Palliative care is generally agreed to be the standard of care for the dying, but there remain some patients for whom intolerable suffering persists. In the face of ethical and legal controversy about the acceptability of physician-assisted suicide and voluntary active euthanasia, voluntarily stopping eating and drinking and terminal sedation have been proposed as ethically superior responses of last resort that do not require changes in professional standards or the law. The clinical and ethical differences and similarities between these 4 practices are critically compared in light of the doctrine of double effect, the active/passive distinction, patient voluntariness, proportionality between risks and benefits, and the physician's potential conflict of duties. Terminal sedation and voluntarily stopping eating and drinking would allow physicians to remain responsive to a wide range of patient suffering, but they are ethically and clinically more complex and closer to physician-assisted suicide and voluntary active euthanasia than is ordinarily acknowledged. Safeguards are presented for any medical action that may hasten death, including determining that palliative care is ineffective, obtaining informed consent, ensuring diagnostic and prognostic clarity, obtaining an independent second opinion, and implementing reporting and monitoring processes. Explicit public policy about which of these practices are permissible would reassure the many patients who fear a bad death in their future and allow for a predictable response for the few whose suffering becomes intolerable in spite of optimal palliative care.

"Palliative care is the standard of care when terminal illness patients find that the burdens of continued life-prolonging treatment outweigh the benefits." To better relieve suffering near the end of life, physicians need to improve their skills in palliative care and to routinely discuss it earlier in the course of terminal illness. In addition, access to palliative care needs to be improved, particularly for those Americans who lack health insurance. However, even the highest-quality palliative care fails or becomes unacceptable for some patients, some of whom request help hastening death. Between 10% and 20% of patients in programs devoted to palliative care still report significant pain 1 week before death. Furthermore, patients request a hastened death not simply because of unrelieved pain, but because of a wide variety of unrelieved physical symptoms in combination with loss of meaning, dignity, and independence.

How should physicians respond when competent, terminally ill patients whose suffering is not relieved by palliative care request help in hastening death? If the patient is receiving life-prolonging interventions, the physician should discontinue them, in accordance with the patient's wishes. Some patients may voluntarily stop eating and drinking (VSED). If the patient has unrelieved pain or other symptoms and accepts sedation, the physician may legally administer terminal sedation (TS). However, it is generally legally impermissible for physicians to participate in physician-assisted suicide (PAS) or voluntary active euthanasia (VAE) in response to such patient requests. The recent Supreme Court decisions that determined that there is no constitutional right to PAS placed great emphasis on the importance of relieving pain and suffering near the end of life. The Court acknowledged the legal acceptability of providing pain relief, even to the point of hastening death if necessary, and left open the possibility that states might choose to legalize PAS under some circumstances.

In this article, we compare VSED, TS, PAS, and VAE as potential interventions of last resort for competent, terminally ill patients who are suffering intolerably in spite of intensive efforts to palliate and who desire a hastened death. Some clinicians and patients may find some of the differences between these practices to be ethically and psychologically critical, whereas others perceive the differences as inconsequential. We will define and compare the practices, examine underlying ethical justifications, and consider appropriate categories of safeguards for whichever practices our society eventually endorses.

DEFINITIONS AND CLINICAL COMPARISONS

With VSED, a patient who is otherwise physically capable of taking nourishment makes an active decision to discontinue all oral intake and then is gradually "allowed to die," primarily due to dehydration or some intervening complication. Depending on the patient's preexisting condition, the process will usually take 1 to 3 weeks or longer if the patient continues to
take some fluids. Voluntarily stopping eating and drinking has several advantages. Many patients lose their appetites and stop eating and drinking in the final stages of many illnesses. Ethically and legally, the right of competent, informed patients to refuse life-prolonging interventions, including artificial hydration and nutrition, is firmly established, and voluntary cessation of “natural” eating and drinking could be considered an extension of that right. Because VSED requires considerable patient resolve, the voluntary nature of the action should be clear. Voluntarily stopping eating and drinking also protects patient privacy and independence, so much so that it potentially requires no participation by a physician.

