DEEP AND CONTINUOUS PALLIATIVE SEDATION WITHOUT ARTIFICIAL NUTRITION AND HYDRATION: AN INTERNATIONAL REVIEW

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ABSTRACT

Deep and continuous palliative sedation combined with withholding or withdrawal of artificial nutrition and hydration ("PSs̄ANH") is a medical process regularly used in end-of-life care to alleviate suffering. But in contrast to other end-of-life options like VSED and MAID which have been the subject of significant commentary and policy attention, PSs̄ANH remains largely unexamined. This Article fills this gap by clarifying the legal status and medical practice of PSs̄ANH in twelve jurisdictions around the world.

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I. INTRODUCTION

It may help the reader to begin with three concrete case examples.[1] A patient has end-stage lung cancer. He is suffering extreme pain and profound discomfort from breathlessness. Unfortunately, this suffering is refractory to other palliative comfort measures and his death from cancer is anticipated within twenty-four to forty-eight hours. The patient asks his physician for deep and continuous palliative sedation because that is the only way to alleviate his suffering. But this patient has an advance directive refusing life-sustaining

1. These examples are adapted, with modification, from the scenarios set out in the Introduction of prior work by the lead author. Jocelyn Downie & Richard Liu, *The Legal Status of Deep and Continuous Palliative Sedation without Artificial Nutrition and Hydration*, 12 MCGILL J. HEALTH & L. 29 (2018).

treatment, including artificial nutrition and hydration.[2] Therefore, the patient's physician refuses to offer palliative sedation for fear of criminal liability. The patient dies after thirty-six hours of agony. Was the physician's fear of liability reasonable?

A second patient has multiple system organ failure and is likely to die within ten to fourteen days. Her profound agitation can be alleviated only by deep sedation. After discussing it with the patient, the physician initiates deep and continuous sedation and withholds artificial nutrition and hydration. The patient dies in twelve days. Was the physician's conduct lawful?

A third patient has Huntington's disease. Her death is inevitable but only after a long, slow decline, including a lengthy period of dementia. The patient has reached the point where she feels her suffering outweighs the value of her life. But her death from the disease is still years away. The patient tells her physician that she would like to have deep and continuous sedation and she refuses artificial nutrition and hydration. Her physician complies, and the patient dies in fifteen days. Was the physician's conduct lawful?

Around the world, there is significant uncertainty and variability in how lawyers and clinicians answer these questions.[3] Deep and continuous palliative sedation combined with withholding or withdrawal of artificial nutrition and hydration (collectively termed "PSs̄ANH") is a medical process regularly used in end-of-life care as a means of alleviating suffering.[4] But PSs̄ANH is often not governed by a clear legal framework. To shed light on different approaches to regulating PSs̄ANH, this Article conducts a comparative analysis of the PSs̄ANH legality across twelve jurisdictions.

To facilitate understanding of this broad issue, we subdivided PSs̄ANH into three categories:

(1) PSs̄ANH *will not* hasten death ("Type 1 PSs̄ANH"),
(2) PSs̄ANH *might, but is not certain to*, hasten death ("Type 2 PSs̄ANH"), and
(3) PSs̄ANH *is certain to* hasten death ("Type 3 PSs̄ANH").

This division maximizes the clarity and precision of comparative analysis. But not all twelve of our target jurisdictions recognize this tripartite distinction.

This research fills a gap in the current literature on the legality of end-of-

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2. Because the patient would be unconscious, they would be unable to eat and drink, and thus dependent upon artificial nutrition and hydration.

3. *See generally* Alexandra Guite-Verret et al., *Continuous Palliative Sedation until Death: A Qualitative Study of Palliative Care Clinicians' Experiences,* 23 BMC PALLIATIVE CARE 104 (2024); Ebun Abarshi et al., *International Variations in Clinical Practice Guidelines for Palliative Sedation: A Systematic Review*, 7 BMJ SUPPORTIVE & PALLIATIVE CARE 223 (2017); Andrea Cuviello et al., *Palliative Sedation Therapy Practice Comparison – A Survey of Pediatric Palliative Care and Pain Management Specialists*, 40 AM. J. HOSPICE & PALLIATIVE MED. 977 (2023).

4. " s̄" is the medical abbreviation for "without."

life options.[5] Other end-of-life options have been more extensively analyzed. For example, the legality of medical assistance in dying ("MAID") has received significant academic attention, particularly with the introduction of euthanasia legislation in several countries in recent decades.[6] Voluntary stopping of eating and drinking ("VSED") has also been the subject of increased commentary.[7]

PSs̄ANH, by contrast, has gone largely unexamined.[8] There is a particularly notable absence of international and comparative analyses of PSs̄ANH. Available international analyses cover palliative care generally rather than PSs̄ANH specifically.[9]

In two respects, this Article goes beyond the rules on palliative sedation laid down in health care guidelines.[10] First, studies analyzing guidelines in various jurisdictions demonstrate that guidelines often do not discuss Type 3 PSs̄ANH (or any type of PSs̄ANH). Instead, they discuss only palliative sedation and the withholding or withdrawal of artificial nutrition and hydration separately).[11] Second, guidelines may provide an incomplete picture of the legality of

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5. This Article follows a 2018 paper by Jocelyn Downie and Richard Liu, which analyzed in depth the legal status of PSs̄ANH in Canada and proposed amendments that would bring coherence and clarity to end-of-life law. Downie & Liu, *supra* note 1. Despite this analysis, PSs̄ANH remains under-researched six years later. *Cf.* Eduardo Garralda et al., *Regulations on Palliative Sedation: An International Survey across Eight European Countries*, 33 EUR. J. PUB. HEALTH 35 (2022) (examining Belgium, Germany, Hungary, Italy, Netherlands, Romania, Spain, and the UK, and concluding that other than France, "most countries . . . regulate PS indirectly through general laws that concern normal medical practice").

6. *See, e.g.*, BEN WHITE ED., LAW AND ASSISTED DYING RESEARCH HANDBOOK (Edward Elgar, forthcoming 2025). MAID legislation is considered in greater depth in the individual analysis of each of these jurisdictions.

7. *See, e.g.*, TIMOTHY E. QUILL ET AL., VOLUNTARILY STOPPING EATING AND DRINKING: A COMPASSIONATE, WIDELY AVAILABLE OPTION FOR HASTENING DEATH (2021); Hope Wechkin et al., *Clinical Guidelines for Voluntarily Stopping Eating and Drinking (VSED)*, 66 J. PAIN & SYMPTOM MGMT. E625 (2023).

8. *See* Garralda et al., *supra* note 5. Despite its lack of attention in legal literature, clinicians more widely support PSs̄ANH than either MAID or VSED. *See, e.g.*, Rogerio A. Dedivitis et al., *Medical Students' and Residents' Views on Euthanasia,* 24 BMC MED. ETHICS 109 (2023). PSs̄ANH has been better examined in the medical literature. *See, e.g.*, Ben Colburn & Bridget Johnston, *Palliative Sedation: Autonomy, Suffering, and Euthanasia*, 17 CURRENT OPINION SUPPORTIVE & PALLIATIVE CARE 214 (2023) (collecting cites of recent reviews).

9. *See* Danuta Mendelson & Timothy Stoltzfus Jost, *A Comparative Study of the Law of Palliative Care and End-of-Life Treatment*, 31 J. L. MED. & ETHICS 130 (2003). *See also* Lauren Gurschick et al., *Palliative Sedation: An Analysis of International Guidelines and Position Statements,* 32 AM. J. HOSPICE & PALLIATIVE MED. 660 (2015).

10. *See, e.g.*, Séverine M Surges et al., *Revised European Association for Palliative Care (EAPC) Recommended Framework on Palliative Sedation: An International Delphi Study*, 38 PALLIATIVE MED. 213 (2024).

11. Séverine M Surges et al., *Review of European Guidelines on Palliative Sedation: A Foundation for the Updating of the European Association for Palliative Care Framework*, 25 J. PALLIATIVE MED. 1721 (2022). A notable exception is the Royal Dutch guidelines, which consider the situation where a patient with refractory symptoms has a life expectancy exceeding two weeks. ROYAL DUTCH MEDICAL ASSOCIATION (KNMG), GUIDELINE END-OF-LIFE DECISIONS 7 (2021), https://www.knmg.nl/download/knmg-guideline-end-of-life-decisions [https://perma.cc/U7ZE-MHA6].

PSs̄ANH. Practitioners often rely on guidelines without any further analysis of the actual legal position of PSs̄ANH and related practices. Because the standard of care is often set or influenced by these guidelines, practitioners can often raise the guidelines as a defense to a claim that they acted in breach of their duty of care. However, guidelines may not provide a complete defense in all situations where medical practitioners administer PSs̄ANH.

In Section II, we provide a clinical overview of palliative sedation. Before assessing its status around the world, the reader needs a clear understanding of what this end-of-life medical option entails. We focus on one specific type of palliative sedation. First, we discuss continuous and deep sedation. The patient's unconsciousness makes them unable to eat or drink and thus dependent upon artificial nutrition and hydration. Second, we focus on palliative sedation combined with withholding artificial nutrition and hydration.

In Section III, we describe the methodology of this project. To provide an informed comparative analysis of PSs̄ANH around the world, we surveyed experts from twelve jurisdictions. This section describes the questionnaire and our other engagement with these jurisdictional experts.

In Section IV, we review the status of PSs̄ANH in twelve jurisdictions. This is the heart of the Article. For each jurisdiction, we proceed in three parts. First, we consider the legality of palliative sedation by analyzing applicable black letter law. This includes any national and local legislation, regulation, and case law that directly or indirectly affects the legality of PSs̄ANH. This part also includes analysis of supranational legislation or case law where that bears on the legality of PSs̄ANH in a particular jurisdiction.[12] In addition to black letter law, this section also considers legally persuasive guidelines (common in this context) even though they are not legally binding.

Second, for each jurisdiction in Section IV, we consider the legality of practices analogous to PSs̄ANH. For example, Type 1 PSs̄ANH is analogous to withholding or withdrawing life-sustaining treatment. Type 3 PSs̄ANH is analogous to euthanasia.[13] We make these comparisons to shed light on whether PSs̄ANH is treated consistently with other practices that may achieve similar results.

Finally, because analysis focused solely on the applicable black letter rules risks misrepresenting the true operation of PSs̄ANH, we consider the medical practice of PSs̄ANH for each jurisdiction in Section IV. This reveals whether there is any meaningful disconnect between the legal status of PSs̄ANH and medical practice. And it helps paint a more accurate picture of how medical professionals apply treatment.

Because the results of this three-part analysis show distinct differences among the twelve jurisdictions, we group them into three categories. First, we

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12. This is the case for those countries which are ECHR signatories. COUNCIL OF EUROPE, *The European Convention on Human Rights*, Council of Europe, https://www.coe.int/en/web/human-rights-convention [https://perma.cc/FAE4-FRXW].

13. *See* GOVERT DEN HARTOGH, WHAT KIND OF DEATH: THE ETHICS OF DETERMINING ONE'S OWN DEATH 123 n.17 (1st ed. 2023).

review four "restrictive jurisdictions" France, Germany, India, and Ireland. Second, we review three "moderate jurisdictions" Belgium, Canada, and England & Wales. Third, we review five "permissive jurisdictions" Australia, Colombia, Netherlands, Switzerland, and the United States of America.

In Section V, we identify and describe twelve main themes from the international review in Section IV. For example, we find that Types 1 and 2 PSs̄ANH are or are likely to be legally permissible in all twelve jurisdictions. But the legal framework governing PSs̄ANH is otherwise often unclear and underdeveloped.

Section VI builds a framework for future work. The lack of clarity described in Sections VI and V may lead to deleterious consequences for both patients and health care practitioners. Patients may be deprived of an important palliative care option. Practitioners might be unwilling to use PSs̄ANH because they fear civil liability, disciplinary penalties, or criminal sanctions. Practitioners should have a clear and precise view of the legality of different end-of-life procedures to be able to make fully informed medical decisions. Legislators should clarify the law on PSs̄ANH, potentially harmonizing the legal status of PSs̄ANH with analogous end-of-life procedures. Treating analogous practices differently, as several jurisdictions currently do, introduces arbitrariness in an already complex area of law.

II. CLINICAL OVERVIEW OF PALLIATIVE SEDATION

Palliative sedation is the monitored use of medications to induce decreased awareness to relieve intractable intolerable suffering for patients who are at the end of their life.[14] Typically, this suffering includes dyspnea, pain, nausea, convulsions, hemorrhages, delirium, and states of anxiety or panic.[15] There are two core elements of palliative sedation. First, palliative sedation requires the patient have severe symptoms that are refractory to standard palliative treatment. Second, palliative sedation uses sedative medications with the primary aim of relieving the patient's symptoms by reducing their awareness (consciousness).[16]

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14. IAN KOPER ET AL. EDS., THE ROLE OF PALLIATIVE SEDATION IN PALLIATIVE CARE (2024); Molly Olsen et al., *Ethical Decision Making with End-of-Life Care: Palliative Sedation and Withholding or Withdrawing Life-Sustaining Treatments*, 85 MAYO CLINIC PROCEEDINGS 949 (2010).

15. Marco Maltoni & Elisabetta Setola, *Palliative Sedation in Patients with Cancer*, 22 CANCER CONTROL 433 (2015); Bernard Lobato Prado et al., *Continuous Palliative Sedation for Patients with Advanced Cancer at a Tertiary Care Cancer Center*, 17 BMC PALLIATIVE CARE 13 (2018); Maria Arantzamendi et al., *Clinical Aspects of Palliative Sedation in Prospective Studies. A Systematic Review* 61 J. PAIN & SYMPTOM MGMT. 831 (2021).

16. Gurschick et al., *supra* note 9; Johannes J. M. van Delden et al., *Should We All Die Asleep? The Problem of the Normalization of Palliative Sedation*, 52 AGE & AGEING 1 (2023); Susan D. Bruce et al., *Palliative Sedation in End-of-Life Care*, 8 J. HOSPICE & PALLIATIVE NURSING 320 (2006). Other common elements include: (1) using the least degree of sedation necessary to relieve suffering and (2) only using palliative sedation for patients already within hours to days of death.

A. Deep and Continuous Palliative Sedation

Palliative sedation is usually practiced when traditional opioid-based therapies are insufficient to control suffering or cause problematic side effects. The precise substance used in clinical practice, barbiturates, have received negative attention. Consequently, globally, palliative centers have shifted to a midazolam-based regime attributed to the drug's short half-life, mild side effects and efficacy.[17]

This Article is concerned with deep (as opposed to light or moderate) and continuous (as opposed to intermittent) palliative sedation.[18] Deep sedation means that the patient is rendered unconscious by the sedation and continuous sedation means that the patient is sedated until death.[19] It is estimated that twelve to eighteen percent of patients around the world receive continuous sedation until death.[20] Mean survival time is generally not statistically different between those patients receiving sedation and those not receiving sedation.[21]

In most institutions, palliative sedation is confined to intensive care units ("ICUs") and operating theaters and is accompanied by cardiac monitoring. However, this clinical practice has been considered controversial as ICUs are specifically equipped and staffed by highly specialized professionals with the aim of preserving life, and thus these rooms are appropriate only for the critically unwell whose primary aim is survival.[22] Additionally, for those prioritizing comfort at the time of inevitable death, ICUs may prove to be an inappropriate setting. So, there is potential for a change in the delivery of palliative sedation.

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17. Tatusya Morita, *Sedation for Symptom Control in Japan: The Importance of Intermittent Use and Communication with Family Members*, 12 J. PAIN & SYMPTOM MGMT. 32 (1996); Ashley Ridley et al., *Nationwide Study of Continuous Deep Sedation Practices among Pediatric Palliative Care Teams*, 65 J. PAIN & SYMPTOM MGMT. 308 (2023).

18. *Cf.* Fang Tan et al., *Continuous Palliative Sedation in Terminally Ill Patients with Cancer: A Retrospective Observational Cohort Study from a Chinese Palliative Care Unit*, 13 BMJ OPEN e071859 (2023) (describing other durations and levels of sedation).

19. Hitoshi Arima, *Continuous Deep Sedation and the Doctrine of Double Effect: Do Physicians Not Intend to Make the Patient Unconscious until Death if They Gradually Increase the Sedatives?* 34 BIOETHICS 977 (2020).

20. Surges et al., *supra* note 11; Madelon T. Heijltjes et al., *Changing Practices in the Use of Continuous Sedation at the End of Life: A Systematic Review of the Literature*, 60 J. PAIN & SYMPTOM MGMT. 828 (2020).

21. B. Barathi & Prabha S. Chandra, *Palliative Sedation in Advanced Cancer Patients: Does It Shorten Survival Time? - A Systematic Review*, 19 INDIAN J. PALLIATIVE CARE 40 (2013); Nigel Sykes & Andrew Thorns, *Sedative Use in the Last Week of Life and the Implications for End-of-Life Decision Making*, 163 ARCHIVES INTERNAL MED. 341 (2003).

22. Zev Schuman & Janet Abrahm, *Implementing Institutional Change: An Institutional Case Study of Palliative Sedation*, 8 J. PALLIATIVE MED. 666 (2005).

B. Artificial Nutrition and Hydration

The question of whether to continue other therapies during palliative sedation is ethically tenuous. These include cardiopulmonary resuscitation, oxygen therapy, and dialysis. But most of the debate concerns artificial nutrition and hydration.[23] Some contend that palliative sedation requires administration of artificial nutrition and hydration because the patient cannot eat or drink, and that continuing artificial nutrition and hydration prevents suffering to an extent. But others counter that it is an unnecessary burden with no proven benefits.[24]

This Article is concerned with palliative sedation accompanied by withholding or withdrawing artificial nutrition and hydration. The combination of the two is different from mere palliative sedation in that the absence of artificial nutrition and hydration may cause death depending on the patient's prognosis from the underlying disease (*i.e.*, the type of PSs̄ANH).[25] When deep and continuous palliative sedation is combined with withholding or withdrawing artificial nutrition and hydration, we term that "PSs̄ANH." But PSs̄ANH has also been referred to by other names, including: "terminal sedation," "palliative sedation to unconsciousness," "deep and continuous sedation," and "sedation in imminently dying patients."[26]

C. Three Categories of PSs̄ANH

To facilitate understanding of this broad issue, we subdivide PSs̄ANH into three categories:

(1) PSs̄ANH *will not* hasten death ("Type 1 PSs̄ANH"),
(2) PSs̄ANH *might, but is not certain to*, hasten death ("Type 2 PSs̄ANH"), and
(3) PSs̄ANH *is certain to* hasten death ("Type 3 PSs̄ANH").

