does not apply to a person who "withholds or withdraws life-prolonging procedures"); W. VA. CONST. art. III, § 23 (providing that constitutional prohibition on assisted suicide and euthanasia does not prohibit "the withholding or withdrawing of life-sustaining treatment, as requested by the patient or the patient's decision-maker"); WIS. STAT. § 154.11 (2025) (providing that the

> state law does not specifically exempt such circumstances, the deliberate choice by a competent individual to forgo nutrition and hydration to hasten death is arguably protected in all U.S. states under the Court's decision in *Cruzan*.[260]

Thus, we can see that inconsistent and imprecise legal distinctions between palliative care and forms of intentional killing pose significant risks. By failing to require demonstrated compliance with the criteria of the principle of double effect that justify its ethical use and the legal permissiveness of the concurrent withholding or withdrawal of life-sustaining measures like nutrition and hydration, the current legal framework effectively permits practices that may constitute physician-assisted suicide or euthanasia, undermining the ethical and legal distinctions intended to separate palliative care from such life-ending acts. Consequences of such conflation are the restriction of access to proper palliative care because of a chilling effect due to fear of legal liability or the legitimation of euthanasia and physician-assisted suicide.[261]

Even in the thirteen states and the District of Columbia where physician-assisted suicide is legal,[262] it remains important to distinguish clearly the alternative practice of authentic palliative sedation.[263] For example, since palliative sedation lacks the strict safeguards required by physician-assisted suicide statutes, such as eligibility criteria, independent second opinions, mandatory periods, and documentation and review requirements,[264] concerns persist that palliative sedation

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"withholding or withdrawal of life-sustaining procedures or feeding tubes" does not constitute suicide).

260 Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 277–78 (1990) (stating that the "principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions," *id.* at 278).

261 *See* Cherny and Portenoy, *supra* note 10, at 36 (arguing that the principle of double effect provides an ethical equilibrium and that "moral reservations of clinicians or family members may result in either the undertreatment of catastrophic symptoms or subsequent guilt and its morbid psychological sequelae").

262 *See* CAL. HEALTH & SAFETY CODE § 443.2 (West 2026); COLO. REV. STAT. § 25-48-103 (2025); DEL. CODE ANN. tit. 16, § 2501C (2026); D.C. CODE § 7-661.05 (2026); HAW. REV. STAT. § 327L-2 (2025); 410 ILL. COMP. STAT. 22/25 (2026); ME. STAT. tit. 22, § 2140 (2025); Baxter v. State, 224 P.3d 1211, 1222 (Mont. 2009) (holding that a terminally ill patient's consent to physician-assisted suicide is a statutory defense to crime of homicide); N.J. STAT. ANN. § 26:16-2 (West 2025); N.M. STAT. ANN. § 24-7C-3 (2025); Medical Aid in Dying Act, 2025 N.Y. Laws 714; OR. REV. STAT. § 127.805 (2025); VT. STAT. ANN. tit. 18, § 5283 (2025); WASH. REV. CODE § 70.245.020 (2025).

263 *See e.g.*, VT. STAT. ANN. tit. 18, § 5288 (2025) ("This chapter shall not limit or otherwise affect the provision, administration, or receipt of palliative sedation consistent with accepted medical standards.").

264 *See* Quill, Lo & Brock, *supra* note 153, at 2103 (proposing additional safeguards for regulating terminal sedation that are modeled after typical safeguards imposed on the practice of physician-assisted suicide).

could be misused as covert euthanasia, bypassing these requirements, in order to hasten death.[265]

IV. RECOMMENDATIONS FOR ENHANCED LEGAL PROTECTIONS

To address the ethical complexities described in this Article, several legal reforms are recommended and should be further studied and developed. Foremost, state laws which prohibit euthanasia or physician-assisted suicide should more clearly define the ethical practice of palliative sedation, particularly when used concurrently with the withdrawal or withholding of life-sustaining treatment. The issue is not whether the law should permit the administration of pain medications to a patient in intractable pain, even if such administration might hasten death. The issue is whether the law in fact permits much more than this ethical use and should be restrained. Such a definition should incorporate each of the critical elements of the principle of double effect, stipulating that palliative sedation is permissible only when the intent of the act is to relieve intractable suffering in imminently dying patients, not to hasten death. But the law should go beyond subjective intent to specify additional criteria demonstrating the objective nature of the act and the proportional need for the measure, such as restricting sedation to cases where death is expected within days or hours and requiring documentation of the patient's condition, the proportionality of the sedation dosage, and the medical necessity of the intervention, ensuring transparency and accountability. Moreover, such statutes should limit the concurrent withholding or withdrawing of nutrition and hydration when doing so would convert the ethical practice of palliative sedation into covert or inadvertent euthanasia, requiring evidence of harm or futility before allowing such sustenance to be denied.[266]