The main disadvantages of VSED are that it may last for weeks and may initially increase suffering because the patient may experience thirst and hunger. Subtle coercion to proceed with the process may occur if patients are not regularly offered the opportunity to eat and drink, yet such offers may be viewed as undermining the patient’s resolve. Some patients, family members, physicians, or nurses may find the notion of “dehydration” or “starving” a patient to death to be morally repugnant. For patients whose current suffering is severe and unreleasable, the process would be unacceptable without sedation and analgesia. If physicians are not involved, palliation of symptoms may be inadequate, the decision to forgo eating and drinking may not be informed, and cases of treatable depression may be missed. Patients are likely to lose mental clarity toward the end of this process, which may undermine their sense of personal integrity or raise questions about whether the action remains voluntary.

Although several articles have proposed VSED as an alternative to other forms of hastened death, there are no data about how frequently such decisions are made or how acceptable they are to patients, families, physicians, or nurses.

With TS, the suffering patient is sedated to unconsciousness, usually through ongoing administration of barbiturates or benzodiazepines. The patient then dies of dehydration, starvation, or some other intervening complication, as all life-sustaining interventions are withheld. Although death is inevitable, it usually does not take place for days or even weeks, depending on clinical circumstances. Because patients are deeply sedated during this terminal period, they are believed to be free of suffering.

It can be argued that death with TS is “foreseen” but not “intended” and that the sedation itself is not causing death. The sedation is intended to relieve suffering, a long-standing and uncontroversial aim of medicine, and the subsequent withdrawal of life-sustaining therapy has wide legal and ethical acceptance. Thus, TS probably requires no change in the law. The recent Supreme Court decision gave strong support to TS, saying that pain in terminally ill patients should be treated, even to the point of rendering the patient unconscious or hastening death. Terminal sedation is already openly practiced by some palliative care and hospice groups in cases of unrelieved suffering, with a reported frequency from 0% to 44% of cases.

Terminal sedation has other practical advantages. It can be carried out in patients with severe physical limitations. The time delay between initiation of TS and death permits second-guessing and reassessment by the health care team and the family. Because the health care team must administer medications and monitor effects, physicians can ensure that the patient’s decision is informed and voluntary before beginning TS. In addition, many proponents believe that it is appropriate to use TS in patients who lack decision-making capacity but appear to be suffering intolerably, provided that the patient’s suffering is extreme and otherwise unreleasable, and the surrogate or family agrees.

Nonetheless, TS remains controversial and has many of the same risks as associated with VAE and PAS. Like VAE, the final actors are the clinicians, not the patient. Terminal sedation could therefore be carried out without explicit discussions with alert patients who appear to be suffering intolerably or even against their wishes. Some competent, terminally ill patients reject TS. They believe that their dignity would be violated if they had to be unconscious for a prolonged time before they died, or that their families would suffer unnecessarily while waiting for them to die. Patients who wish to die in their own homes may not be able to arrange TS because it probably requires admission to a health care facility. There is some controversy in the anesthesia literature about whether heavily sedated persons are actually free of suffering or simply unable to report or remember it. In some clinical situations, TS cannot relieve the patient’s symptoms, as when a patient is bleeding uncontrollably from an eroding lesion or a refractory coagulation disorder, cannot swallow secretions because of widespread oropharyngeal cancer, or has refractory diarrhea from the acquired immunodeficiency syndrome (AIDS). Although such patients are probably not conscious of their condition once sedated, their death is unlikely to be dignified or remembered as peaceful by their families. Finally, and perhaps most critically, there may be confusion about the physician’s ethical responsibility for contributing to the patient’s death.

With PAS, the physician provides the means, usually a prescription of a large dose of barbiturates, by which a patient can end his or her life. Although the physician is morally responsible for this assistance, the patient has to carry out the final act. Physician-assisted suicide has several advantages. For some patients, access to a lethal dose of medication may give them the freedom and reassurance to continue living, knowing they can escape if and when they choose. Because patients have to ingest the drug by their own hand, their action is likely to be voluntary. Physicians report being more comfortable with PAS than VAE, presumably because their participation is indirect.