Type 1 PSs̄ANH is palliative sedation that *will not* hasten the patient's death. For example, the patient's death may be imminent (within hours) from their underlying illness. Therefore, stopping artificial nutrition and hydration during palliative sedation would be causally unrelated to the patient's death. The patient dies from their underlying illness long before experiencing the effects of dehydration.

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23. HARTOGH, *supra* note 13, at 119-51 (calling the combination of palliative sedation and withholding ANH the "dual procedure").

24. Gillian Craig, *On Withholding Artificial Hydration and Nutrition from Terminally Ill Sedated Patients: The Debate Continues*, 22 J. MED. ETHICS 147 (1996).

25. In contrast, there is little evidence that palliative sedation alone hastens death. *See, e.g.*, Cheol Hwang, *Current Status and Future Directions of Research on Palliative Sedation*, 25 J. HOSPICE & PALLIATIVE CARE 193 (2022).

26. Gurschick et al. *supra* note 9; Surges et al., *supra* note 11; Olsen et al., *supra* note 14; Wesbee Victor, *Palliative Sedation: A Better Alternative Than Euthanasia* (2022) (Theology Thesis, Catholic Univ. of Am.) (ProQuest).

Type 2 PSs̄ANH is palliative sedation that *might* hasten the patient's death. Dehydration can cause death after just a few days in a fragile patient. Therefore, in a patient whose death was not expected for more than five days, stopping artificial nutrition and hydration during palliative sedation *might* be causally unrelated to the patient's death. Furthermore, because prognostication is imprecise, even if death were expected sooner, the patient's death *might* have been hastened by stopping nutrition and hydration.

Type 3 PSs̄ANH is palliative sedation that *certainly* hastens the patient's death. Take a patient who is not actively dying from their underlying illness. Their death is months or years away. Despite quality palliative care, this patient may have symptoms that they (or their family if the patient is incapacitated) consider intolerable. So, the clinicians provide PSs̄ANH.[27] When the patient dies, it is not because of their underlying illness. It is because they did not get nutrition and hydration.

III. METHODOLOGY OF INTERNATIONAL REVIEW

This Article is an international review paper that surveys experts from twelve jurisdictions through a standardized template questionnaire that the team designed.[28] The experts are leading legal academics and/or medical practitioners in the field.

Jurisdiction	Expert(s)	Affiliation(s)
Australia	Professor Cameron Stewart	University of Sydney
Belgium	Professor Tom Goffin	Ghent University
Canada	Richard Liu	Solicitor (England & Wales); Attorney (New York)
	Dr. Joshua Wales	Mount Sinai Hospital (Toronto)

27. Type 3 PSs̄ANH may be unusual because most clinical guidelines require that continuous deep palliative sedation be used only for patients at the very end of life, with a life expectancy of just hours to days. *See* M. Maltoni et al., *Palliative Sedation in End-of-Life care and Survival: A Systematic Review*, 30 J. CLINICAL ONCOLOGY 1378 (2012). Indeed, this requirement is included specifically to avoid causing death (or at least the appearance of causing death). But there is significant variability regarding how close to death the patient must be. *See, e.g.*, Jeffrey T. Berger, *Rethinking Guidelines for the Use of Palliative Sedation*, 40 HASTINGS CTR. REP. 32 (2010).

28. The completed questionnaires are held on file by the authors and are available upon request to April Xiaoyi Xu at xxu@jd21.law.harvard.edu.

Colombia	Natalia Acevedo Guerrero	Georgetown University O'Neill Institute
	Professor Silvia Serrano Guzmán	Georgetown University O'Neill Institute
	Professor Oscar Cabrera	Georgetown University O'Neill Institute
England & Wales	Professor Emily Jackson	London School of Economics
France	Professor Stephanie Rohlfing-Dijoux	Université Paris Nanterre
Germany	Dr. Gesine Benze	University of Göttingen
	Małgorzata Able	University of Göttingen
India	Dhavani Mehta	Vidhi Centre for Legal Policy
	Dr. Navin Salins	Kasturba Medical College
Ireland	Professor Mary Donnelly	University College Cork
Netherlands	Professor Paul Mevis	Erasmus University Rotterdam
	Professor Agnes van der Heide	Erasmus University Rotterdam
	Professor Johannes (Hans) van Delden	University Medical Center, Utrecht University
Switzerland	Professor Sabrina Burgat	Université de Neuchâtel
	Professor Mélanie Levy	University of Neuchâtel

United States of America	Konstantin Tretyakov	Office of the Massachusetts Attorney General
	Professor Thaddeus Mason Pope	Mitchell Hamline School of Law

The questionnaire covered three areas for each jurisdiction: (1) the legality of PSS̄ANH, (2) PSS̄ANH and analogous practices, and (3) the medical practice of PSS̄ANH. We included in this Article only those jurisdictions for which there was a sufficient level of detail provided.

Part One: Legality of PSS̄ANH. On the legality of PSS̄ANH, the questionnaire asked each jurisdictional expert about: (1) local, provincial, federal, national, and supra-national legislation applicable to each type of PSS̄ANH, (2) notable past or current legislative attempts, and (3) relevant domestic and international case law. This part of the questionnaire also gathered information on whether there are any defenses or doctrines pertaining to end-of-life treatment (*e.g.*, the double effect doctrine[29]) that might affect the use of each of the three types of PSS̄ANH.

Admittedly, we are not offering a complete and comprehensive analysis of the legality of PSS̄ANH in each jurisdiction. That would require the application of first principles criminal law analysis, a project generally beyond the scope of this Article.[30] The work previously performed by Jocelyn Downie and Richard Liu offers an example of how first principles criminal law analysis can be applied to end-of-life care law (in the Canadian context).[31] But even that work shows that such an analysis does not clear out all potential issues and situations encountered around PSS̄ANH. Moreover, the fact that we must resort to first principles criminal law analysis to determine whether PSS̄ANH is legal in a jurisdiction already shows that such jurisdiction's current legal framework is unacceptably unclear.

Part Two: PSS̄ANH and Analogous Practices. As to the analogous practices portion of the questionnaire, the survey collected information on practices that the jurisdictional experts considered analogous to each type of PSS̄ANH, as well as information on the legal status of those practices.

Part Three: Medical Practice of PSS̄ANH. Finally, the questionnaire asked how widely each type of PSS̄ANH is used in each jurisdiction as a matter of medical practice. It also asked whether there is divergence between principle and practice in such application, and what factors influence the divergence (*e.g.*,

29. Alison McIntyre, *Doctrine of Double Effect*, in THE STANFORD ENCYCLOPEDIA OF PHILOSOPHY, https://plato.stanford.edu/entries/double-effect/ [https://perma.cc/3QUY-585L].

30. While this is the general approach of this Article, several jurisdictional efforts supply a few references that go some way toward application of first principles analysis.

31. Downie & Liu, *supra* note 1.

medical culture, costs/resource limitations, education, socioeconomic factors, regional differences).

Our research team was actively in contact with our jurisdictional experts, requesting further information where necessary. The analysis for each jurisdiction is directly based on responses to the questionnaire and each expert was given a chance to review and comment on the sections of the Article relevant to their jurisdiction.

Our team selected these twelve jurisdictions because we strive to analyze PSāANH across a range of legal and socioeconomic contexts. We included both common law and civil law countries (such as Canada and Germany, respectively). We included countries with a range of permissiveness on euthanasia and assisted suicide (from more permissive jurisdictions, such as Switzerland, to less permissive ones, such as England & Wales). We included both jurisdictions with federal control over health law (such as France) and jurisdictions with provincial or state control over health law (including Australia). And we included jurisdictions at varying stages of development (including developing countries such as Colombia and India and developed countries such as Switzerland). Meanwhile, the Article strives to be as broad as possible so that it can serve as a potential guide for considering these issues in other jurisdictions beyond the twelve covered.

IV. INTERNATIONAL REVIEW OF LEGAL STATUS AND MEDICAL PRACTICE

This section discusses each of the twelve jurisdictions individually, although we grouped these jurisdictions into three categories: restrictive, moderate, and permissive. In all three categories, Types 1 and 2 PSāANH are or are likely permissible. The differences relate to the most controversial practice—Type 3 PSāANH.

Restrictive Jurisdictions. In restrictive jurisdictions both Types 1 and 2 PSāANH are or are likely permissible. But Type 3 PSāANH is not permissible or there is a lack of support for saying that Type 3 PSāANH is permissible. These four restrictive jurisdictions are France, Germany, India, and Ireland.

Moderate Jurisdictions. In moderate jurisdictions both Types 1 and 2 PSāANH are or are likely permissible. Type 3 PSāANH is possibly or arguably permissible (in medically appropriate circumstances). These three moderate jurisdictions are Belgium, Canada, and England & Wales.

Permissive Jurisdictions. In permissive jurisdictions both Types 1 and 2 PSāANH are or are likely permissible. Type 3 PSāANH is or is probably permissible (in medically appropriate circumstances). The five permissive jurisdictions are Australia, Colombia, the Netherlands, Switzerland, and the United States of America.

A. Restrictive Jurisdictions

Four jurisdictions take a generally restrictive approach to PSs̄ANH: France, Germany, India, and Ireland. Both Types 1 and 2 PSs̄ANH are or are likely permissible. But Type 3 PSs̄ANH is not permissible or there is a lack of support for saying that Type 3 PSs̄ANH is permissible.

Jurisdiction	Type 1	Type 2	Type 3
France	Y	Y	N
Germany	Y	Y	N
India	Y	Y	N
Ireland	Y	Y	N

1. France

Both Types 1 and 2 PSs̄ANH are permissible and practiced in France.[32] But Type 3 PSs̄ANH is prohibited and is not practiced.

a. Legality of PSs̄ANH in France

In terms of Type 1 PSs̄ANH, on February 2, 2016, France passed new end-of-life legislation.[33] The Claeys–Leonetti Act integrates for the first time a ban on unreasonable therapeutic obstinacy with the possibility of terminal sedation. The Claeys–Leonetti Act was integrated in the French Code of Public Health.

Two sections of the Claeys–Leonetti Act refer specifically to sedation and end-of-life care:

> The doctor shall implement all analgesic and sedative treatments to respond to the refractory suffering of the patient in the advanced or terminal phase, even if they may have the effect of shortening life. . .[34]

> At the patient's request to avoid all suffering and not to be subjected to unreasonable obstinacy, deep and continuous sedation causing an alteration of consciousness maintained until death, associated with analgesia and the cessation of all life-sustaining treatments, is

32. The local jurisdictional expert for this section was Professor Stephanie Rohlfing-Dijoux.

33. Code de la Santé Publique [C. Santé Pub.] [Public Health Code] (Fr.), https://www.legifrance.gouv.fr/codes/texte_lc/LEGITEXT000006072665/2024-05-06/ [https://perma.cc/5U8A-K6TH].

34. *Id.*

> implemented in the following cases:
>
> 1° When the patient suffering from a serious and incurable disease and whose vital prognosis is engaged in the short term presents a suffering refractory to treatments.
>
> 2° When the decision of the patient suffering from a serious and incurable disease to stop a treatment engages his or her vital prognosis in the short term and is likely to cause unbearable suffering.
>
> When the patient is unable to express their wishes and, as part of the refusal of unreasonable obstinacy referred to in Article L. 1110-5-1, in the event that the doctor stops life-sustaining treatment, the doctor shall apply deep and continuous sedation causing an alteration of consciousness maintained until death, combined with analgesia.
>
> The deep and continuous sedation associated with analgesia provided for in this article shall be implemented in accordance with the collegiate procedure defined by regulation, which enables the health care team to check beforehand that the conditions for its application provided for in the preceding paragraphs are met.[35]

In short, Type 1 PSs̄ANH is broadly permitted under the Claeys–Leonetti Act.

In contrast, Type 2 PSs̄ANH must be an exceptional treatment that can be provided only under very strict conditions. The principal legal rules are the same as for Type 1 PSs̄ANH. The law explicitly authorizes the withdrawal and withholding of life-sustaining treatments combined with deep sedation under certain conditions. Notably, the decision for deep and continuous sedation until death must always be discussed in a collegial procedure.[36] This collective decision-making process for the medical team is very important in this type of sedation because the team cannot communicate with the patient.

The condition of "refractory or insupportable suffering" is difficult to define because it contains a subjective element and requires an evaluation of the effectiveness of the treatment which is very difficult.[37] Before the implementation of deep sedation, the physician must have tried in vain all other possibilities of reducing suffering.[38]

A particular form of sedation involves "deep and continuous sedation until death occurs." This sedation is only possible in exceptional cases at the request

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35. *Id.* at Art. L1110-5-2.

36. *Id.* at Art. L1110-5-2 §§ 2 & 3.

37. Clémence Joly et al., *Refractory Sufferings at the End of Life: Which Considerations, Which Propositions?* (*Souffrances Réfractaires En Fin De Vie: Quelles Réflexions, Quelles Propositions?)* 40 LA PRESSE MÉDICALE 341 (2011).

38. Code de la Santé Publique (hereinafter the "French Pub. Health Code") at Art. L1110-5-2 (requiring that suffering be "refractory" to other measures).

of the patient or their relatives if two conditions are met: (1) the vital prognosis is engaged in the short term and (2) suffering is refractory to analgesic treatments.[39] Deep sedation may have as a side effect a shortening of the patient's life and cuts off possible communication between the patient, on the one hand, and the medical team, family, and relatives, on the other hand. However, unlike euthanasia, there is no intention to cause death. Rather, the intention is to relieve the patient and allow them to die a gentle and peaceful death without pain and to make the death gentler for the family accompanying the patient (the doctrine of double effect).

Type 3 PSŝANH is governed by the same legislation as the two other types. Sedation is used for patients with a serious and incurable illness with the aim of avoiding any suffering and of not increasing unreasonable obstinacy in cases where: "the vital prognostic is engaged at short term," and the patient's suffering is refractory to medical treatments and where the decision to stop life sustaining measures engages the vital prognostic at short term and may cause insupportable suffering (*e.g.*, artificial ventilation).[40]

However, the conditions established by the law can be very difficult to evaluate.[41] The term "prognosis of life committed in the short term" means that there remain only a few hours or at most a few days for the patient to live. The sedation can be intermittent, transitory or continuous. It can continue until there is a decrease of attention or the loss of consciousness. Sedation cannot be given to cause death but can be given to allow for a peaceful and serene death. Death must be caused by illness and not by sedation. It excludes an intention other than this sole relief (notably excluding a desire to shorten life, whether for compassionate reasons or at the request of the patient). Ambiguity consists in the distinction between deep sedation and euthanasia.

A notable case in France is the *Lambert* case, where the question was whether shortening of life by withdrawing artificial nutrition and hydration against the wish of the patient's parents was justified by the interdiction of medical futility in the French Health Act.[42] The patient was tetraplegic since 2008 and completely dependent.[43] No communication could be established with him.[44] But he was able to breathe without ventilatory support.[45] This situation remained until July 2019, where he died after withdrawing artificial hydration

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39. *Id*.

40. *Id*.

41. E Lucchi et al., *Could Palliative Sedation Be Seen as Unnamed Euthanasia? A Survey among Healthcare Professionals in Oncology*, 22 BMC PALLIATIVE CARE 97 (2023) (finding that the "prognosis, crucial to decide a deep and continuous sedation maintained until death, appears to be very difficult and various, between hours and few weeks").

42. CE, Ass., Mme Lambert, 24 June 2014, Nos. 375081, 375090, 375092, https://www.conseil-etat.fr/decisions-de-justice/jurisprudence/les-grandes-decisions-depuis-1873/ce-ass.-24-juin-2014-mme-lambert-n-s-375081-375090-et-37509 [https://perma.cc/AB5U-2VVY].

43. *Id.*

44. *Id.*

45. *Id.*

and nutrition.[46]

The relevant law stipulates:

> The means mentioned in Article L. 1110-5 must not be carried out or continued when they result from unreasonable obstinacy. When they appear unnecessary, disproportionate or when they have no other effect than the artificial maintenance of life, they may be suspended or not undertaken, in accordance with the patient's wishes and, if the patient is unable to express their wishes, at the end of a collegiate procedure defined by regulation.[47]
>
> Artificial nutrition and hydration constitute treatments that may be stopped in accordance with the first paragraph of this article. When the acts mentioned in the first two paragraphs of this article are suspended or not undertaken, the doctor shall safeguard the dignity of the dying person and ensure the quality of his life by providing the palliative care mentioned in Article L. 1110-10.[48]

Both abundant jurisprudence and more than a decade of discussion on the *Lambert* case demonstrate the historic hostility of France towards active euthanasia (which is not lawful). Moreover, passive euthanasia by stopping treatment was also rejected by a large part of the population. Vincent Lambert's wife wanted the withdrawal of life-sustaining measures while his parents and siblings fought to maintain his life even in such a neuro-vegetative state without any hope for a cure.[49] A long legal battle followed until the judgment of the European Court of Human Rights, which has not been acted on.[50] In the end, after exhausting all legal remedies, the parents had to accept the decision and the treatment of Mr. Lambert was withdrawn on July 2, 2019. He died on July 11, 2019.[51] The *Lambert* case contributed substantially to the evolution of the French law in the past few years.[52]

In December 2022, the Citizens' Convention on the End of Life was established by the French government to examine the issue of whether

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46. *Id.*

47. French Pub. Health Code, *supra* note 38, at Art. L1110-5-1.

48. *Id.*

49. Lambert v. France, App. No. 46043/14, 62 Eur. Ct. H.R. 16 (2015).

50. *Id*.