A model statute may contain the following provisions:

(1) A section articulating a clear legislative purpose such as: "The purpose of this statute is to clarify that palliative sedation, when administered in accordance with established ethical standards for the relief of refractory symptoms in terminally ill patients, does not constitute physician-assisted suicide or euthanasia. This exclusion emphasizes an objective evaluation of the medical act itself, focusing on the legitimacy of

265 Liu, Pope & Xu, *supra* note 25, at 148; *see also* Richard M. Doerflinger, *The Effect of Legalizing Assisted Suicide on Palliative Care and Suicide Rates: A Response to Compassion and Choices*, CHARLOTTE LOZIER INST., Mar. 2017, at 1, 7 (noting that, in states that legalize physician-assisted suicide, authentic palliative care tends to be negatively impacted).

266 In contrast, Liu et al. call for legal reforms to *harmonize* the legal status of withholding food and water with palliative sedation. *See* Liu, Pope & Xu, *supra* note 25, at 72.

the palliative justification and the proportionality of the medications used, and is not solely dependent on the demonstrated subjective intent or mental state of the physician or patient."

(2) Clear and complete definitions such as:
   (a) ***Palliative Sedation*** means the proportional administration of sedative medications by a licensed healthcare practitioner to a terminally ill patient for the primary purpose of alleviating refractory symptoms, such as severe pain, agitation, dyspnea, or delirium, that cannot be adequately controlled through other reasonably available means.
   (b) ***Refractory Symptoms*** means symptoms in a terminally ill patient that persist despite maximal tolerated doses of standard palliative interventions, as determined by prevailing medical guidelines and documented in the patient's medical record.
   (c) ***Terminally Ill Patient*** means a patient diagnosed with an incurable disease or condition expected to result in death within [insert number of days/weeks] as certified by at least one licensed physician.
   (d) ***Proportional Administration*** means the use of sedative medications titrated to the minimum effective dose necessary to achieve symptom relief, in accordance with evidence-based medical protocols, without exceeding dosages that would knowingly cause death as the primary outcome.

(3) Provisions that make clear that palliative sedation shall not be deemed physician-assisted suicide, euthanasia, or any form of criminal homicide under [relevant state criminal code sections], under the following conditions:
   (a) The act is performed solely for a terminally ill patient experiencing refractory symptoms, as evidenced by:
      (i) a documented medical assessment confirming the symptoms' refractory nature; and
      (ii) consultation with at least one additional licensed healthcare practitioner specializing in palliative or hospice care, who concurs with the palliative justification.
   (b) The medications are administered in a proportional manner, as demonstrated by:
      (i) titration starting from the lowest effective dose and escalating only as necessary to achieve symptom control; and

(ii) regular monitoring and adjustment based on the patient's response.

(4) Provisions requiring documentation and oversight to ensure compliance, e.g.:

(a) Healthcare practitioners administering palliative sedation must maintain detailed records, including:

(i) the patient's diagnosis and prognosis;

(ii) descriptions of refractory symptoms and prior failed interventions;

(iii) consultation reports;

(iv) medication dosages, administration schedules, and monitoring notes; and

(v) informed consent from the patient (supported where necessary by a capacity assessment) or their authorized surrogate, acknowledging potential risks such as hastened death as a secondary effect.

(b) [Insert appropriate state health authority] must establish oversight mechanisms, such as periodic audits or reporting requirements, to ensure adherence to this statute.

By codifying these parameters, states can create a consistent legal standard that coherently distinguishes palliative sedation from euthanasia, reducing ambiguity and protecting both patients and healthcare practitioners from unintended legal consequences, and also ensuring that ethical and effective palliative options remain for patients who suffer at the end of life.

Additionally, while it is beyond the scope of this Article to explain the unique challenges posed by palliative sedation to receiving authentic informed consent, greater study is required to ensure the dying patient and his family is fully informed before the administration of sedation. While some may argue that existing state law requiring informed consent is adequate, the unique challenges of the context of palliative sedation, including the patient's diminished medical decisional capacity and the potential for coercion or conflicts of interest, require tailored safeguards beyond standard informed consent requirements. In particular, tailored informed consent laws could address the administration of palliative sedation to ensure patients and their families fully understand the procedure and its implications, such as the purpose, risks, and expected outcomes of palliative sedation, its potential to reduce consciousness, and its relationship to life-sustaining treatments like nutrition and hydration. By strengthening informed consent requirements, states can ensure that patients make informed decisions while protecting against misuse of sedation or withdrawal of life-sustaining treatments and comfort care that might

inadvertently cause death. This reform would also mitigate the chilling effect on healthcare practitioners, who may hesitate to offer palliative sedation due to fears of legal liability, thereby improving access to ethical end-of-life care.