Opponents of PAS believe that it violates traditional moral and professional prohibitions against intentionally contributing to a patient’s death. Physician-assisted suicide also has several practical disadvantages. Self-administration does not guarantee competence or voluntariness. The patient may have impaired judgment at the time of the request or the act or may be influenced by external pressures. Physician-assisted suicide is limited to patients who are physically capable of taking the medication themselves. It is not always effective, so families may be faced with a patient who is vomiting, aspirating, or cognitively impaired, but not dying. Patients brought to the emergency department after ineffective attempts are likely to receive unwanted life-prolonging treatment. Requiring physicians to be present when patients ingest the medication could coerce an ambivalent patient to proceed, yet their absence may leave families to respond to medical complications alone.

Physician-assisted suicide is illegal in most states, but no physicians have ever been successfully prosecuted for their participation. Several studies have documented a secret practice of PAS in the United States. In Washington State, 12% of physicians responding to a survey had received genuine re-
quests for PAS within the year studied. Twenty-four percent of requests were acceded to, and over half of those patients died as a result. An Oregon study showed similar results.  Physician-assisted suicide is usually conducted covertly, without consultation, guidelines, or documentation. Public controversy about legalizing PAS continues in the United States. After narrow defeats of referenda in the states of Washington and California, an Oregon referendum was passed in 1994 that legalized PAS, subject to certain safeguards. After a series of legal challenges, the Oregon legislature required that the referenda be resubmitted to the electorate this November before implementation, and it was repassed this November by a margin of 59% to 40%. The US Supreme Court ruled that laws in the states of Washington and New York prohibiting PAS were not unconstitutional, but the Court simultaneously encouraged public discussion and state experimentation through the legislative and referendum processes.  

With VAE, the physician not only provides the means, but is the final actor by administering a lethal injection at the patient’s request. As practiced in the Netherlands, the patient is sedated to unconsciousness and then given a lethal injection of a muscle-paralyzing agent like curare. For patients who are prepared to die because their suffering is intolerable, VAE has the advantages of being quick and effective. Patients need not have manual dexterity, the ability to swallow, or an intact gastrointestinal system. Voluntary active euthanasia also requires active and direct physician participation. Physicians can ensure the patient’s competence and voluntariness at the time of the act, support the family, and respond to complications. The directness of the act makes the physician’s moral responsibility clear.

On the other hand, VAE explicitly and directly conflicts with traditional medical prohibitions against intentionally causing death. Although intended to relieve suffering, VAE achieves this goal by causing death. Furthermore, VAE could be conducted without explicit patient consent. If abused, VAE could then be used on patients who appear to be suffering severely or posturing extreme burdens to physician, family, or society, but have lost the mental capacity to make informed decisions.

The Netherlands is the only country where VAE and PAS are openly practiced, regulated, and studied, although the practices remain technically illegal. According to the Remmelink report, VAE accounts for 1.5% to 2.4% of all deaths, and PAS, another 0.2% to 0.4%. In 0.7% to 0.8% of deaths, active euthanasia was performed on patients who had lost the capacity to consent, raising concern about whether guidelines restricting VAE to competent patients can be enforced in practice.

United States laws prohibiting VAE, however, are stricter than those governing PAS and more likely to be prosecuted. Physicians are also more reluctant to participate in VAE even if it were legalized. Even less is known about the secret practice of VAE than of PAS in the United States. The recent Washington State study showed that 4% of physicians had received a genuine request for VAE within the year studied, and 24% of those responded by administering a lethal injection. Voluntary active euthanasia was recently legalized in a province of Australia, but this legislation was subsequently reversed by the legislature.