51. *Vincent Lambert: Frenchman at Centre of End-of-Life Debate Dies*, BBC NEWS (July 11, 2019).

52. There is also non-binding soft law in France. *Cf.* Société Française d'Accompagnement et de Soins Palliatifs (French Society of Accompaniment and Palliative Care), Recommandations (June 9, 2017) (Fr.) (making recommendations concerning the three types of sedation), https://www.sfap.org/rubrique/les-recommandations-sur-la-sedation [https://perma.cc/NDU3-UHTU].

euthanasia and assisted dying should be permissible in some form in France.[53] The Convention consisted of 184 citizens drawn at random, supported by testimony from experts (including medical doctors), those living with chronic illness, and faith leaders.[54] Seventy-six percent of the citizen participants voted in favor of permitting euthanasia and/or assisted suicide under certain conditions at the end of life and a report was published on April 2, 2023 containing the views of both the majority and the minority of the citizen participants.[55] In May and June 2024 the National Assembly extensively debated legislation to authorize euthanasia and/or assisted suicide.[56]

b. PSsANH and analogous practices in France

French legislation only allows terminally ill patients to request for their lives to be ended without any active assistance.[57] Euthanasia is an act intentionally aiming to bring an end to a person's life at his explicit request. This should be distinguished from assisted suicide, where an ill person in a state that he cannot commit suicide by himself, wants to die with the help of someone else. The right for a suffering person to die voluntarily and peacefully is not granted if the person needs active help to die. Both active euthanasia and assisted suicide are not allowed in France.[58]

The goal of deep and continuous sedation until the death is "to avoid any suffering and not to undergo unreasonable medical futility."[59] It will provoke an "alteration of consciousness maintained until death."[60] It is not intended to decrease the survival time of patients, but to relieve pain.[61] Its effects on possible shortening of life are justified by the double effect theory. This is the principle that a drug will relieve pain while it may have the side effect of shortening life.[62]

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53. Conseil Économique, *La Convention Citoyenne sur la Fin de Vie, c'est Quoi?* https://conventioncitoyennesurlafindevie.lecese.fr/la-convention-citoyenne-sur-la-fin-de-vie-c-est-quoi [https://perma.cc/63H2-KKEV].

54. Ansel Herz, *End of Life Citizens' Assembly Concludes with 92% Consensus, Delivers Recommendations to Macron*, DEMOCRACY NEXT (April 4, 2023), https://www.demnext.org/news/democracy-in-france-end-of-life-citizens-assembly-concludes-with-92-consensus-delivers-recommendations-to-macron [https://perma.cc/Z87Y-KSBW].

55. Conseil Économique, *La Convention Citoyenne sur la Fin de Vie Conclut ses Travaux* (Feb. 2, 2023), https://conventioncitoyennesurlafindevie.lecese.fr/actualites/la-convention-citoyenne-sur-la-fin-de-vie-conclut-ses-travaux [https://perma.cc/ZU7Y-ZMTH].

56. Assemblée Nationale, *Accompagnement des Malades et de la Fin de Vie: Examen du Projet de Loi en Séance Publique*, https://www.assemblee-nationale.fr/dyn/actualites-accueil-hub/accompagnement-des-malades-et-de-la-fin-de-vie-examen-du-projet-de-loi-en-seance-publique [https://perma.cc/DQU7-8N39].

57. Alexandre de Nonneville et al., *End-of-Life Practices in France under the Claeys-Leonetti Law: Report of Three Cases in the Oncology Unit*, 20 CASE REP ONCOLOGY 650 (2016).

58. *Id*.

59. French Pub. Health Code, *supra* note 38, at Art. L1110-5-1.

60. *Id*.

61. Steven Farrelly-Jackson, *Intentions at the End of Life: Continuous Deep Sedation and France's Claeys-Leonetti Law*, 49 J. MED. & PHIL. 43 (2024).

62. *Id*.

This is expressly allowed by the legislation.[63]

Therefore, it seems very important that the conditions of deep and continuous sedation be controlled so as not to fall into the field of euthanasia, as both result in a potential shortening of life. Deep sedation is not permitted in the case of non-curable illnesses that are not life-threatening in the short term, in the case of psychological illnesses (*e.g.*, depression) or in the case of age-related dementia. The condition in French law for the deep sedation until death and a shortening of the life of the patient (doctrine of double effect) is that the vital prognosis is engaged in the short term.[64] This is not the case with Type 3 PSsANH and, in such cases, sedation with a double effect would not be allowed.

For Type 3 PSsANH in France, Legislative Proposal 3755 served to affirm the free choice of the end of life and to ensure universal access to palliative care in France.[65] But this proposal, aiming to legalize euthanasia, failed because it could not find the required majority support in the French National Assembly.[66]

c. Medical practice of PSsANH in France

In France, Types 1 and 2 PSsANH are used in hospitals and elderly homes and even for palliative care at home.[67] Nevertheless, there are no statistics on the use of sedation. Type 3 PSsANH, on the other hand, is currently prohibited in France.

In terms of the divergence between principle and practice in the application of PSsANH, extreme practices of physicians deciding, at their own discretion, whether to shorten the life of their patients were still common in France up until a few years ago and are named "lytic cocktails."

Another important point here is resource limitation. The Claeys-Leonetti Act also provides for the possibility of sedation in institutions for senior citizens or at home (as it is often the wish of people to die at home). But this is almost impossible to implement in institutions because they lack sufficient means to practice deep sedation and to monitor patients who continue to require care. This applies *a fortiori* to the practice of home sedation. There are also regional differences. In some remote regions in France, there are sometimes insufficient critical care beds to offer sedation to all patients in need.

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63. French Pub. Health Code, *supra* note 38, at Art. L1110-5-3 § 2.

64. *Id*. at Art. L1110-5-2.

65. Assemblée Nationale, *Proposition de Loi No. 3755: Visant à Affirmer le Libre Choix de la Fin de Vie et à Assurer un Accès Universel aux Soins Palliatifs en France*, https://www.assemblee-nationale.fr/dyn/15/textes/l15b3755_proposition-loi [https://perma.cc/3N6X-BX58].

66. Assemblée Nationale, *Libre choix de la fin de vie*, https://www.assemblee-nationale.fr/dyn/15/dossiers/choix_fin_de_vie [https://perma.cc/9Y3U-Q2QJ].

67. *See* Louis Auffray et al., *Tension Between Continuous and Deep Sedation and Assistance in Dying: A National Survey of Intensive Care Professionals' Perceptions,* 43(1) ANESTHESIA CRITICAL CARE & PAIN MED. 101317 (2024); *see also* Matthieu Le Dorze et al., *Continuous and Deep Sedation until Death after a Decision to Withdraw Life-Sustaining Therapies in Intensive Care Units: A National Survey*, 37(3) PALLIATIVE MED. 1202 (2023). PSsANH is also used in pediatric settings. *See* Ridley et al., *supra* note 17.

2. Germany

As with France, both Types 1 and 2 PSs̄ANH are permissible in Germany.[68, 69] While evidence suggests that clinicians provide Type 1 PSs̄ANH, it is unclear how often they provide Type 2 PSs̄ANH. Type 3 PSs̄ANH is prohibited and likely unavailable. In general, the indication for sedation and the indication of artificial nutrition and hydration are seen as independent decisions.

There are no national guidelines on palliative sedation in Germany.[70] Nevertheless, there are recommendations in relation to sedation in specialist palliative care settings.[71] Furthermore there are general requirements based on expert consensus in the Extended S3 Guideline: Palliative Care for Patients with Incurable Cancer concerning use of sedation in the dying phase.[72]

As there are no dedicated national guidelines the European Association for Palliative Care recommended Framework on Palliative Sedation (the "EAPC Framework"), revised in 2023, gives some guidance.[73] Principles of the EAPC Framework are found in the standard operating procedure written by the Palliative Care Working Group of the Comprehensive Cancer Center, Germany, founded by German Cancer Aid.[74] This procedure was valid until January 31, 2018 and is yet to be updated.

a. Legality of PSs̄ANH in Germany

The use of means to relieve suffering (*e.g.*, morphine) which may have the secondary effect of shortening life is considered "indirect euthanasia" or unintended side effects of "end of life therapy" under German law.[75] There is no legislation at the federal level that explicitly regulates palliative sedation. Nevertheless, the legality of palliative sedation is affected by provisions in the

68. The local jurisdictional experts for this section were Dr. Gesine Benze and Małgorzata Able.

69. *See* GERMAN ASSOCIATION FOR PALLIATIVE MEDICINE, *Recommendations for the Use of Sedative Drugs in Specialist Palliative Care*, GERMAN ASSOCIATION FOR PALLIATIVE MEDICINE (2021), https://www.dgpalliativmedizin.de/images/210422_Broschuere_SedPall_Gesamt.pdf [https://perma.cc/VE6U-M4ZQ].

70. GERMAN ASSOCIATION FOR PALLIATIVE MEDICINE, *supra* note 69.

71. *Id*.

72. *See* GERMAN GUIDELINES IN ONCOLOGY PROGRAM, *Extended S3 Guideline: Palliative Care for Patients with Incurable Cancer*, GERMAN GUIDELINES IN ONCOLOGY PROGRAM (2020), https://www.leitlinienprogramm-onkologie.de/fileadmin/user_upload/Downloads/Leitlinien/Palliativmedizin/Version_2/GGPO_Palliative_Care_ShortVersion_2.2.pdf [https://perma.cc/C382-Q55Z].

73. Surges et al., *supra* note 11. *See also* Severine Marie Surges et al., *New Recommendations on Palliative Sedation*, 38 SCHMERZ 365 (2024) (describing new recommendations in Germany following the EAPC update).

74. Karin Oechsle et al., *SOP – Palliative Sedierung*, 23 DER ONKOLOGE 469 (2017).

75. M. Quante, *Passive, Indirect and Direct Active Euthanasia – Descriptive and Ethical Solid Distinctions*, 10 ETHIK MED. 206 (1998).

German Criminal and Civil Codes that apply to the doctor-patient relationship.[76]

In 2015, Germany enacted a new law criminalizing the professional promotion of suicide.[77] This provision criminalized offering assisted suicide as a professionalized service, but was declared incompatible with the Basic Law and therefore null and void by the Federal Constitutional Court in 2020.[78] In April 2021, another draft bill was introduced to regulate assisted suicide but the legislative proposal lapsed at the end of the legislative period.[79] Importantly, the German Criminal Code still criminalizes "active euthanasia" or "killing on request" where death is actively intended, rather than merely a consequence of a medical procedure performed for a different purpose.[80] This section is compatible both with Germany's Basic Law and with the European Convention on Human Rights.[81]

Therefore, where the objective of Type 3 PS̄ANH is to alleviate suffering by causing death, this is impermissible.[82] Nevertheless, "indirect euthanasia" remains generally permissible if performed in accordance with the general requirements for authorization of medical action.[83] This requires that the measure is medically indicated, that the patient is informed of possible life-shortening side effects, and that the patient consents to this measure.[84]

There are several noteworthy decisions of the German Federal Court of Justice. According to a 2010 decision, palliative sedation is an "act of euthanasia justified by consent . . . in the form of so-called "indirect euthanasia," which takes place with the acceptance of a possible premature onset of death as a side effect of a medically indicated palliative measure."[85] Therefore, the mere fact that the administration of painkillers to alleviate suffering (in accordance with the patient's express or presumed consent) may accelerate death—as may well be the case for palliative sedation—does not automatically render such administration impermissible.

Medical treatment of a patient at the end of their life is subject to the same rules as any other treatment.[86] The rights and obligations are primarily derived

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76. GERMAN ASSOCIATION FOR PALLIATIVE MEDICINE, *supra* note 69, at 17.

77. Gesetz zur Strafbarkeit der geschäftsmäßigen Förderung der Selbsttötung [Act Criminalizing Commercial Promotion of Suicide], Dec. 3, 2015, BGBL I at 2170, § 217 (Ger.) (effective Dec. 10, 2015).

78. Bundesverfassungsgericht [BVerfG] [Federal Constitutional Court] Feb. 26, 2020, § 217 StGB (Ger.) (considering medical guidance on handling suicidal tendencies and death wishes following the decision, as noted by the German Medical Association).

79. BT-Drucks. 19/28691 (Ger.).

80. German Criminal Code (StGB) § 216 (Ger.).

81. BGHSt 55, 191 = NJW 2010, 2963, para. 35 (Ger.); BGH, NStZ 2003, 537, 538 (Ger.); ADOLF LAUFS, CHRISTIAN KATZENMEIER, VOLKER LIPP, MEDICAL LAW 227 (C.H. Beck 2009) (original title: *Arztrecht*).

82. German Criminal Code (StGB) § 216 (Ger.).

83. LAUFS, KATZENMEIER & LIPP, *supra note* 81, at 228 (§§ 630a ff. BGB) (Ger.).

84. Laufs, NJW 763 (1996) (Ger.); Verrel MedR 1997, 248 ff.; LAUFS, KATZENMEIER & LIPP, *supra* note 81, at 228.

85. BGH, NJW 2963 (2010) (Ger.).

86. LAUFS, KATZENMEIER & LIPP, *supra* note 81, at 224.

from the treatment contract in accordance with the rules discussed above.[87] However, those rules are often insufficient to justify the wide range of necessary medical measures.[88] From a legal perspective, palliative sedation must be medically indicated with regard to the specified treatment goal.[89] The primary aim of sedation as a treatment method is to alleviate or end suffering.[90] A sedative measure must be with the intention of alleviating suffering, not to hasten the patient's death. Further, palliative sedation requires the patient's consent following prior adequate explanation by the physician.[91]

b. PSs̄ANH and analogous practices in Germany

Type 1 PSs̄ANH, the least controversial type of PSs̄ANH, is generally analogous to other palliative care that may be used where symptoms cannot otherwise be alleviated.[92] Type 2 PSs̄ANH is somewhat analogous to potentially life-shortening opioid use that may be employed where the patient experiences intense pain or dyspnea that requires quick relief.[93] Type 3 PSs̄ANH, being certain to shorten life, is analogous to euthanasia.[94] Again, where the certainty of shortened life is not merely a consequence but an objective of Type 3 PSs̄ANH, this type of PSs̄ANH is unlawful.[95]

c. Medical practice of PSs̄ANH in Germany

Studies that focus exclusively on the practice of palliative sedation in Germany are quite dated. Stiel et al. relies on a 2012 dataset.[96] Jaspers et al. relies on data from 2005 and 2006.[97] More recent studies, such as Salzmann et al., cover non-representative attitudes of physicians towards PSs̄ANH in the context of one specific disease (amyotrophic lateral sclerosis).[98]

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87. German Civil Code (BGB) §§ 630a ff. (Ger.).

88. LAUFS, KATZENMEIER & LIPP, *supra* note 81, at 224.

89. *Cf.* German Civil Code (BGB) § 1901b(1) (Ger.).

90. Christoph Ostgathe et al., *Expert-approved Best Practice Recommendations on the Use of Sedative Drugs and Intentional Sedation in Specialist Palliative Care (SedPall)*, 22 BMC PALLIATIVE CARE 126 (2023).

91. Bürgerliches Gesetzbuch [BGB] [German Civil Code] §§ 630d, 630e, para. 1, sentence 1, https://www.gesetze-im-internet.de/englisch_bgb/englisch_bgb.html [https://perma.cc/7WEN-233G] (Ger.).

92. *See supra* section II.

93. *Id.*

94. *Id.*

95. German Criminal Code (StGB) § 216 (Ger.).

96. Stephanie Stiel et al., *Palliative Sedation in Germany: Factors and Treatment Practices Associated with Different Sedation Rate Estimates in Palliative and Hospice Care Services*, 17 BMC PALLIATIVE CARE 48 (2018).

97. Birgit Jaspers et al., *Palliative Sedation in Germany: How Much Do We Know? A Prospective Survey*, 15 J. PALLIATIVE MED. 672 (2012).

98. Laura Salzmann et al., *Palliative Sedation in Amyotrophic Lateral Sclerosis: Results of a Nationwide Survey among Neurologists and Palliative Care Practitioners in Germany*, 22 BMC NEUROLOGY 161 (2022).

But there is some more recent evidence from a survey concerning practices and experiences with continuous use of sedatives in the last days of life. A questionnaire was distributed to 8,550 physicians, 546 of whom were from Germany.[99] Over ninety percent of German respondents reported that they had clinical experience with continuous use of sedatives in the last twelve months.[100] Ninety-nine percent considered it acceptable to use sedatives to relieve suffering in the last days of life in cases of physical suffering. Sixty-five percent considered it acceptable in cases of psycho-existential suffering in the absence of physical symptoms. This fell to forty percent where the patient was expected to live for several weeks. Notably, fewer than five percent of physicians expressly mentioned the relevance of an intention to shorten the dying process.[101]

Therefore, while exact data is lacking, it seems that Type 1 PSs̄ANH—where patients are in their last days of life and PSs̄ANH will not reduce life expectancy—is widely used in Germany. In the dying phase, deep continuous sedation until death is a legitimate medical action as a last resort for rare cases where it is not possible to relieve the patient's suffering in a satisfactory manner by either casual or symptomatic treatment or by withdrawing measures.[102] However, it remains unclear how widespread Types 2 and 3 PSs̄ANH are. Type 3 PSs̄ANH is unlawful where its objective is to end or shorten life.[103] Therefore, it is likely to be quite rare and to go unreported in official questionnaires.

3. India

As in France and Germany, Types 1 and 2 PSs̄ANH are permissible in India.[104] Type 1 PSs̄ANH is commonly used, while Type 2 PSs̄ANH is less common. Type 3 PSs̄ANH is likely neither permissible nor available to patients.

a. Legality of PSs̄ANH in India

In India, there is no dedicated national legislation that is directly applicable to any type of PSs̄ANH. The only national quasi-legislative instrument that is potentially applicable is the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002 (the "Indian Medical Council Regulations").[105] These regulations apply to Types 1 and 2 PSs̄ANH.