Additionally, to further promote ethical and patient-centered care, states and professional organizations may consider the development of standardized language for advance directives that explicitly contemplate the appropriate use of palliative sedation. Such provisions would enable patients to articulate their wishes clearly, ensuring that their end-of-life care conforms to their wishes and reducing the risk of misinterpretation by healthcare practitioners or family members. For instance, advance directives could include options for patients to authorize palliative sedation only under specific conditions, such as imminent death or unmanageable suffering, and make clear that life-sustaining measures such as nutrition and hydration be continued, where appropriate, thereby reinforcing the ethical boundaries of the practice. By incorporating palliative sedation into advance care planning, states can prevent scenarios in which vague or inadequate directives lead to unintended or ethically questionable outcomes.

To ensure the ethical administration of palliative sedation, training programs for healthcare practitioners prescribing this intervention are critical.[267] These programs should educate physicians and other relevant medical professionals on the principle of double effect, the appropriate clinical indications for palliative sedation, and the importance of proportional dosing tailored to symptom severity. Training should also cover the ethical and legal implications of combining sedation with the withdrawal of life-sustaining treatments, emphasizing the need to maintain a clear distinction between relieving suffering and causing death. By equipping practitioners with the knowledge and skills to navigate these complex scenarios, mandatory training would reduce the risk of misuse and enhance confidence in delivering care that is both ethically sound and is ordered toward the relief of suffering, ensuring that all persons experiencing intractable pain at the end of life have adequate, informed care.

267 As of 2022, eighteen states have passed legislation regarding educational programs to promote palliative care. Ella Taggart & Salom Teshale, *States Make Progress on Palliative Care*, NAT'L ACAD. FOR STATE HEALTH POL'Y (Nov. 23, 2022), https://nashp.org/states-make-progress-on-palliative-care/ [https://perma.cc/FFM4-Z5HH]. Further study should investigate the efficacy of such programs on the provision of palliative care. *See generally* AMS. UNITED FOR LIFE, PAIN MEDICINE EDUCATION ACT: MODEL LEGISLATION & POLICY GUIDE (2017).

CONCLUSION

The lack of genuine pain management and quality end-of-life care is often used as a justification for legalized physician-assisted suicide or euthanasia. On the other hand, the availability of palliative sedation, when appropriately administered, can be a vital tool for alleviating intractable suffering at the end of life, reducing the perceived need for physician-assisted suicide or euthanasia. The lack of such care fails to relieve suffering and creates the conditions for subtle or overt pressures—such as feeling like a "burden" on family—that influence decisions about life-ending measures. Vulnerable patients may feel they have no real choice but to pursue assisted dying. As Britain's Health Secretary Wes Streeting said in a 2024 interview regarding the "assisted dying" law then under consideration in Parliament: "Candidly, when I think about this question of being a burden, I do not think that palliative care, end-of-life care in this country is in a condition yet where we are giving people the freedom to choose, without being coerced by the lack of support available."[268]

While it is vitally important that patients have adequate access to care that responds fully to their needs and concerns at the end of life, this Article has argued that the absence of clear definitions and stringent safeguards, along with the widespread permissibility of withdrawing or withholding nutrition and hydration, risks its misuse as a covert form of euthanasia. The expansion of palliative sedation beyond its original and ethical framework is "fueled by widespread and culturally anchored convictions about the meaning of aging, vulnerability, dependence, suffering, and dying. And, these are once more the same convictions that drive the euthanasia practice."[269] To respond properly to these deeply human fears while protecting the dignity of human life and ensuring compassionate care at the "hour of death," lawmakers must establish clear legal frameworks to guide the practice of palliative sedation.

268 Henry Bodkin, *State of End-of-Life Care in Britain Means We Are Not Ready for Assisted Dying, Streeting Suggests*, TELEGRAPH (Sep. 7, 2024, 19:04 BST), https://www.telegraph.co.uk/politics/2024/09/07/end-of-life-care-assisted-dying-health-secretary-streeting/ [https://perma.cc/YJR3-7MK7].

269 ten Have & Welie, *supra* note 74, at 133.