**ETHICAL COMPARISONS BETWEEN THE PRACTICES**

Many normative ethical analyses use the doctrine of double effect and the distinction between active and passive assistance to distinguish between currently permissible acts that may hasten death (forgoing life-sustaining treatment and high-dose pain medications) and those that are impermissible (PAS and VAE). Both TS and VSED have been argued to be ethically preferable alternatives to PAS and VAE on the basis of similar arguments. In this section, we will critically examine these analyses. We also discuss the issues of voluntariness, proportionality, and conflict of duties, which may ultimately be more central to the ethical evaluation of these options. We suggest that there are more problems with the doctrine of double effect and the active/passive distinction than are ordinarily acknowledged and that TS and VSED are more complex and less easily distinguished ethically from PAS and VAE than proponents seem to realize. Our discussion in this section will be restricted to the potential ethical permissibility of these actions and not the public policy implications.

**Doctrine of Double Effect**

When evaluating an action, the doctrine of double effect distinguishes between effects that a person intends (both the end sought and the means taken to the end) and consequences that are foreseen but unintended. As long as the physician’s intentions are good, it is permissible to perform actions with foreseeable consequences that it would be wrong to intend. In this view, intentionally causing death is morally impermissible, even if desired by a competent patient whose suffering could not otherwise be relieved. But if death comes unintentionally as the consequence of an otherwise well-intentioned intervention, even if foreseen with a high probability, the physician’s action can be morally acceptable. The unintended but foreseen bad effect must also be proportional to the intended good effects.

The doctrine of double effect has been important in justifying the use of sufficient pain medications to relieve suffering near the end of life. When high-dose opioids are used to treat pain, neither the patient nor the physician intends to accelerate death, but they accept the risk of unintentionally hastening death in order to relieve the pain. The doctrine of double effect has also been used to distinguish TS from PAS and VAE. Relief of suffering is intended in all 3 options, but death is argued to be intended with PAS and VAE but is merely foreseen with TS. Yet to us it seems implausible to claim that death is unintended when a patient who wants to die is sedated to the point of coma, and intravenous fluids and artificial nutrition are withheld, making death certain. Although the overarching intention of the sedation is to relieve the patient’s suffering, the additional step of withholding fluids and nutrition is not needed to relieve pain, but is typically taken to hasten the patient’s wished-for death. In contrast, when patients are similarly sedated to treat conditions like status epilepticus, therapies such as fluids and mechanical ventilation are continued with the goal of prolonging life.

According to the doctrine of double effect, intentionally taking life is always morally impermissible, whereas doing so foreseeably but unintentionally can be permissible when it produces a proportionate good. As applied to end-of-life medical decision making, the intentions of the physician are given more moral weight than the wishes and circumstances of the patient. An alternative view is that it is morally wrong to take the life of a person who wants to live, whether doing so intentionally or foreseeably. In this view, what makes TS morally permissible is that the patient gives informed consent to it, not that the physician only foresees but does not intend the patient’s inevitable death.

The issue of intention is particularly complicated because
The determination of what is intended by the patient or physician is often difficult to verify and because practices that are universally accepted may involve the intention to hasten death in some cases. The application and the moral importance of both the active/passive distinction and the doctrine of double effect are notoriously controversial and should not serve as the primary basis of determining the morality of these practices.

Voluntariness

We suggest that the patient's wishes and competent consent are more ethically important than whether the acts are categorized as active or passive or whether death is intended or unintended by the physician. With competent patients, some of these acts would be morally permissible without the patient's voluntary and informed consent. Any of these actions would violate a competent patient's autonomy and would be both immoral and illegal if the patient did not understand that death was the inevitable consequence of the action or if the decision was coerced or contrary to the patient's wishes. The ethical principle of autonomy focuses on patients' rights to make important decisions about their lives, including what happens to their bodies, and may support genuinely autonomous forms of these acts.