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99. Madelon T. Heijltjes et al., *Physicians' Opinion and Practice with the Continuous Use of Sedatives in the Last Days of Life*, 63 J. PAIN & SYMPTOM MGMT. 78, 79, 85 (2022).

100. *Id*. at 84 (figure 3).

101. *Id*. at 81.

102. GERMAN GUIDELINES IN ONCOLOGY PROGRAM, *supra* note 72, at 173.

103. German Criminal Code (StGB) § 216 (Ger.).

104. The local jurisdictional experts for this section were Dhavani Mehta and Dr. Navin Salins.

105. Indian Medical Council, *Professional Conduct, Etiquette and Ethics Regulations, 2002* (March 11, 2002),

Chapter 6 of the Indian Medical Council Regulations is titled "Unethical Acts" and physicians are forbidden from aiding, abetting, or committing unethical acts listed in the chapter.[106] Chapter 6.7 addresses euthanasia. The Indian Medical Council Regulations state that practicing euthanasia shall constitute unethical conduct. However, there is an exception for withdrawing supporting devices that sustain cardiopulmonary function. This suggests that the Indian Medical Council Regulations only contemplate withdrawal of support systems after brain death.[107]

In terms of Type 3 PSs̄ANH, if palliative sedation were indeed to be considered an overt act, the most applicable law would be the Indian Penal Code of 1860 (the "Indian Penal Code").[108] Section 32 equates illegal acts with illegal omissions, and is thus relevant, to the extent that withdrawing or withholding artificial nutrition or hydration might be considered an illegal omission.

Under Section 300 of the Indian Penal Code, intention to cause death is not the only possible *mens rea* for murder.[109] It equally suffices to show that the putative offender "knows that [his act] is so imminently dangerous that it must, in all probability, cause death . . . and commits such act without any excuse for incurring the risk of causing death or injury." Type 3 PSs̄ANH is, by its nature, carried out with the knowledge that it will cause death. Nevertheless, it remains open to debate whether a sufficient "excuse" can be made for Type 3 PSs̄ANH to negate liability for murder (and, if so, in what circumstances).

Efforts have, at times, been made to clarify the law regarding PSs̄ANH in India through attempts at legislative reform (although they have not been enacted). The Law Commission of India has, for instance, suggested—in two of its reports—possible changes to the law applicable to the administration of PSs̄ANH. The five key recommendations of the Law Commission's March 2006 report (and the accompanying draft bill) are:

(1) Recognize the right of a competent patient to withhold or withdraw medical treatment.[110]
(2) Designate "Advance Medical Directives" and medical power-of-attorney as void, of no effect, and not binding on medical

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https://wbconsumers.gov.in/writereaddata/ACT%20&%20RULES/Relevant%20Act%20&%20Rules/Code%20of%20Medical%20Ethics%20Regulations.pdf [https://perma.cc/P95U-KRSK]. These regulations were published in the *Gazette of India* on April 6, 2002. They were issued under the Indian Medical Council Act 1956, specifically, in exercise of the powers conferred under section 20A, read with section 33(m).

106. *Id.*

107. *Id.*

108. Indian Penal Code, 1860, Act 45 of 1860, https://www.indiacode.nic.in/bitstream/123456789/4219/1/THE-INDIAN-PENAL-CODE-1860.pdf [https://perma.cc/7AQS-K5AV].

109. *Id*.

110. Law Comm'n of India, Report No. 196, *Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners)* (2006), at 408, http://www.commonlii.org/in/other/lawreform/INLC/2006/2.html [https://perma.cc/2BXS-RCZ8].

practitioners.[111]

(3) Allow medical practitioners to withhold or withdraw medical treatment from competent patients who may not have taken an informed decision as well as from incompetent patients, provided that the practitioner's decision is taken in their best interests.[112]
(4) Set out a detailed procedure for withholding or withdrawing medical treatment when it is undertaken in the instances referred to in the previous point.[113]
(5) Protect medical practitioners from criminal liability for withholding or withdrawing medical treatment in accordance with the provisions of the bill.[114]

The draft bill also defined "palliative care" as "the provision of reasonable medical and nursing procedures for the relief of physical pain, suffering, discomfort or emotional and psycho-social suffering" and "the reasonable provision for food and water."[115] It stated that medical practitioners were not "debarred" from administering palliative care even if other medical treatment was withheld or withdrawn.[116] The bill was intended to apply only to persons who suffered terminal illness.[117]

The Law Commission of India's August 2012 report also contained a draft bill with the same title as that featured in the March 2006 report.[118] There are some differences between the two drafts of the bill in regard to the procedure to be observed by medical practitioners while withholding or withdrawing medical treatment, including—most notably—designating the High Court of India's approval as "a condition precedent to stopping life-supporting measures."[119] The 2012 report of the Law Commission also urged Governments to frame schemes that would extend palliative care to terminally ill patients undergoing suffering and pain.[120]

The most important and recent case on this issue is *Common Cause (A Registered Society) v. Union of India.*[121] Here, the Supreme Court was invited to examine all aspects of euthanasia-related issues, and to develop exhaustive

111. *Id.* at 409.
112. *Id.* at 408.
113. *Id.* at 409-12.
114. *Id.* at 413.
115. *Id.* at 423.
116. *Id.* at 429.
117. *Id.* at 420.
118. Law Comm'n of India, Report No. 241, *Passive Euthanasia – A Relook* 1 (2012), https://cdnbbsr.s3waas.gov.in/s3ca0daec69b5adc880fb464895726dbdf/uploads/2022/08/2022081061-1.pdf [https://perma.cc/3J79-T6BD].
119. *Id.* (The High Court of India's approval was added to account for the 2011 judgement of the Supreme Court of India in *Aruna Shanbaug v. Union of India*, where the prior approval of the High Court was required for the withholding or withdrawal of life-support).
120. *Id.*
121. Common Cause (A Regd. Society) v. Union of India, 5 SCC 1 (2018) (India), https://indiankanoon.org/doc/184449972/ [https://perma.cc/AME8-YDFC].

guidelines regarding euthanasia. Although the Supreme Court's judgment was unanimous, it consisted of four separate opinions. Therefore, it is difficult to determine what the ratio of the case is. Importantly, the Supreme Court's judgment recognized the legal validity of advance medical directives and reaffirmed the right of competent persons to refuse life-sustaining treatment.[122] Moreover, the judgment recognized that medical practitioners could legally withhold or withdraw life-sustaining treatment from persons who might not have executed advance medical directives or from persons who lacked the capacity to make informed decisions.

It is clear from the *Common Cause* case that Types 1 and 2 PSs̄ANH would be legal, although the focus remains on the withholding or withdrawal rather than the administration of palliative sedation. With respect to Type 3 PSs̄ANH, it is unclear whether the administration of palliative sedation would be considered a positive act in the same way as the administration of a lethal injection would. The latter is the only kind of act that the judgment considers—as held in previous cases, such an act would be criminal. For instance, the Supreme Court says:

> [T]he authorities, we have noted from other jurisdictions, have observed the distinctions between the administration of lethal injection or certain medicines to cause painless death and non-administration of certain treatment which can prolong the life in cases where the process of dying that has commenced is not reversible or withdrawal of the treatment that has been given to the patient because of the absolute absence of possibility of saving the life.[123]

A question, therefore, as far as Type 3 PSs̄ANH is concerned, is whether the process of dying in that case could have said to have commenced.

The other question that remains unclear is the definition of terminal illness. It is important to note that the judgment recognizes the legal validity of withholding or withdrawing life-sustaining treatment only when a person is

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122. *Id*. ¶ 191. Note that in the State of West Bengal, there are rules on advance directives. The West Bengal Clinical Establishment Rules deal with discharge, death, and terminal care. West Bengal Clinical Establishments (Registration, Regulation and Transparency) Act 2017, https://prsindia.org/files/bills_acts/acts_states/west-bengal/2017/2017WB4.pdf [https://perma.cc/NW6X-TB45]; West Bengal Clinical Establishment (Registration, Regulation and Transparency) Rules 2017, https://indiankanoon.org/doc/68440793/ [https://perma.cc/RH4D-GFDM]. Rule 15(8) confers a right on a patient to execute an "advance directive" after consulting with the primary consultant. The advance directive could include a health care proxy or a living will, provided that it is executed in a form that may be notified. The advance directive is defined as "a document with written instructions made by a person before he/she reaches the terminal phase of a terminal illness or a persistent vegetative state and incapable [*sic*] of making decisions about medical treatment when the question of administering the treatment arises." Any patient executing such directive must be informed of the medical consequences of their choice and must also release those involved in the patient's care from any obligation relative to the consequences of their decision. The patient's decision must not prejudice public health and safety).

123. Common Cause, 5 SCC at 160.

"terminally ill and is undergoing prolonged medical treatment with no hope of recovery and cure of the ailment."[124]

b. PSs̄ANH and analogous practices in India

Type 1 PSs̄ANH is analogous to ordinary sedation where non-physical symptoms like anxiety and restlessness are managed with benzodiazepines without lowering of consciousness.[125]

Type 2 PSs̄ANH is analogous to proportionate palliative sedation where benzodiazepines are used to manage intolerable symptoms by titrating the dose to a level of maximal symptom relief while maintaining alertness as much as possible. The first line agent usually considered for palliative sedation is midazolam, a water-soluble compound, which is relatively inexpensive and easily accessible, and which easily mixes with other medications. If the patient's symptoms and distress are refractory to midazolam, phenobarbitone (an anti-convulsant and a sedative) and levomepromazine (an anti-psychotic and a sedative) can be considered as second line agents. In refractory cases propofol is tried as a third line agent. Opioids are not used for palliative sedation.[126]

Type 3 PSs̄ANH is not practiced in a legal setting in India (and therefore has no analogous practice).[127]

c. Medical practice of PSs̄ANH in India

In India, Type 1 PSs̄ANH is often used, while Type 2 PSs̄ANH is only occasionally used. Type 2 PSs̄ANH is used only in a specialist palliative care setting, only after a multi-disciplinary family meeting, and only after consensus regarding the goals of care is established. Type 3 PSs̄ANH is not used.

There had been divergence between (1) the procedure implemented by some medical professionals and hospitals regarding the withholding or withdrawing life-sustaining treatment, and (2) the lengthy procedure that was laid down by the Supreme Court in the *Common Cause* case. Both the AIIMS end-of-life care guidelines and the BLUE MAPLE guidelines set out a modified pathway for withholding or withdrawing life-sustaining treatment.[128]

The guidelines laid down by the Supreme Court in the *Common Cause* case could not be implemented in practice.[129] They set out a three-step process before life-sustaining treatment could be withheld or withdrawn. The process was so

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124. *Id.* at 191-92.

125. See *supra* section II.

126. *Id*.

127. *See supra* section IV.A.3.a.

128. All India Inst. of Med. Scis. (New Delhi), GUIDELINES FOR END OF LIFE CARE (2020), https://aiims.edu/images/pdf/notice/irch-9-3-20.pdf [https://perma.cc/PED3-5TWZ]; Kasturba Hospital, *Blue Maple* (2019), https://palliumindia.org/wp-content/uploads/2021/10/BLUE-MAPLE-End-of-Life-Care-Manipal.pdf [https://perma.cc/SX2D-7MG9].

129. Raj Kumar Mani et al., *Simplified Legal Procedure for End-of-Life Decisions in India: A New Dawn in the Care of the Dying?* 27 INDIAN J. CRITICAL CARE MED. 374 (2023).

lengthy that it had no chance of being applicable to real-life critical care situations. Apart from this, the administrative machinery that was required had not been created. Officials were unaware of their obligations set out in the judgment.[130]

This placed medical professionals in a peculiar situation. If they refused to withhold or withdraw life-sustaining treatment in accordance with the patient's wishes because the appropriate machinery was not in place, they were in contravention of the judgment. But if they withheld or withdrew life-sustaining treatment anyway, they were at risk of not complying with the letter of the Supreme Court's guidelines. In this scenario, certain medical professionals and institutions took it upon themselves to create a procedure that complied with the Supreme Court's intention as much as possible (and indeed, contains even more safeguards and requirements for documentation than the Supreme Court's guidelines).

The Supreme Court of India passed an order on January 24, 2023, in an application for clarification/modification of the judgement in the *Common Cause* case.[131] This application was filed by the Indian Society of Critical Care Medicine. This order does not change the ratio of the *Common Cause* case. But it does modify the procedure laid down in the judgment for the withholding or withdrawing of life-support and the implementation of advance medical directives.[132] The new guidelines have brought withholding or withdrawing life-support within the realm of possibility—namely streamlining the procedures required and making them less cumbersome.[133] The most significant changes involve lowering eligibility criteria in respect of members of the required medical boards and reducing the involvement of judicial magistrates.[134]

Patients from vulnerable socio-economic backgrounds are often not able to bear the costs of life-sustaining treatment. In such instances, when they request treatment to be withheld or withdrawn, doctors and hospitals issue "discharge against medical advice" to protect themselves from liability. Unfortunately, this means that when such treatment is withheld or withdrawn, patients and their family members are provided with no support at all, not even comfort care. Treatment is often withheld or withdrawn in an ambulance while leaving the hospital.

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130. Akshat Agarwal, *Towards a 'Good Death': Uncovering the Confusion in End-of-Life-Care Law in India*, 6 NUJS L. REV. 1 (2023); Mahesh Radhakrishnan Menon, *Ethics and Medicolegal Aspects of Withdrawal of Treatment in Critical Care Patients without Advanced Directives in India: Who will Guard the Guardians Themselves?* 28 INDIAN J. CRITICAL CARE MED. 15 (2023).

131. Common Cause (A Regd. Society) v. Union of India, 5 SCC 1 (2018), https://main.sci.gov.in/supremecourt/2019/25360/25360_2019_3_504_41295_Judgement_24-Jan-2023.pdf [https://perma.cc/5VH7-UUQH]; Order, MA No. 1699/2019 in WP (C) No. 215/2005 (India 2023), https://www.scobserver.in/wp-content/uploads/2021/09/25360_2019_3_504_41295_Order_24-Jan-2023.pdf [https://perma.cc/9GGV-7VNC].

132. *Id.* at 14-37.

133. *Id*.

134. *Id.* at 20-21.

4. Ireland

As in France, Germany, and India, Types 1 and 2 PSāANH are permissible in Ireland.[135] But there is little evidence on how widely either is practiced.

a. Legality of PSāANH in Ireland

Type 1 PSāANH has two elements: (1) a request for terminal sedation and (2) a refusal of artificial nutrition and hydration.[136] Both fit within the provisions for Advance Healthcare Directives in the Assisted Decision-Making (Capacity) Act 2015 (the "2015 Act").[137]

There are two relevant elements to this aspect of the 2015 Act. First, the patient must request treatment (*i.e.*, in respect of the terminal sedation element).[138] This request does not have to be complied with—but if it is not, the health-care provider must provide an explanation as to why it is not complied with. Second, a person may refuse treatment in an advance health directive.[139] Provided that the advance health directive is valid and applicable, it is legally binding. It is not possible in an advance health directive to refuse basic care—however, this does not include artificial nutrition and hydration. So, there is no restriction on refusal in this regard.

There is no direct legislation regarding the second and third types of PSāANH. Criminal law might be relevant. The relevant legislation criminalizes aiding, abetting, counselling, or procuring suicide—without an exemption for medical professionals.[140] There is no caselaw regarding the interpretation of aiding and abetting.

In terms of legislative efforts, while there is none specific to PSāANH, the 2015 Act provides for advance healthcare directives. For Type 3 PSāANH, following the publication of a Private Members' Dying with Dignity Bill 2020, a Special Oireachtas Committee engaged in public consultation on the matter of legalizing assisted dying.[141]

As to caselaw in Ireland, there is none specific to PSāANH. For Type 1 PSāANH, the courts have confirmed the relevance of constitutional rights of a person lacking capacity (in a near persistent vegetative state).[142] The courts

135. The local jurisdictional expert for this section was Professor Mary Donnelly.

136. *See supra* section II.

137. Assisted Decision-Making (Capacity) Act 2015 (Act No. 64/2015)(Ir.), https://www.irishstatutebook.ie/eli/2015/act/64/enacted/en/html [https://perma.cc/V594-4V5H]. Although the 2015 Act was signed into law on December 30, 2015, it only came into force on April 26, 2023.

138. *Id.* § 84.

139. *Id.* §§ 82-93.

140. Criminal Law (Suicide) Act 1993 § 2(2) (Ir.), https://www.irishstatutebook.ie/eli/1993/act/11/section/2/enacted/en/html [https://perma.cc/7984-PQQQ].

141. Dying with Dignity Bill 2020, Dublin Stationery Office, https://data.oireachtas.ie/ie/oireachtas/bill/2020/24/eng/initiated/b2420d.pdf [https://perma.cc/8ZGP-WTC6].

142. Re a Ward of Court [1995] IESC 1.

made a similar finding in other cases.[143] Most recently they took a similar approach but with more focus on the will and preference of the person.[144]

For Type 3 PSs̄ANH, the Irish Supreme Court affirmed that this is no constitutional right to assisted suicide—and so legislation prohibiting assisting in suicide is not unconstitutional.[145] Type 3 PSs̄ANH may be seen as analogous to assisted suicide in Ireland.

There are several sources of non-binding soft law, although with no specific reference to PSs̄ANH. For Type 1, there is the Medical Council Guide to Professional Conduct and Ethics for Registered Medical Professionals (the "Medical Council Guide"), which is provided by the regulatory body for the medical profession.[146] It does not have force of law but has regulatory force through the fitness to practice regime (legislated for under Medical Practitioners Act 2007).[147] The Medical Council Guide confirms the patient's right to consent and refuse.[148] It also confirms that if clinicians decide that providing artificial nutrition and hydration has no overall benefit to the patient, they do not have to provide it.[149]

The Health Services Executive National Consent Policy (the "Health Services Policy") is also relevant and is issued by the State health provider and applies only to Health Service Executive ("HSE") or HSE-funded services. It also confirms the right to refuse treatment.[150]

For Type 3, both the Medical Council Guide and the Health Services Policy may be relevant.[151] Neither contains reference to suicide.

b. PSs̄ANH and analogous practices in Ireland

In Ireland, Type 1 PSs̄ANH may incorporate elements of palliative care practice. Type 2 PSs̄ANH is analogous to potentially life-shortening opioid use and may also incorporate elements of standard palliative practice. For Type 3 PSs̄ANH, there may be differences at a level of detail, however, assisted suicide may be an analogous practice.

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143. Health Service Executive v. J.M. (A Ward of Court) & Ors. [2017] IEHC 399 ¶ 90 (noting a constitutional strong presumption in favor of taking all steps which will prolong life of an incapacitated patient).

144. A. v. Patricia Hickey, Committee of the Ward, & Health Service Executive [2021] IEHC 318.

145. Fleming v. Ireland & Ors. [2013] IESC 19.

146. MEDICAL COUNCIL OF IRELAND, GUIDE TO PROFESSIONAL CONDUCT AND ETHICS FOR REGISTERED MEDICAL PROFESSIONALS (8th ed. 2019).

147. Medical Practitioners Act 2007 (Ir.), https://www.irishstatutebook.ie/eli/2007/act/25/enacted/en/html [https://perma.cc/2F8V-CAUA].

148. MEDICAL COUNCIL OF IRELAND, *supra* note 146, at 33-41.

149. *Id*. at 20.

150. HEALTH SERV. EXEC., NATIONAL CONSENT POLICY (2024), https://www2.healthservice.hse.ie/organisation/national-pppgs/hse-national-consent-policy/ [https://perma.cc/SL87-J9V5].

151. MEDICAL COUNCIL OF IRELAND, *supra* note 146; HEALTH SERV. EXEC., *supra* note 150.

c. Medical Practice of PSs̄ANH in Ireland

No information was provided.

B. Moderate Jurisdictions

In the previous section, we saw that four jurisdictions take a restrictive approach to PSs̄ANH: France, Germany, India, and Ireland. In contrast, three jurisdictions take a moderate approach to PSs̄ANH: Belgium, Canada, and England & Wales. Both Types 1 and 2 PSs̄ANH are or are likely permissible. In contrast to the restrictive jurisdictions, Type 3 PSs̄ANH is possibly or arguably permissible.

Jurisdiction	Type 1	Type 2	Type 3
Belgium	Y	Y	Y/N
Canada	Y	Y	Y/N
England & Wales	Y	Y	Y/N

1. Belgium

Both Types 1 and 2 PSs̄ANH are legal and practiced in Belgium.[152] Type 3 PSs̄ANH is also possibly legal (and practiced).

a. Legality of PSs̄ANH in Belgium

In terms of all three Types of PSs̄ANH, the applicable law on patient rights stipulates:

> The patient has the right to refuse or withdraw the consent . . . for an intervention. . . . If the patient, while still able to exercise the rights set out in this Act, has given written notice of refusal to undergo a well-defined intervention by the healthcare professional, this refusal must be respected—provided the patient does not revoke it at a time when he is able to exercise his rights himself.[153]

A patient may at any moment refuse their consent for a treatment or

152. The local jurisdictional expert for this section was Professor Tom Goffin.

153. Patient's Rights Act 2002, Art. 8/1 (Belg.), Loi relative aux Droits des Patients, https://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=2002082245&table_name=loi [https://perma.cc/VQ8X-LZ9Z] (also available at https://extranet.who.int/mindbank/item/2359 [https://perma.cc/YAG6-RA7C]).

withdraw the consent that has already been given.[154] The permission to violate the right to physical integrity can be revoked. The consent of the patient required at both the moment the medical (services) contract is agreed upon and when it crosses the patient's physical integrity. If a competent patient refuses a medical treatment, the physician has no other choice but to withdraw treatment. The physician has a right to treat only insofar as the patient has given their consent.

Moreover, the physician must inform the patient about the consequences of their refusal.[155] If the physician concludes that the refusal is not informed or has been unduly influenced by others, this does not confer a right to treat that patient against their wishes. Rather, the physician may try to convince the patient to accept the treatment or offer them alternative solutions. If the patient continues to refuse, the physician may end the medical (services) contract.

Even after the refusal of (further) life-sustaining treatment, the therapeutic relationship between patient and physician remains in effect, provided neither party has opted otherwise.[156] Consequently, the duty of the physician and the healthcare team towards the patient remains. Basic nursing care must still be provided to ensure dignified and respectful treatment of the patient. Care must be taken not to abandon, avoid, or neglect the patient.

With respect to Type 3 PSS̄ANH, there is some applicable federal case law.[157] The legality of pain relief with life-shortening effect remains the object of discussion. Some criminal lawyers advise physicians who practice pain relief to adhere to all the legal conditions for euthanasia to be legally safe.[158] This would imply that pain relief can only be applied after the patient's explicit request and must be communicated to the Federal Commission for Control and

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154. *Id. See also* H. NYS, INTERNATIONAL ENCYCLOPAEDIA OF LAWS: MEDICAL LAW 164-171 (2024).

155. Patient's Rights Act 2002, *supra* note 153, at Art. 8/1.

156. *Id.*

157. *See, e.g.*, Raf Van Goethem vs. Tom Balthazar Kamer van Inbeschuldigings telling Gent. (When a terminally ill woman died in a retirement home two days after being placed on a morphine pump, the retirement home's delegate filed a civil complaint against the nurse responsible for the woman's palliative care. The civil party accused the nurse of committing euthanasia. The court-appointed expert concluded that only forty milligrams (or four ampoules of ten milligrams) were found in the body of the patient—certainly not a lethal dose for a terminal cancer patient. The Council Chamber of the court of first instance in Dendermonde ruled that there was no cause for prosecution. The civil party appealed the decision to suspend the prosecution. The nurse was acquitted. The Chamber of Indictment held that it is accepted medical practice to treat patients for whom no cure is available with intensive pain relief—even if the treatment has an unintended but accepted life-shortening effect. While a physicians' use of drugs to alleviate pain (even though the dose will certainly hasten death) is an accepted medical practice in Belgium, the legal basis for this general acceptance remains unclear. This case provides some support for this acceptance.).

158. Belgian Order of Physicians, *Notice Regarding Palliative Care, Euthanasia, and Other End-of-Life Medical Decisions* (Mar. 22, 2003) (not available in English - *Avis Relatif Aux Soins Palliatifs, À L'euthanasie et À D'autres Décisions Médicales Concernant La Fin de Vie)*, https://ordomedic.be/fr/avis/deontologie/consentement-eclaire/avis-relatif-aux-soins-palliatifs-a-l-euthanasie-et-a-d-autres-decisions-medicales-concernant-la-fin-de-vie [https://perma.cc/9Y9W-NWMA].

Evaluation of Euthanasia. Moreover, during the parliamentary discussion of the Law on Euthanasia, the legislature clearly expressed its view that pain relief and euthanasia should not be dealt with in the same way.[159]

One widely held view is that shortening the dying process in a manner which leads to a death without suffering can be a legitimate subsidiary objective of the administration of pain relief. This reasoning is based on the doctrine of double effect. Shortening life as a result of alleviating pain is morally (and by analogy, legally) permissible. Although it can be foreseen, death in such a case is not intended either for itself or as a means of achieving the goal of alleviating suffering. Instead, what is intended is the alleviation of the patient's suffering. Their death is not a means to achieve that goal. In contrast, administering the same drug to cause the patient to die to put an end to this suffering would not be permissible.

In other words, the physician who administers pain relieving drugs has no "intention" to end the life of the patient; they have merely "foreseen" this consequence. From a moral point of view the distinction between "intention" and "foresight" has been criticized. The critics argue that it is questionable whether the distinction can be made in the clear-cut way that adherents to the doctrine of double effect suppose.[160] From a legal point of view, it is even more important that Belgian criminal law makes no distinction between intention and foresight.

The Belgian Criminal Code states that "homicide with the intention of causing death is treated as murder."[161] According to commentators, there is no difference between a direct intention and an indirect or possible intention.[162] Indirect intention involves an actor acting deliberately, without directly desiring the consequences of their action. In such cases, the actor foresees the possibility that these consequences may arrive but acts, nonetheless. If the consequence materializes (*i.e.*, the patient dies), it is no defense for the physician to argue that they did not wish for the patient to die. Thus, under the present Belgian law, the distinction between intentional and unintentional shortening of the life of the patient is untenable.

There may exist circumstances that make it legal for a physician to use drugs to alleviate pain with the indirectly intended but foreseen consequence that the patient's death will be hastened. One of these circumstances involves a "situation of necessity" or conflict of duties. In the case of pain relief, this conflict may arise between the general duty to respect the life of the patient and the professional duty following from the medical (services) contract to alleviate the pain and suffering of the dying patient. This situation of necessity is sometimes called the "sedative necessity."[163] Although this justification may

159. Toni C. Saad, *Euthanasia in Belgium: Legal, Historical and Political Review*, 32 ISSUES L. & MED. 183 (2017).

160. HERMAN NYS, MEDICAL LAW IN BELGIUM ¶¶ 366-69 (7th ed. 2022).

161. Belgian Crim. Code, Art. 393.

162. NYS, *supra* note 160, ¶ 366.

163. *Id.*

offer a solution in some cases, Belgian law is overall unsatisfactory in this respect; the legal rule is far from clear. Ultimately, the key inquiry involves what the doctor claims they were trying to achieve.

This criminal law regime has important consequences for the civil law aspects of pain relief. The autonomy of the patient is in this respect is not yet recognized. A physician is obliged to alleviate pain at the request of or in agreement with the dying patient.[164] However, when the administration of the drugs has the foreseeable consequence that the life of the patient will be shortened, it is up to the physician to decide whether they accept this consequence. The physician is not obliged to accept this consequence. In other words, the patient is at the mercy of the physician, who himself or herself is at the mercy of the judicial system.

b. PSs̄ANH and analogous practices in Belgium

There are no analogues to Type 3 PSs̄ANH in Belgium.[165] The Belgian law on euthanasia stipulates that euthanasia necessarily involves the intentional killing of a person.[166] If the death of the person is merely a known consequence of a pain-relieving treatment, then the administration of the treatment is not euthanasia.

c. Medical practice of PSs̄ANH in Belgium

All three types of PSs̄ANH are used widely in Belgium. However, there is no broad-based evidence of divergences between principle and practice in the application of PSs̄ANH in Belgium.

2. Canada

Like Belgium, both Types 1 and 2 PSs̄ANH are legal and practiced in Canada.[167] Type 3 PSs̄ANH is also possibly legal (and practiced). This section summarizes and builds on the work done by Joceyln Downie and Richard Liu in 2018 on the legality of PSs̄ANH in Canada.[168]

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164. Patient's Rights Act 2002, Art. 11 (Belg.) (providing a right to alleviation of pain).

165. The legal uncertainty that surrounds pain relief also surrounds palliative and terminal sedation. In its opinion on the Law on Euthanasia, the Belgian Council of State recommended that the legislature clarify whether "controlled" sedation (as it was termed by the Council) should be regarded as euthanasia or palliative care. But this recommendation has not been followed. *Cf.* D. Lossignol, *Euthanasia: Medications and Medical Procedures*, 29 REV. MED. BRUX. 435 (2008).

166. Belgian Act on Euthanasia of May 28, 2002, M.B., May 28, 2002, http://eol.law.dal.ca/wp-content/uploads/2015/06/Euthanasia-Act.pdf [https://perma.cc/B5W8-7LMP].

167. The local jurisdictional experts for this section were Richard Liu and Dr. Joshua Wales (for Part III only).

168. Downie & Liu, *supra* note 1.

a. Legality of PSs̄ANH in Canada

In Canada, there is no federal legislation that directly addresses the legality of any type of PSs̄ANH. However, at a provincial level in Québec, legislation was introduced in 2015 that pertains to all three types of PSs̄ANH.[169] Two sections set out the right of patients in Québec to "palliative care" and, more specifically, to "continuous palliative sedation"—provided that the various parameters are met.[170] The Québec Act defines "continuous palliative sedation" as:

> care that is offered *as part of palliative care* and consists of administering medications or substances to an end-of-life patient to relieve their suffering by rendering them unconscious without interruption until death ensues. . ."[171]

Meanwhile, "palliative care" is defined as:

> the total and active care delivered by an interdisciplinary team to patients suffering from a disease with reserved prognosis, in order to relieve their suffering, without delaying or hastening death. . .[172]

Admittedly, the Québec Act does not specifically and explicitly address the withholding or withdrawal of artificial nutrition and hydration. Nevertheless, as mentioned above, section 3(5) defines "continuous palliative sedation" as part of "palliative care", whilst section 3(4) defines "palliative care" as care that does not hasten death. As the absence of artificial nutrition and hydration within Type 1 PSs̄ANH does not hasten death, it is reasonable to conclude that the Québec Act permits Type 1 PSs̄ANH.

Treatment of Type 2 PSs̄ANH is likely different, given that Type 2 PSs̄ANH does not necessarily fulfill the requirement in section 3(4) of the Québec Act of not "delaying or hastening death." Therefore, it is arguable that the Québec Act does not necessarily permit Type 2 PSs̄ANH, given that the Québec Act is permissive, not prohibitive, in nature and its definition of "palliative sedation" only captures Type 1 PSs̄ANH.

A similar analysis (to that applied to Type 2 PSs̄ANH) vis-à-vis the Québec Act can be applied to Type 3 PSs̄ANH. Indeed, given that it is inherent in the use of Type 3 PSs̄ANH that it will (rather than may) hasten death, it appears even less likely that the Québec Act permits Type 3 PSs̄ANH.

As far as relevant case law is concerned, there do not appear to be any judicial decisions directly relating to Type 1 PSs̄ANH. This arguably reflects a

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169. An Act Respecting End-of-Life Care, c. S-32.0001 (Can.) (hereinafter the "Québec Act").

170. *Id.* at §§ 4, 24.

171. *Id.* at § 3(5) (emphasis added).

172. *Id.* at § 3(4).

tacit assumption on the part of Canadian judges that Type 1 PSs̄ANH is legally permissible. By contrast, there is case law (on both a federal and provincial level) that is potentially applicable to Types 2 and 3 PSs̄ANH.

One such case is *Rodriguez v. British Columbia*,[173] where Sue Rodriguez—suffering from Lou Gehrig's disease—unsuccessfully challenged the prohibition on assisted suicide.[174] Interestingly, in the Supreme Court of Canada's judgment, Justice Sopinka appears to imply that the doctrine of double effect may be part of Canadian law. So, if the intention of a doctor administering drugs to a patient is to help them, then their act is lawful, even if foreseen to possibly, or even certainly, shorten the patient's life.[175]

If true, this would offer a possible defense for physicians carrying out Type 2 or Type 3 PSs̄ANH. In the Supreme Court of British Columbia's 2012 judgment in *Carter v. Canada (Attorney General)*,[176] during which the Court struck down the Criminal Code provision forbidding assisted suicide, Justice Smith appears to support Justice Sopinka's remarks made in *Rodriguez.* This arguably lends support to the double effect doctrine, and, in turn, the availability of a defense for Type 2 and Type 3 PSs̄ANH. However, certain caveats must be borne in mind. The doctrine of double effect was rejected in all but name by the Supreme Court of Canada in *R. v. Keegstra* (a case decided before *Rodriguez*[177]), and, crucially, again—by the same court—in the post-*Rodriguez* case of *R. v. Chartrand*.[178]

Furthermore, it is unclear whether Justice Sopinka would have included PSs̄ANH in his definition of palliative care (especially given that the majority in *Rodriguez* did not refer to palliative sedation), or whether he was only contemplating the potentially life-shortening effects of pain medications. Also, Justice Smith later agreed with the Attorney General of Canada's claim that "the criminal law does not appear to recognize a distinction between intentionally bringing about a prohibited consequence and doing something knowing that the prohibited consequence is virtually certain to result."[179] Moreover, Justice Smith rejected the idea of any "widespread acceptance of a moral or ethical distinction between active and passive euthanasia."[180]

Nevertheless, Justice Smith also notably suggested in *Carter* that "[palliative sedation] may fall within the principles" guiding "potentially life-shortening symptom relief."[181] This statement arguably suggests that at least some forms of PSs̄ANH are lawful (although it is not made entirely clear whether Type 2 PSs̄ANH falls within this category).

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173. Rodriguez v. British Columbia, [1993] 3 S.C.R. 519.
174. Rodriguez challenged the legality of *Criminal Code* section 241.
175. Rodriguez, *supra* note 173, at ¶ 23.
176. Carter v. Canada (Attorney General), 2012 BCSC 1587.
177. R. v. Keegstra, [1990] 3 S.C.R. 697.
178. R. v. Chartrand, [1994] 2 S.C.R. 864.
179. Carter, *supra* note 176, at ¶ 327.
180. *Id.*
181. *Id.* at ¶ 226.

The Supreme Court of Canada's subsequent judgment in *Carter* (following an appeal of the outcome of the hearing in the Supreme Court of British Columbia[182]) provided an opportunity to clarify Justice Smith's comments on double effect (and, potentially, if applicable, its relationship with PSs̄ANH). Unfortunately, this opportunity was, by and large, not taken. Instead, the justices made relatively general remarks affirming that patients were allowed "to request palliative sedation [or] refuse artificial nutrition and hydration."[183] This seemingly suggests that at least some types of PSs̄ANH are legally permitted. But the court did not elaborate upon the circumstances in which PSs̄ANH is allowed.