However, because most of these acts require cooperation from physicians and, in the case of TS, the health care team, the autonomy of participating medical professionals also warrants consideration. Because TS, VSE, P.A.S., and VAE are not part of usual medical practice and they all result in a hastened death, clinicians should have the right to determine the nature and extent of their own participation. All physicians should respect patients' decisions to forgo life-sustaining treatment, including artificial hydration and nutrition, and provide standard palliative care, including skillful pain and symptom management. If society permits some or all of these practices (currently TS and VSE are open to discussion), physicians who choose not to participate because of personal moral considerations should at a minimum discuss all available alternatives in the spiri of informed consent and respect for patient autonomy. Physicians are free to express their own objections to these practices as part of the informed process, to propose alternative approaches, and to transfer care to another physician if the patient continues to request actions to hasten death that they find unacceptable.

Proportionality

The principles of beneficence and nonmalefice obligate the physician to act in the patient's best interests and to avoid causing nonharm. The concept of proportionality requires that the risk of causing harm must bear a direct relationship to the danger and immediacy of the patient's clinical situation and the expected benefit of the intervention. The greater the patient's suffering, the greater the risk the physician can take of potentially contributing to the patient's death, so long as the patient understands and accepts that risk. For a patient with lung cancer who is anxious and short of breath, the risk of small doses of morphine or anxiolytics is warranted. At a later time, if the patient is near death and gasping for air, more aggressive sedation is warranted, even in dosages that may well cause respiratory depression. Although proportionality is an important element of the doctrine of double effect, proportionality can be applied independently of this doctrine. Sometimes a patient's suffering cannot be relieved despite optimal palliative care, and continuing to live causes torment that can end only with death. Such extreme circumstances sometimes warrant extraordinary medical actions, and the forms of hastening death under consideration in this article may satisfy the requirement of proportionality. The re
requirement of proportionality, which all health care interventions should meet, does not support any principled ethical distinction between these 4 options.

Conflict of Duties

Unreleivable, intolerable suffering by patients at the end of life may create for physicians an explicit conflict between their ethical and professional duty to relieve suffering and their understanding of their ethical and professional duty not to use at least some means of deliberately hastening death. \(^\text{55,26}\) Physicians who believe they should respond to such suffering by according to the patient's request for a hastened death may find themselves caught between their duty to the patient as a caregiver and their duty to obey the law as a citizen. \(^\text{51}\) Solutions often can be found in the intensive application of palliative care, or within the currently legitimated options of forgoing life supports. VSED, or TS. Situations in which VSED or TS may not be adequate include terminally ill patients with uncontrolled bleeding, obstruction from nasopharyngeal cancer, and refractory AIDS diarrhea or patients who believe that spending their last days intravenously sedated would be meaningless, frightening, or degrading. Clearly the physician has a moral obligation not to abandon patients in refractory suffering; \(^\text{51}\) hence, those physicians who could not provide some or all of these options because of moral or legal reservations should be required to search assiduously with the patient for mutually acceptable solutions.

SAFEGUARDS

In the United States, health care is undergoing a radical reform driven more by market forces than by commitments to quality of care. \(^\text{1,52}\) and 42 million persons are currently uninsured. Capitated reimbursement could provide financial incentives to encourage terminally ill patients to hasten their deaths. Physicians' participation in hastening death by any of these methods can be justified only as a last resort when standard palliative measures are ineffective or unacceptable to the patient.

Safeguards to protect vulnerable patients from the risk of error, abuse, or coercion must be constructed for any of these practices that are ultimately accepted. These risks, which have been extensively cited in the debates about PAS and VAE, \(^\text{24,51}\) also exist for TS and VSED. Both TS and VSED could be carried out without ensuring that optimal palliative care has been provided. This risk may be particularly great if VSED is carried out without physician involvement. In TS, physicians who unreflectively believe that death is unintended or that it is not their explicit purpose may fail to acknowledge the inevitable consequences of their action or their responsibility.

The typical safeguards proposed for regulating VAE and PAS are intended to allow physicians to respond to unrelied suffering, while ensuring that adequate palliative measures are used, and that patient decisions are autonomous. These safeguards need to balance respect for patient privacy with the need to adequately oversee these interventions. Similar professional safeguards should be considered for TS and VSED, even if these practices are already sanctioned by the law. The challenge of safeguards is to be flexible enough to be responsive to individual patient dilemmas and rigorous enough to protect vulnerable persons.