Another relevant case is the 2019 decision of the Superior Court of Québec in *Truchon v. Attorney General of Canada*.[184] There, it was held that Canada's and Québec's legislation on MAID breached Canada's Criminal Code insofar as the federal legislation required that, for MAID to be provided, a person's natural death has become "reasonably foreseeable," and insofar as the Québec legislation, required that a person be at the "end of life."[185]

If MAID and PSs̄ANH were held to be sufficiently analogous such that the rules on MAID should mirror the rules on PSs̄ANH, then the *Truchon* judgment could potentially be taken to act as an argument in favor of the legality of Type 2 (and possibly, at least in some circumstances, Type 3) PSs̄ANH.

Although PSs̄ANH and MAID are not entirely interchangeable, much of the reasoning in *Truchon* is arguably equally as applicable to PSs̄ANH. Take, for example, the Superior Court of Québec's analysis on rights to liberty and security of the person. There is particular focus placed on the suffering caused to the plaintiffs through being deprived of their autonomy to make decisions as to medical procedures carried out on them.

Indeed, special emphasis is placed on the Supreme Court of Canada's *Carter v. Canada (Attorney General)* judgment to assert that "[c]ompetent adults have long since enjoyed the right in Canada to decide their own fate and to direct the course of their own medical care, even if their decision inevitably leads to their death."[186] The same paragraph appears to imply that the law on palliative sedation (presumably including PSs̄ANH) was, at the time of the judgment, ahead of the law on MAID in this regard, leading to an "incongruous" situation that needed to be remedied through changing the law on MAID.

A potential legal equivalence between PSs̄ANH and MAID is even more relevant as regards Type 3 PSs̄ANH (compared to Type 2 PSs̄ANH). Type 3 PSs̄ANH appears to cover the kind of situations where death is not only not

182. Carter v. Canada (Attorney General), [2015] SCC 5, https://www.canlii.org/en/ca/scc/doc/2015/2015scc5/2015scc5.html [https://perma.cc/6QZ5-4HCL].

183. *Id.* at ¶ 66.

184. Truchon v. Attorney General of Canada, 2019 QCCS 3792, https://www.canlii.org/en/qc/qccs/doc/2019/2019qccs3792/2019qccs3792.html?searchUrlHash=AAAAAQANdHJ1Y2hvbiBnbGFkdQAAAAAB&resultIndex=1 [https://perma.cc/4VT7-Z9G7].

185. *Id*. at ¶ 734.

186. *Id.* at ¶ 526.

inevitable and immediately imminent, but, moreover, where death is not even "reasonably foreseeable."[187]

An area outside of case law and legislation should be taken into consideration. Relevant non-binding but persuasive "soft law" bears on PSs̄ANH. The 2016 guidelines produced by the *Société québécoise des médecins de soins palliatifs* and *Collège des médecins du Québec* appear to assume that Types 1 and 2 PSs̄ANH are legal, as they state that continuous sedation is permissible for patients expected to survive for no longer than two weeks.[188]

Type 3 PSs̄ANH is not directly addressed by the Québec guidelines, and, as a result, there is some ambiguity as to whether the guidelines permit it. The guidelines state that "[c]ontinuous sedation should be reserved for patients with . . . a prognosis of survival or two weeks or less" (which appears to undermine arguments that Type 3 PSs̄ANH is allowed).[189] But we are later told that "sedation may be initiated" for patients with a longer prognosis, with the proviso that whether said sedation will be continuous (as opposed to intermittent) "depend[s] on how the patient's condition evolves."[190]

Other guidelines, such as those by the BC Centre for Palliative Care and those by Mervyn Dean et al., also comment on palliative sedation.[191] However, these guidelines are limited in their usefulness—Dean et al. decline to provide recommendations regarding the withholding or withdrawal of artificial nutrition or hydration, instead simply noting that "the longer the anticipated time before death the greater the ethical challenges and the more controversial the procedure, especially regarding decisions around nutrition and hydration during sedation."[192] Meanwhile, the BC Centre for Palliative Care states that healthcare providers should consider interventions such as artificial hydration or nutrition "separately from the decision to proceed with" palliative sedation.[193]

b. PSs̄ANH and analogous practices in Canada

Type 1 PSs̄ANH is analogous to medical procedures in general which do

187. *See supra* section III.C.

188. College of Medicine of Québec, *Palliative Sedation at the End of Life, (Aug. 2016)*, https://epe.lac-bac.gc.ca/100/200/300/cmq/palliative_sedation/LaSedationPalliativeEnFinDeVie_EN_final.pdf [https://perma.cc/ZSS8-ZAH8].

189. *Id*. at 13.

190. *Id*.

191. BC Centre for Palliative Care, *B.C. Inter-Professional Palliative Symptom Management Guidelines, Refractory Symptoms and Palliative Sedation*, BC CENTRE FOR PALLIATIVE CARE (Jun. 2019), https://www.fraserhealth.ca/-/media/Project/FraserHealth/FraserHealth/Health-Professionals/Professionals-Resources/Hospice-palliative-care/Refractory-symptoms-and-palliative-sedation-therapy.pdf [https://perma.cc/97XF-M25Q]; Mervyn M. Dean et al., *Framework for Continuous Palliative Sedation Therapy in Canada*, 15 J. PALLIATIVE MED. 870 (2012).

192. Dean et al., *supra* note 191, at 871.

193. BC Centre for Palliative Care, *supra* note 191, at 4.

not shorten life and for which there is no reason to believe that they are unlawful. Type 2 PSs̄ANH is arguably analogous to potentially life-shortening opioid use—they can both potentially (but not certainly, or always) have the unintended added consequence of reducing the patient's life expectancy. Type 3 PSs̄ANH is broadly analogous to MAID.

Canada has no specific legal framework (whether in terms of legislation, case law, or "soft law") for potentially life-shortening opioid use. Regarding MAID, in June 2016 the Canadian Parliament passed Bill C-14, legalizing MAID for patients with a grievous and irremediable medical condition causing enduring, intolerable, and irremediable suffering.[194] In March 2021, the law was further amended by Bill C-7, which allows assisted dying in certain situations, including—in some cases, provided that the requisite safeguards are complied with—where a patient's natural death is not reasonably foreseeable.[195]

c. Medical practice of PSs̄ANH in Canada

Type 1 PSs̄ANH is widely practiced in Canada.[196] Deep continuous sedation in the last few days of life is particularly common in the context of agitated delirium and dyspnea. Most commonly, practitioners begin with intermittent sedation (such as pro re nata or "PRN"-only midazolam) and then escalate to deep continuous sedation if suffering remains refractory to treatment.

Most clinicians likely do not distinguish between Type 1 and Type 2 PSs̄ANH. Clinicians instead likely rely on guidelines that suggest palliative sedation only be made available to patients in the last two weeks of their lives (encompassing both Types 1 and 2 PSs̄ANH).[197] Moreover, clinicians are also less likely to make a distinction between those receiving and those not receiving artificial nutrition or hydration, as it generally appears that treatment methods such as IV fluids in the last two weeks of life are unlikely to prolong life in any meaningful way, and are also associated with significant adverse effects.

Type 2 PSs̄ANH is likely employed less frequently in practice than Type 1 PSs̄ANH for several reasons. First, as Dean et al. note in their widely cited *Framework for Deep Continuous Palliative Sedation*, "the longer the anticipated time before death, the greater the ethical challenges and the more controversial the procedure."[198] Type 2 PSs̄ANH is certainly less frequent, given the discomfort shown regarding a longer or more nebulous prognosis. Second,

194. Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying) (Jun. 17, 2016), https://www.parl.ca/LegisInfo/en/bill/42-1/C-14 [https://perma.cc/3DQQ-ZNRP].

195. Bill C-7, An Act to Amend the Criminal Code (Medical Assistance in Dying) (Mar. 17, 2021), https://www.parl.ca/legisinfo/en/bill/43-2/c-7 [https://perma.cc/VSR9-A5PJ].

196. Some studies show growth following legalization of MAID. *See, e.g.*, Amy Nolen et al., *Impact of Legalization of Medical Assistance in Dying on the Use of Palliative Sedation in a Tertiary Care Hospital: A Retrospective Chart Review*, 39 AM. J. HOSPICE & PALLIATIVE CARE 442 (2022).

197. *See* College of Medicine of Québec, *supra* note 188.

198. Dean et al., *supra* note 191.

the most common indications for palliative sedation (namely, delirium and dyspnea) are ones that, when severe enough to merit sedation, would be accompanied by a short prognosis of a few days.

Finally, the extent to which clinicians are comfortable with providing sedation for existential distress varies greatly. It is often impossible to clearly delineate the elements of suffering, particularly in the final two weeks of life when there is more often a constellation of physical symptoms that lead to existential distress. While some physicians are comfortable with sedation for existential distress when accompanied by the other requisite criteria (namely, a prognosis of one to two weeks), other physicians are not comfortable with this, and may instead suggest MAID.

Conversely, Type 3 PSs̄ANH would not be considered an ethically appropriate standard of care from a medical practitioner's perspective. MAID or VSED would be more obvious potential solutions to the intractable suffering of individuals requesting Type 3 PSs̄ANH.

There does not seem to be any significant divergence between principle and practice in terms of how the criteria for PSs̄ANH are applied. Clinicians tend to rely most heavily on whatever published guidelines are available in Canada. Across the board, for PSs̄ANH to be applied, a patient's prognosis must be one to two weeks, with symptoms intractable with current treatment. Still, deep continuous sedation is more likely to be used in home-based settings, where the absence of round-the-clock nursing makes PRN management of acute symptom issues more difficult. By contrast, in hospitals, with constant nursing care, clinicians are more likely to rely on frequent administration of PRNs than standing infusions of sedatives. Deep continuous sedation, when indicated, is significantly easier for families to manage than intermittent sedation, or PRN symptom management.

In practice, there appears not to be any divergence regarding the application of PSs̄ANH based on socioeconomic factors, aside from (potential) disparities in accessing advanced tertiary palliative care for patients with low socioeconomic status. In terms of regional differences, some areas in Canada may have shortages of medication infusion pumps, which are often required for effective sedation.

3. England & Wales

Like Belgium and Canada, both Types 1 and 2 PSs̄ANH are legal and practiced.[199] Type 3 PSs̄ANH is also possibly legal (and practiced).

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199. The local jurisdictional expert for this section was Professor Emily Jackson. This section does not consider the new Terminally Ill Adults (End of Life) Bill, which passed its second reading in Parliament on November 29, 2024 (but which has a few additional stages left before it may become law, which is not certain to occur). The Bill's long title states that it allows "adults who are terminally ill, subject to safeguards and protections, to request and be provided with assistance to end their own life. . ." *See* Terminally Ill Adults (End of Life) Bill,

In England & Wales, palliative sedation is subject to the law applicable to medical treatment more generally. And a distinction is therefore drawn between (1) those cases where the patient has capacity and is able to give informed consent to treatment, and (2) those cases where the patient lacks capacity, and decisions about their medical treatment have to be taken by someone else, in practice usually their doctor, in their best interests.[200] If there is disagreement or uncertainty over what treatment should be provided to a patient who lacks capacity, or over whether the patient does, in fact, lack capacity, the treating Trust's lawyers can make an application to the court.

a. Legality of PSs̄ANH in England & Wales

There is no specific Type 1 PSs̄ANH legislation.[201] If the patient has capacity, and the doctor assesses that this is a reasonable request and would be compatible with his duty to make the care of his patient his first concern, then, with the patient's informed consent, the doctor could give the patient continuous/deep sedation.

If the patient lacks capacity, then the Mental Capacity Act 2005 (the "MCA 2005") applies, and the doctor must treat the patient in their best interests.[202] "Best interests" is not confined to what is clinically best, but also accommodates, the patients' values and beliefs, and past and present wishes and feelings.[203] Once the patient has been sedated, they will lack capacity, and then the question will be whether they have made a valid and applicable advance decision to refuse clinically assisted artificial nutrition and hydration ("CANH").[204]

If the patient has an advance decision, it is binding on the doctors (though there are, in practice, many reasons why there might be doubt about their advance decision's validity and applicability, such as questions over whether she had capacity at the time she executed the advance decision. If the patient has not made a binding advance decision, the question as to whether CANH can be withdrawn will be judged by whether it is in their best interests. Because of the increasing primacy of the patient's values/views/beliefs (since *Aintree University Hospitals Foundation Trust v. James*[205]), the decision will generally be to respect the patient's wishes, where these were known about, even if they did not manage to make a binding advance decision.

Regarding Type 2 PSs̄ANH, the same rules apply. The only other relevant

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https://publications.parliament.uk/pa/bills/cbill/59-01/0012/240012.pdf [https://perma.cc/TXH3-92VU].

200. Garralda et al, *supra* note 5, at 39.

201. *Id*.

202. Mental Capacity Act 2005 c.9 (UK) § 1(5), https://www.legislation.gov.uk/ukpga/2005/9/contents [https://perma.cc/Z4TK-QJN9].

203. *Id.* § 4.

204. *Id.* §§ 24-26.

205. Aintree University Hospitals Foundation Trust v. James [2013] UKSC 67.

statutory provision is section 4(5) of the MCA which specifies:

> Where the determination relates to life-sustaining treatment [the best interests decision-maker] must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.[206]

In practice, this provision has not stood in the way of withdrawing CANH. The word "desire" is (perhaps deliberately) vague, unlike words with more unambiguous legal meaning like "intend." For Type 3 PSs̄ANH, again, the principles are the same. The MCA is extremely unlikely to interfere with a decision to withdraw CANH.

In terms of caselaw, there is some relevant caselaw in the UK for different types of PSs̄ANH. For Types 1 and 2 PSs̄ANH, one of the most important cases on CANH is the UK Supreme Court in *An NHS Trust v. Y*.[207] In this case, the family and the treating team of Mr. Y, a man in a minimally conscious state, agreed that CANH was no longer in his best interests.[208] The NHS Trust responsible for his care sought a declaration from the High Court that it did not need to seek endorsement from the Court of Protection. The court held that, as a matter of law, court approval was not required.[209] The Official Solicitor obtained leave to take the case straight to the UK Supreme Court. As a result of the Supreme Court's judgment, it is now clear that, as with other medical treatments, applications to the court are necessary only where there is disagreement or a lack of clarity over whether withdrawal of CANH is in the best interests of a patient in a prolonged disorder of consciousness.[210]

Other cases establish that the decision about CANH withdrawal must be taken in the patient's best interests, and that their recent and previous wishes, feelings, and values are critical in making that judgement. For example, in *Avon and Wiltshire Mental Health Partnership v. WA*, WA had had a traumatic past in Palestine and suffered sexual abuse in Italy.[211] After arriving in the UK as a refugee, he had become fixated with the Home Office's re-assignation of his date of birth, which he perceived to be an assault on his identity. He went on hunger strike and was detained under the Mental Health Act 1983.[212] His fixation meant he had become unable to weigh information to decide on receiving CANH. Hayden J hoped that WA's foster carers might be able to change his mind. But if they could not, his non-capacitious refusal of CANH

206. Mental Capacity Act 2005 § 4(5).

207. An NHS Trust v. Y [2018] UKSC 46, https://www.supremecourt.uk/cases/uksc-2017-0202 [https://perma.cc/H8V2-VAAK].

208. *Id.* ¶ 3.

209. *Id.* ¶ 4.

210. *Id.* ¶ 126.

211. Avon and Wiltshire Mental Health Partnership v. WA [2020] EWCA 37, https://www.bailii.org/ew/cases/EWCOP/2020/37.html [https://perma.cc/HHK4-LZR4].

212. *Id.* ¶¶ 14-15.

was to be respected.[213]

For Types 2 and 3 PSS̄ANH, a notable case in the UK is *Briggs v. Briggs.*[214] Mr. Briggs sustained serious brain injuries in a road traffic accident. His treating team thought that he should be transferred to a rehabilitation unit, but Charles J was clear that:

> if the decision that P would have made, and so their wishes on such an intensely personal issue can be ascertained with sufficient certainty it should generally prevail over the very strong presumption in favour of preserving life.[215]

Charles J was of the view that Baker J's suggestion in *Re M* that the court should be "particularly cautious about attaching significant weight" to M's previously expressed wishes "runs counter to the holistic approach that the Supreme Court confirms is to be taken to enabling P to do what he would have wanted if of full capacity."[216]

In terms of non-binding soft laws and guidelines relevant to all three types

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213. *Id.* at 102. Justice Hayden's explanation states that, "I have concluded that the rigidity of his thinking in this regard has occluded his capacity, in the sense that its overwhelming importance to him inhibits his ability to weigh the advantages and disadvantages of his decision to reject CANH. This does not mean that I regard WA's reasoning as delusional or even as flawed. On the contrary, I have little difficulty in understanding how important a date of birth is to a young man deracinated from his family and homeland and whose autonomy was, during the course of his childhood and adolescence, crushed by sadistic torture and subsequent sexual abuse. The fact that this aspect of WA's thinking overwhelms all else does not mean that it does not weigh heavily in the balance when determining where his best interests lie. I consider a decision such as this that is, of itself, entirely coherent, clearly articulated and consistently expressed, requires to be given very great weight. In many circumstances such a decision, even where P is incapacitous, would nonetheless be determinative. . . [I]t must be emphasised that loss of capacity does not override respect for personal autonomy. Protecting the autonomy of the incapacitous is every bit as important as protecting the autonomy of the capacitous. . . I consider that every effort should be made, with the parents at the centre of the process, to persuade, cajole and encourage WA to accept nutrition and hydration. . . No effort should be spared in encouraging him to choose life. This said, I have come to the clear view that when WA says no to CANH his refusal should be respected. No must mean no!"

214. Briggs v. Briggs [2016] EWCA 53, https://www.bailii.org/ew/cases/EWCOP/2016/53.html [https://perma.cc/T7PW-LWPD].

215. *Id.* ¶ 62.