Categories of safeguards include the following:

1. Palliative care ineffective: Excellent palliative care must be available, yet insufficient to relieve intolerable suffering for a particular patient.

2. Informed consent: Patients must be fully informed about and capable of understanding their condition and treatment alternatives (and their risks and benefits). Requests for a hastened death must be patient initiated, free of undue influence, and enduring. Waiting periods must be flexible, depending on the nearness of inevitable death and the severity of immediate suffering.

3. Diagnostic and prognostic clarity: Patients must have a clearly diagnosed disease with known lethality. The prognosis must be understood, including the degree of uncertainty about outcomes (ie, how long the patient might live).

4. Independent second opinion: A consultant with expertise in palliative care should review the case. Specialists should also review any questions about the patient's diagnosis or prognosis. A psychiatrist should consult if there is uncertainty about treatable depression or about the patient's mental capacity.

5. Documentation and review: Explicit processes for documentation, reporting, and review should be in place to ensure accountability.

The restriction of any of these methods to the terminally ill involves a trade-off. Some patients who suffer greatly from incurable, but not terminal, illnesses and who are unresponsive to palliative measures will be denied access to a hastened death and forced to continue suffering against their will. Other patients whose request for a hastened death is denied will avoid a premature death because their suffering can subsequently be relieved with more intensive palliative care. Some methods (eg, PAS, VAE, TS) might be restricted to the terminally ill because of the inherent inequities of access, concerns about error, and abuse, and lack of experience with the process. Others (eg, VSED) might be allowed for those who are incurably ill but not imminently dying, if they meet all other criteria, because of the inherent waiting period, the great resolve that they require, and the opportunity for reconsideration. If any methods are extended to the incurably, but not terminally, ill, safeguards should be more stringent, including substantial waiting periods and mandatory assessment by psychiatrists and specialists, because the risk and consequences of error are increased.

We believe that clinical, ethical, and policy differences and similarities among these 4 practices need to be debated openly, both publicly and within the medical profession. Some may worry that a discussion of the similarities between VSED and TS on the one hand and PAS and VAE on the other may undermine the desired goal of optimal relief of suffering at the end of life. \(^\text{1,44}\) Others may worry that a critical analysis of the principles of double effect or the active/passive distinction as applied to VSED and TS may undermine efforts to improve pain relief or to ensure that patient's or surrogate's decisions to forgo unwanted life-sustaining therapy are respected. \(^\text{57}\) However, hidden, ambiguous practices, inconsistent justifications, and failure to acknowledge the risks of accepted practices may also undermine the quality of terminal care and put patients at unwarranted risk.

Allowing a hastened death only in the context of access to good palliative care puts it in its proper perspective as a small but important facet of comprehensive care for all dying patients. \(^\text{1,44}\) Currently, TS and VSED are probably legal and are widely accepted by hospice and palliative care physicians. However, they may not be readily available because some physicians may continue to have moral objections and legal fears about these options. Physician-assisted suicide is illegal in most states, but may be difficult, if not impossible, to suc-
cessfully prosecute if it is carried out at the request of an informed patient. Voluntary active euthanasia is illegal and more likely to be aggressively prosecuted if uncovered. In the United States, there is an underground, erotically available practice of PAS and even VAE that is quietly condoned.

Explicit public policies about which of these 4 practices are permissible and under what circumstances could have important benefits. Those who fear a bad death would face the end of life knowing that their physicians could respond openly if their worst fears materialize. For most, reassurance will be all that is needed, because good palliative care is generally effective. Explicit guidelines for the practices that are deemed permissible can also encourage clinicians to explore why a patient requests hastening of death, to search for palliative care alternatives, and to respond to those whose suffering is greatest.

Dr Lo is supported by National Institute of Mental Health Center grant MH44249 and by the Robert Wood Johnson Foundation. We want to thank Diane Meier, MD, and Frank Miller, PhD, for their work on early drafts of the manuscript and an anonymous reviewer who gave persistent clarifying feedback.

References