216. *Id.* ¶¶ 78, 80. The court's reasoning is that "[m]embers of the family told me that in their view Mr Briggs would regard his present situation as horrible and one that he would not wish to continue. Included within the reasons given are that a life in which he did not have the ability to communicate with his wife and child is not one that he would be willing to have. In her second statement his wife says in her view even if Mr Briggs was peaceful, if he was experiencing anything at all, she can imagine Mr Briggs asking, 'why are you torturing me?' . . . I have concluded that as I am sure that if Mr Briggs had been sitting in my chair and heard all the evidence and argument he would, in exercise of his right of self-determination, not have consented to further CANH treatment that his best interests are best promoted by the court not giving that consent on his behalf. This means that the court is doing on behalf of Mr Briggs what he would have wanted and done for himself in what he thought was his own best interests if he was able to do so."

of PSs̄ANH, it is worth reviewing the Royal College of Physicians and British Medical Association's publication.[217] These guidelines emphasize the need for an assessment of whether it is in the "best interests" of the patient to continue CANH.[218] When making this assessment, factors such as the patient's life expectancy and potential for recovery are relevant. But these are not the only factors requiring consideration. The patient's quality of life (in the event of CANH being applied) must also be considered.[219] Furthermore, whilst a second opinion is generally required when a decision is taken to withdraw CANH where the patient is not expected to die within the coming days, this does not necessarily mean that the second opinion will go against the original decision.[220] Therefore, whilst, under these guidelines, Type 1 PSs̄ANH is permissible, it is also the case that there is nothing in the guidelines necessarily prohibiting Type 2 or Type 3 PSs̄ANH. Regarding legal safeguards for the three Types, for capacitous patients, the question would be whether the patient gave informed consent, and for incapacious patients, whether it is in their best interests.

b. PSs̄ANH and analogous practices in England & Wales

For Type 1 PSs̄ANH, painkillers and removal of a feeding tube are analogous. For Type 2 and 3 PSs̄ANH, potentially life-shortening opioid use is analogous. From the patient's perspective, Type 3 PSs̄ANH could be indistinguishable from euthanasia. But note that Type 3 *could* be lawful; contrast euthanasia. A doctor who carries out euthanasia would be convicted of murder and receive a mandatory life sentence. Life-shortening opioid use is lawful. In *Airedale NHS Trust v. Bland*, Lord Goff notes "the established rule that a doctor may, when caring for a patient who is, for example, dying of cancer, lawfully administer painkilling drugs despite the fact that he *knows* that an incidental effect of that application will be to abbreviate the patient's life."[221]

In England, euthanasia would ordinarily amount to murder and new prosecution guidance has set out for the first time in October 2023 the factors tending in favor of or against bringing prosecution.[222] A doctor (or other healthcare professional) who deliberately ends the life of their patient is subject to the ordinary criminal law and being a doctor (or other healthcare professional)

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217. Royal College of Physicians, *Clinically Assisted Nutrition and Hydration (CANH) and Adults Who Lack the Capacity to Consent: Guidance for Decision-Making in England and Wales*, BRITISH MEDICAL ASSOCIATION (2018), https://www.bma.org.uk/media/1161/bma-clinically-assisted-nutrition-hydration-canh-full-guidance.pdf [https://perma.cc/LF5P-HP3U].

218. *Id.* Executive Summary ¶¶ 17-19.

219. *Id.* § 5.2.

220. *Id.* § 2.8.

221. Airedale NHS Trust v. Bland [1993] AC 789 (emphasis added).

222. Crown Prosecution Service, *Homicide: Murder, Manslaughter, Infanticide and Causing or Allowing the Death or Serious Injury of a Child or Vulnerable Adult*, CPS (Oct. 15, 2024), https://www.cps.gov.uk/legal-guidance/homicide-murder-manslaughter-infanticide-and-causing-or-allowing-death-or-serious [https://perma.cc/4SRZ-SXK9].

is in itself a factor tending in favor of prosecution.[223] That doctor (or other healthcare professional) would often satisfy both the *actus reus* (proof of conduct, and proof that the conduct caused death), and the *mens rea* (the intention to kill or to cause grievous bodily harm) required for the crime of murder. The doctor's motive and the consent of the victim are irrelevant, as is the fact that the patient would have died soon anyway. Because murder carries a mandatory life sentence, the fact that the doctor acted for compassionate reasons cannot be considered in sentencing.

Causation can probably be established. When a doctor gives a fatal dose of drugs to a patient who is terminally ill, there may be some evidential difficulty in establishing that the doctor's actions, rather than the patient's pre-existing illness, caused the patient's death. But to be guilty of murder, the defendant's conduct needs to have only "contributed significantly" to or have been "a substantial cause" of the death. It need not be the sole reason for the patient's death. If causation cannot be established, a doctor who administered a potentially lethal injection might be charged with attempted murder.[224] While there have been prosecutions for such cases, no doctor who has complied with a patient's request to end their life has ever been convicted of the full offense of murder. There has been some evidence of leniency towards doctors who acted for compassionate reasons.[225]

c. Medical practice of PSs̄ANH in England & Wales

Insufficient information was provided.

C. Permissive Jurisdictions

We have seen four jurisdictions take a restrictive approach and three take a moderate approach to PSs̄ANH. In contrast to these, five other jurisdictions take a more permissive approach to PSs̄ANH: Australia, Colombia, the Netherlands, Switzerland, and the United States of America. Not only are Types 1 and 2 PSs̄ANH permissible or likely permissible as in other jurisdictions but Type 3 PSs̄ANH is or is probably permissible.

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223. *Id*.

224. *See, e.g.*, R v. Cox [1992] 12 BMLR 38 (Eng.), *reprinted*, 1 MED. L. REV. 232 (1993).

225. *See, e.g.*, R v. Moor [1999] Crim L.R. 2000 Jul 568 (Eng.). This case is summarized in several articles. Anthony Arlidge, *The Trial of Dr David Moor Case Comment*, [2000] CRIM. L. REV. 31 (2000); James Goss, *A Postscript to the Trial of Dr David Moor*, [2000] CRIM. L. REV. 568 (2000); J.C. Smith, *A Comment on Moor's Case,* [2000] CRIM. L. REV. 41 (2000).

Jurisdiction	Type 1	Type 2	Type 3
Australia	Y	Y	Y
Colombia	Y	Y	Y
Netherlands	Y	Y	Y
Switzerland	Y	Y	Y
United States of America	Y	Y	Y

1. Australia

In contrast to the restrictive and moderate jurisdictions analyzed above, Australia permits not only Types 1 and 2 PSs̄ANH but also probably Type 3 PSs̄ANH.[226] All three types are practiced in Australia.

a. Legality of PSs̄ANH in Australia

Criminal law in Australia is split between common law states (where the common law is the source of law, as amended by statute) and criminal code states (where the Griffith Criminal code, as amended over time is the sole source of law).[227] None of these laws would be engaged in Type 1 PSs̄ANH scenarios. In terms of Type 2 PSs̄ANH, in common law states, recklessness is sufficient to satisfy the intentional element (*mens rea*) of murder. Recklessness is defined by knowledge that the accused's behavior is likely (*i.e.*, more probable than not) to cause death.[228] In terms of causation, the cause must be an operating and substantial cause of death but does not need to be the sole cause of death.[229]

In a Type 2 PSs̄ANH scenario, death would be too difficult to prove as having been caused by the PSs̄ANH. The Australian Code jurisdictions of Western Australia, Queensland and the Northern Territory do not expressly recognize recklessness, and it is arguable that recklessness is not a mental

226. The local jurisdictional expert for this section was Professor Cameron Stewart.

227. Here is the split and sources of criminal law in all Australian states and territories: Australian Capital Territory: common law, *Crimes Act 1900* (ACT); New South Wales: common law, *Crimes Act 1900* (NSW); Victoria: common law, *Crimes Act 1958* (Vic); South Australia: common law, *Criminal Law Consolidation Act 1935* (SA); Northern Territory: *Criminal Code* (NT); Queensland: *Criminal Code* (Qld); Tasmania: *Criminal Code* (Tas); Western Australia: *Criminal Code* (WA). *See also* Stella Tarrant, *Building Bridges in Australian Criminal Law: Codification and the Common Law* (2013) 39(3) MONASH UNIVERSITY L.R. 837, 838-40, 850.

228. R v. Crabbe (1985) 156 CLR 464 (Austl.).

229. Royall v. R (1991) 172 CLR 378 (Austl.).

element in these jurisdictions.[230] The Tasmanian Code states that an accused is liable for an act which causes death where they ought to have known it was likely to cause death.[231]

For Type 3 PSs̄ANH, Queensland, South Australia and Western Australia specifically exclude palliative care from criminal liability. In Queensland, the Criminal Code provides that a doctor, or someone authorized in writing by a doctor, who hastens a person's death through palliative care, is not criminally responsible for the death if: (1) the palliative care is to maintain or improve the comfort of a person who is subject to pain and suffering; (2) provided in good faith and with reasonable care and skill; and (3) reasonable, having regard to the person's state at the time and in the circumstances of the case.[232] To be reasonable, the palliative care must accord with good medical practice.

In South Australia, palliative care is not the cause of death if provided with the consent of the patient or the patient's representative, in good faith and without negligence, and in accordance with proper professional standards of palliative care.[233] Western Australia provides that a person who hastens another person's death through medical treatment (including pain and symptom relief) is not criminally responsible for that person's death if the treatment was: (1) provided in good faith, (2) with reasonable care and skill, and (3) reasonable, having regard to the person's state at the time and all the circumstances of the case.[234]

Some jurisdictions in Australia speak to a general right to palliative care without referencing criminal liability.[235] There is a legislative effort where the New South Wales Law Reform Commission provided a draft bill in its *Review of the Guardianship Act 1987*.[236] That proposed reform included the adoption of a similar approach to the South Australian provisions discussed above.

There is caselaw on Type 3 PSs̄ANH. The Family Court of Australia is a federal court that has shared power over decision concerning healthcare of children (the power is shared with state and territory supreme courts). In *Re Baby D, (No 2)*, the Family Court recognized that double effect reasoning could be used for terminal sedation of a child.[237] The basic facts involved a premature twin who had suffered a catastrophic brain injury after being extubated and then having his throat close over. A tube was reinserted but only after extensive time without oxygen. The child was later taken off ventilatory support, but the tube

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230. Ian Campbell, *Recklessness in Intentional Murder under the Australian Codes*, 10 CRIM. L. J. 3 (1986).

231. *Criminal Code Act 1924* (Tas) s 157(1)(c).

232. *Criminal Code Act 1899* (Qld) s 282A.

233. *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 17.

234. *Criminal Code Act Compilation Act 1913* (WA) s 259.

235. *Medical Treatment (Health Directions) Act 2006* (ACT) s 17 (reasonable palliative care to be provided when the patient has an advance directive); *see* Medical Treatment Planning and Decisions Act 2016 (Vic) s 54.

236. New South Wales Law Reform Commission, *Review of the Guardianship Act 1987*, (Report No 145, August 2018).

237. Re Baby D (No 2), (2011) 258 FLR 290 (Austl.).

remained in situ. Eventually it was agreed by doctors and parents that it was in the child's best interests to have the tube removed even though it was likely to cause death. The judge agreed that the parents could consent to sedation to ensure that the child would not suffer. Double effect reasoning was employed by medical experts.[238]

Syme v. Medical Board of Australia (Review and Regulation) concerned an "immediate action" hearing on whether to suspend a doctor for posing a risk to the health and safety of the public after prescribing Nembutal to a patient who then died.[239] The Tribunal found that use of the drug was an acceptable application of double effect and that the doctor was not a risk to public health or safety.[240] Australia is a statutory jurisdiction to regulate registered health professionals. The legislation is operationalized at the state and territory level, although the system is referred to as a "National Law" due to some uniformity in the provisions across the country.

b. PSs̄ANH and analogous practices in Australia

For Type 1 PSs̄ANH, voluntary stopping of eating and drinking is an analogous practice when combined with sedation at the near end of life as withholding food and drink is very common at this stage. For Type 2 PSs̄ANH, potentially life-shortening opioid use is an analogous practice, as opiates have a depressing effect on respiration. As to Type 3 PSs̄ANH, there is no moral or ethical reason for distinguishing between the practices of accelerating death using Type 3 PSs̄ANH and voluntary assisted dying from an Australian legal perspective. The use of opiates is treated the same as the use of sedatives for the purposes of the laws described above. All states have legislated for voluntary assisted dying.[241] Federal bans on Australian territories passing voluntary assisted dying laws have recently been removed.[242] The Australia Capital Territory has already moved to enact voluntary assisted dying legislation.[243] The Northern Territory must still enact legislation to operationalize voluntary assisted dying.

c. Medical practice of PSs̄ANH in Australia

In Australia, all three types of PSs̄ANH are widely used. However, there is very little evidence of practice available. There are likely differences between

238. *Id.* ¶¶ 81, 97, 139.

239. Syme v. Medical Board of Australia (Review and Regulation) (2016) VCAT 2150 (Austl.), https://jade.io/article/509767 [https://perma.cc/8D26-FNHH].

240. *Id.* ¶¶ 179-184.

241. End of Life Law in Australia, *Voluntary Assisted Dying*, QUEENSLAND UNIVERSITY OF TECHNOLOGY, (Sept. 5, 2024) https://end-of-life.qut.edu.au/assisteddying [https://perma.cc/78VS-96Q7].

242. *Restoring Territory Rights Act 2022* (Cth) s 3 (Austl.).

243. *Voluntary Assisted Dying Bill 2023* (Cth)(Austl.).

urban and rural medical practice, but there is still relatively little evidence to support this.

2. Colombia

Unlike Australia, in Colombia, the development of PSs̄ANH has been tied to the constitutional recognition of the right to die with dignity as a right with different facets.[244] This development led to legislative developments on palliative care and to a robust set of regulations, guidelines, and protocols from the Ministry of Health. The current legal framework in Colombia allows patients to access Type 1 PSs̄ANH under the general concept of palliative care when the patient has refractory symptoms and physical or psychological suffering. Patients can access Type 2 PSs̄ANH by opting to request withholding or withdrawal of artificial nutrition and hydration in the context of a terminal state or the presence of a chronic, degenerative, or irreversible disease. Finally, adults and children older than six years old who are experiencing intense physical or mental suffering, caused by bodily injury or serious and incurable disease can access active euthanasia or medically assisted suicide, procedures that are comparable to Type 3 PSs̄ANH.

The practice of the different types of PSs̄ANH faces different challenges in the country, including: (1) lack of clarity with respect to specific time frames related to the prognosis of death required for Types 1 and 2 PSs̄ANH, (2) absence of official data and statistics, (3) unequal distribution of pain medications and palliative care services, and (4) different access barriers to euthanasia.

a. Legality of PSs̄ANH in Colombia

In terms of Type 1 PSs̄ANH, Colombia's Palliative Care Act recognizes a right to palliative care.[245] Patients can access palliative sedation, under the general concept of palliative care, when:

244. The local jurisdictional experts for this section were Natalia Acevedo Guerrero, Professor Silvia Serrano Guzmán, and Professor Oscar Cabrera.

245. L. 1733, Septiembre 8, 2014, DIARIO OFICIAL [D.O.] (Colom.) ("Palliative Care Act 1733") ("Consuelo Devis Saavedra"), https://www.funcionpublica.gov.co/eva/gestornormativo/norma.php?i=59379 [https://perma.cc/G7QJ-LFFX]. Under the Political Constitution of 1991, which affirmed Colombia's centralized political system, legislation, rulings from the Constitutional Court, and administrative regulations issued by the Minister of Health apply to all provinces. Palliative care is defined as: "[t]he appropriate care for the patient with a terminal, chronic, degenerative, and irreversible disease where the control of pain and other symptoms requires, in addition to medical, social, and spiritual support, psychological and family support, during illness and mourning. The goal of palliative care is to achieve the best possible quality of life for the patient and their family. Palliative medicine affirms life and views dying as a normal process." (Palliative Care Act 1733 Article 4).

> (1) There is a presence of refractory symptoms which can present at end-of-life and when there is presence of physical or psychological suffering;
> (2) There is a therapeutic indication after a careful medical evaluation; and
> (3) There is specific and explicit consent provided by the patient after accessing information from a physician. Consent can be established in an advance directive document or provided by a specific person to which the patient has delegated for decision making at the end of life.[246]

In developing the Palliative Care Act, the Minister of Health and Social Protection (the "Minister") issued administrative guidance that provided further details on the right to palliative care:

> The right to palliative care, which implies that every patient affected by terminal, chronic, degenerative, irreversible disease with a high impact of quality of life, have access to comprehensive palliative care. Such care includes the following:
>
> - Access to health technologies (drugs, services, and procedures) . . . ;
> - The reference of a palliative care clinical practice guideline in each service where this type of patient is cared for; . . .
> - Access to opioid medications as indicated in Circular 22 of 2016 of the Ministry, through which it is instructed on the "Guidelines for Managing Access to Opioid Medications for pain management and care by specialists in pain and/or palliative care and equipment of health that have technicians, professionals or specialists in the area of health, with certified training or competencies related to health care of patients requiring pain management and palliative care."[247]

The Minister also issued the administrative guidance that develops the procedure for creating end-of-life advance care directives documents.[248]

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246. *Id.* Art. 4; MINISTER OF HEALTH AND SOCIAL PROTECTION, Circular 023 (2016) (Colom.), https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/DIJ/circular-023-2016.pdf [https://perma.cc/5L9L-UCZK]; MINISTER OF HEALTH AND SOCIAL PROTECTION, *Circular 2665* (2018) (Colom.), https://www.minsalud.gov.co/Normatividad_Nuevo/Resoluci%C3%B3n%20No.%202665%20de%202018.pdf [https://perma.cc/JJG9-6CLJ]; MINISTER OF HEALTH AND SOCIAL PROTECTION AND THE HEALTH AND TECHNOLOGY ASSESSMENT INSTITUTE, *Clinical Practice Guide for the Care of Patients in Palliative Care (Guide No. 58)* (2016) (Colom.), https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/CA/gpc-completa-cuidados-paliativos-adopcion.pdf [https://perma.cc/YH84-A6VA].

247. Circular 023, *supra* note 246, at Art. 1.

248. Circular 2665, *supra* note 246, at Art. 2.

The Clinical Practice Guide for the Care of Patients in Palliative Care describes the best standards based on an expert consensus. It recognizes palliative sedation as an alternative that can be performed with: (1) the express consent of a patient, (2) a therapeutic indication, and (3) the presence of refractory symptoms and suffering. The guide establishes that the goal of this type of sedation is to "*relieve suffering*" and establishes the following requirements:

(1) A correct therapeutic indication made by a doctor in the final phase of life;
(2) Professionals with clear and complete information on the process, with registration in the clinic history; and
(3) Administration of drugs in the doses and combinations necessary to achieve the adequate level of sedation.[249]

Refractory symptoms are defined as symptoms which appear once possibilities for intervention are exhausted. It recommends the use of "midazolam" as the first option for sedation in response to most symptoms and the Ramsay scale to monitor the level of sedation of the patient.[250] The 2015 Clinical Protocol for the Procedure of Euthanasia also defines a refractory symptom as one that cannot be adequately controlled with the available treatments and in an agonizing phase. The protocol defines palliative sedation and palliative sedation in agony. These definitions are relevant for Type 2 PSs̄ANH and are described below.

The Minister clarified that the requirements to access palliative sedation in Colombia are:

(1) A correct therapeutic indication;
(2) The explicit consent of the patient, or of the family if the patient is incompetent;
(3) Clear and complete information on the process, with a record in the clinical history; and
(4) The administration of drugs in the necessary doses and combinations until achieving the adequate level of sedation.[251]

Furthermore, according to the Minister, a correct prescription of this type of sedation requires a careful evaluation of the end-of-life diagnosis, the presence of symptoms and refractory physical or mental suffering, and an assessment of the patient's competence in making decisions.[252]

Based on the legislation, administrative regulations, and the official

249. *Clinical Practice Guide*, *supra* note 246, at 66 (recommendation D).

250. *Id.*

251. Response given by the Minister of Health and Social Protection to an information request sent by researchers on March 31, 2022.

252. *Id.*

response given by the Minister, Colombian patients can access palliative sedation if they comply with three requirements:

(1) A certified presence of refractory symptoms that can present in the context of end of life and when there is presence of physical or phycological suffering;
(2) A therapeutic indication after a careful medical evaluation; and
(3) Specific and explicit consent by the patient after accessing adequate and complete information.

With respect to case law, the Constitutional Court of Colombia has recognized palliative care as one of the different facets of the fundamental right "to die with dignity" that can potentially contribute to increased dignity at the end of life.[253] This principle was reaffirmed in another case where the Court recognized a right to choose between euthanasia and palliative care.[254] The Court has also clarified that palliative care services should not be limited to patients afflicted with terminal illness, writing that "it is also for patients with chronic, degenerative and irreversible diseases with a high impact on quality of life. It includes not only pain management but also other symptoms, considering psychopathological, physical, emotional, social, and spiritual aspects of the patient and his family."[255] This right provides for effective and timely provision of such treatments.[256]

Children and adolescents can access palliative care.[257] The Minister considers four crucial aspects for the decision making of minors at the end of life: (1) their capacity to communicate a decision, (2) their capacity to understand, (3) their capacity of reasoning, and (4) and their capacity of judgment.[258]

In terms of Type 2 PSs̄ANH, patients can access this type if: (1) the patient has a terminal, chronic, degenerative or irreversible disease and (2) the patient provides informed consent to adjust or refuse care or treatment or has an advance directive document with a specific request to the withholding or

253. Corte Constitucional [C.C.] [Constitutional Court], Julio 22, 2021, Sentencia C-233/21 (Colom.), https://www.corteconstitucional.gov.co/relatoria/2021/C-233-21.htm [https://perma.cc/SFF6-ZZXK].

254. Corte Constitucional [C.C.] [Constitutional Court], Diciembre 15, 2014, Sentencia T-970/14 (Colom.).

255. Corte Constitucional [C.C.] [Constitutional Court], Diciembre 12, 2017, Sentencia T-721/17 (Colom.).

256. Corte Constitucional [C.C.] [Constitutional Court], Agosto 25, 2017, Sentencia T-544/17 (Colom.).

257. If the patient who requires palliative care is a boy or girl under fourteen years of age, it will be their parents or adults responsible for their care who will submit the request. If the patient is an adolescent between fourteen and eighteen years old, he/she will be consulted about the decision to be made. Act 1733 of 2014, art. 5, num. 6 (Colom.).

258. MINISTERIO DE SALUD Y PROTECCIÓN SOCIAL [Ministry of Health and Social Protection], *Resolución Número 825* [Resolution 825] (2018), Art. 4 (Colom.).

withdrawal of artificial hydration and nutrition in the context of a terminal state.[259] Children and adolescents can also refuse or withdraw from medical intervention.[260]

The Minister has distinguished between palliative sedation and palliative sedation in agony.[261] Palliative sedation is defined as a "deliberate decrease in the patient's level of consciousness through the administration of appropriate medications in order to avoid suffering caused by one or more refractory symptom."[262] By contrast, palliative sedation in agony is defined as a procedure used *"*when the patient is in his last days or hours of life in order to alleviate intense suffering."[263]

The Palliative Care Act indicates that when patients are going through a terminal, chronic, degenerative, and irreversible disease with a high impact on the quality of life, they have the right to opt out of "unnecessary medical treatments that avoid prolonging a dignified life in the patient and in the case of death their willingness or not to donate organs."[264] Patients can opt out of medical procedures.[265] Specifically, they have the right "[t]o voluntarily and early desist from unnecessary medical treatments that do not comply with the principles of therapeutic proportionality and do not represent a dignified life."[266] This preference to avoid treatment can be expressed through an advance directive.[267] In the advance directive, patients can reject certain disproportionate measures, whether invasive or not, including artificial nutrition and hydration.[268]

The Colombian legal framework probably accepts both Types 1 and 2 PSs̄ANH. This would be included within the definitions of palliative care and the right of a patient in a terminal or chronic state to refuse medical treatment. But Colombian acceptance of Types 1 and 2 PSs̄ANH is not explicit with respect to specific time frames related to the prognosis of death. The legal framework allows a patient to request palliative sedation and the withholding or withdrawing of artificial hydration and nutrition. But patients can do that only

259. Palliative Care Act 1733, *supra* note 245; Circular 023, *supra* note 246; Circular 2665, *supra* note 246; MINISTERIO DE SALUD Y PROTECCIÓN SOCIAL [Minister of Health and Social Protection], *Resolución Número 1216* [Resolution 1216] (2015) (Colom.), https://www.minsalud.gov.co/Normatividad_Nuevo/Resoluci%C3%B3n%201216%20de%202015.pdf [https://perma.cc/U7EU-HYTA]; Resolution 825, *supra* note 258.

260. Resolution 825, *supra* note 258, at Art. 6.

261. MINISTERIO DE SALUD Y PROTECCIÓN SOCIAL [Ministry of Health and Social Protection], Protocolo ara la Aplicación de Procedimiento de Eutanasia en Colombia [Clinical Protocol for the Procedure of Euthanasia], at 21, 85 (2015) (Colom.).

262. *Id.*

263. *Id.*

264. Palliative Care Act 1733, *supra* note 245.

265. *Id*. The Administrative Resolution 1216 of 2015 that created the requirements for the "Scientific Interdisciplinary Committees for the Right to Die," and the Circular 2665 of 2018 that developed the requirements for the advance directive documents, establish that principle.

266. Resolution 1216, *supra* note 259, at Art. 4.

267. *Id*. at Art. 5.

268. Communication from Minister of Health and Social Protection to Colombia jurisdictional experts in response to an information request (March 31, 2022).

in cases where there is a terminal, chronic, degenerative and irreversible disease with a high impact on quality of life. The law makes no distinction related to the concrete impacts of PSs̄ANH in hastening the death. But the patient must present refractory symptoms. We need more empirical data collection to understand whether this requirement constitutes a barrier or a limitation.

With respect to case law, the Constitutional Court has held that there is no incompatibility between palliative care, the adjustment or rejection of medical treatment, and euthanasia.[269] This means that each person should determine the channel that best suits their health condition, personal interests, and own concept of dignified life. Thus, the Constitutional Court has emphasized that no one can be forced to "[e]xhaust one facet before another, nor accept a treatment that he considers disproportional."[270] The Constitutional Court has further held "[t]he assessment of the need to limit therapeutic effort is based on professional judgment on the futility of a given intervention, based on a weighted assessment process, and consultation between different professionals. In the face of uncertainty, clinicians must take the wishes of the patient or their representatives into account."[271]

There is no specific mention of Type 3 PSs̄ANH in existing legislation. This means there is no clarity about the specific time frames related to the prognosis of death that is required to access palliative sedation. Therefore, the legal possibility of accessing this type of PSs̄ANH depends on the medical evaluation.[272] People with neurodegenerative diseases (such as Huntington's disease, Alzheimer's, dementia, among others) would be able to access Type 3 PSs̄ANH if they have refractory suffering or refractory symptoms because that qualified them to access palliative sedation.[273]

Recognizing that this type of sedation hastens death, it is important to acknowledge that, in Colombia, euthanasia has been legal since 1997 and has been highly regulated by the Minister.[274] Such heightened regulation may explain the absence of specific regulations governing this type of PSs̄ANH.

The 2015 Protocol for the Application of the Euthanasia Procedure recognizes euthanasia as a right and a health procedure that is covered by the health benefits plan.[275] As such, anyone can access euthanasia if they have been

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269. *See* Ruling C-233, *supra note* 253, ¶ 480 (Colom.).

270. *Id.* ¶ 411.

271. Corte Constitucional [C.C.] [Constitutional Court], 2017, Sentencia T-721/17 ¶ 6.1.8 (Colom.), https://www.corteconstitucional.gov.co/relatoria/2017/t-721-17.htm [https://perma.cc/S54B-6JZ9]

272. This is the original analysis of the Colombia jurisdictional experts based on the Constitutional Court rulings and other authorities discussed in this section.

273. *Id.*

274. Corte Constitucional [C.C.] [Constitutional Court], Mayo 20, 1997, Sentencia C-239/97 (Colom.); Corte Constitucional [C.C.] [Constitutional Court], Nov 29, 2024, Sentencia T-445/24 (Colom.), https://www.corteconstitucional.gov.co/relatoria/2024/T-445-24.htm [https://perma.cc/3DX9-9EEZ].

275. Resolution 1216, *supra* note 259, at Art. 4 (creating the requirements for the "Scientific Interdisciplinary Committees for the Right to Die").

diagnosed with a serious and incurable injury or illness that causes pain incompatible with a dignified life.[276] This protocol examines the relevant medical evidence in the subject and provide recommendations for identifying suitable candidates for euthanasia.

In other words, patients can access euthanasia if they: (1) give their free and informed consent (which can be provided in an advance directive document or be substituted, under specific circumstances), (2) require it from the "Scientific Interdisciplinary Committee for the Guarantee of the Right to Die with Dignity" in a specific clinic or hospital, and (3) certify that they are experiencing intense physical or mental suffering, caused by bodily injury or serious and incurable disease.[277]

Children and adolescents can access euthanasia from the age of six if they are terminally ill and are in constant and unbearable suffering which cannot be relieved.[278] Minors between the ages of six and twelve must obtain parental approval and must meet a certain level of neurocognitive and psychological development, such that their concept of death meets the level expected for a child over the age of twelve.[279] Children between twelve and fourteen can access euthanasia even if their parents disagree.[280] After fourteen, no parental involvement is needed, provided that all the requirements for euthanasia are fulfilled.[281]

With respect to case law, the Constitutional Court has held criminal punishment unconstitutional for a mercy killing when both (1) done with the victim's consent and (2) carried out by a doctor when the patient is terminally ill.[282] The Constitutional Court has held that:

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276. MINISTERIO DE SALUD Y PROTECCIÓN SOCIAL, *supra* note 261.

277. *Id.*; MINISTERIO DE SALUD Y PROTECCIÓN SOCIAL [Ministry of Health and Social Protection], Resolución Número 971 de 2021 [Resolution 971] (2021) (establishing guidelines regarding the functioning of the "Interdisciplinary Scientific Committees for the Right to Die with Dignity"); *see also* Ruling C-233, *supra* note 253.

278. Corte Constitucional [C.C.] [Constitutional Court], Diciembre 12, 2017, Sentencia T-721/17 (Colom.); Corte Constitucional [C.C.] [Constitutional Court], Agosto 25, 2017, Sentencia T-544/17 (Colom.); Resolution 825, *supra* note 258.

279. Resolution 825, *supra* note 258, at ch. III. *See also* Stephanie Nolan, *Colombia Takes Medically Assisted Death into the Morally Murky World of Terminally Ill Children*, GLOBE & MAIL (Mar. 1, 2019).

280. *Id.*

281. *Id.*

282. Corte Constitucional [C.C.] [Constitutional Court], Mayo 20, 1997, Sentencia C-239/97 (Colom.); *see also* Corte Constitucional [C.C.] [Constitutional Court], Diciembre 15, 2014, Sentencia T-970/14 (Colom.); Corte Constitucional [C.C.] [Constitutional Court], Marzo 14, 2016, Sentencia T-132/16 (Colom.); Corte Constitucional [C.C.] [Constitutional Court], mayo 12, 2017, Sentencia T-322/17 (Colom.); Corte Constitucional [C.C.] [Constitutional Court], Julio 4, 2017, Sentencia T-423/17 (Colom.); Corte Constitucional [C.C.] [Constitutional Court], Diciembre 12, 2017, Sentencia T-721/17 (Colom.); Corte Constitucional [C.C.] [Constitutional Court], Agosto 25, 2017, Sentencia T-544/17 (Colom.); Corte Constitucional [C.C.] [Constitutional Court], Febrero 18, 2020, Sentencia T-060/20 (Colom.).

> The fundamental right to live in a dignified manner thus implies the right to die with dignity, since condemning a person to prolong their existence for a short time, when they do not want it and suffer from deep afflictions, is equivalent not to not only to cruel and inhuman treatment, prohibited by the Charter, but to an annulment of their dignity and autonomy as a moral subject. The person would be reduced to an instrument for the preservation of life as an abstract value.[283]

The Constitutional Court has also held requiring affliction with a terminal disease for accessing euthanasia to be unconstitutional.[284] The Constitutional Court held that such requirements were "disproportionate" because they "prevent people affected by the aforementioned diseases from exercising their self-determination and choosing the way to end their life and generates a deterrent effect on health professionals."[285]

In May 2022 the Constitutional Court analyzed "aid to suicide" as a criminal offense. It ruled that medical assisted suicide could not be criminalized when: (1) a certified physician preforms it, (2) there is free, informed, and conscious consent, and (3) the person has an intense physical or psychological suffering, resulting from bodily injury or serious and incurable illness. When the requirements that exist today to access euthanasia are fulfilled, medical assistance for suicide has been considered within the constitutional limits.[286]

The Constitutional Court stated that medical assisted suicide is another manifestation of the right to die. That right guarantees, even to a greater extent, human dignity, autonomy and free development of the personality, as it is the patient who self-administers the prescribed medication and takes control over the causal process of death.[287] But the Minister still needs to regulate this medical practice.

b. PSs̄ANH and analogous practices in Colombia

Type 1 PSs̄ANH can be subsumed under the national legal framework and definition of palliative care because it is not the aim of this type of sedation to hasten death. Rather, it is to relieve suffering, discomfort, and/or pain at the end of life. Type 2 PSs̄ANH has no analogues under Colombian law. Since it combines palliative sedation with the withholding of artificial nutrition and hydration, but it is uncertain to hasten death, it will not be analogous to the use of life-shortening opioid use that implies a positive action from physicians. Life-

283. Corte Constitucional [C.C.] [Constitutional Court], Diciembre 15, 2014, Sentencia T-970/14 (Colom.); CONSTITUCIÓN POLÍTICA DE COLOMBIA [C.P.] art. 12.

284. Corte Constitucional [C.C.] [Constitutional Court], Julio 22, 2021, Sentencia C-233/21 (Colom.).

285. *Id.*

286. Corte Constitucional [C.C.] [Constitutional Court], mayo, 11, 2022, Sentencia C-164/22 (Colom.).

287. *Id.*

shortening opioid use would be more analogous to active euthanasia.

Type 3 PSs̄ANH is most like voluntary active euthanasia and medical assisted suicide, both legal means in Colombia, because the goals of both procedures are similar from a Colombian legal perspective. Even if physicians use different medications and tools for these two practices, they both hasten death in a short period of time while relieving pain and suffering at the end of life. Moreover, for both Type 3 PSs̄ANH and active euthanasia, patients are sedated.

Clinical guidelines for euthanasia in Colombia suggest sedation before administrating the euthanasia medication. The 2015 Clinical Protocol for the Procedure of Euthanasia recommends using "sublingual administration of benzodiazepine (first medication) in order to provide sedation previous to the venous cannulation where the rest of the medications for euthanasia will be provided."[288] As some people might opt for Type 3 PSs̄ANH over euthanasia, they are distinct options. However, in Colombia, Type 3 PSs̄ANH usage is limited to patients with refractory symptoms which have a specific medical indication.

c. Medical practice of PSs̄ANH in Colombia

With respect to Type 1 PSs̄ANH, eighteen percent of the Colombian population suffers from chronic diseases and would benefit from palliative care.[289] Moreover, thirty percent of Colombians died while needing palliative care.[290] This same report states that Colombia placed sixty-eighth out of eighty countries in the 2015 World Ranking of Palliative Care.[291] About seventy percent of terminal patients or patients with chronic pain in Colombia died in suffering conditions due to lack of access to this type of service.[292]

The main barriers to accessing palliative care include: (1) limitations on the availability of opioid medications, (2) lack of awareness of the legal standards of palliative care, (3) legislation which does not adjust to the reality of the territories, (4) absence of quality standards for palliative care, (5) high costs for patients who must travel to other cities and municipalities, (6) limited medical education and training, (7) low levels of public information about palliative care,

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288. Clinical Protocol for the Procedure of Euthanasia, *supra* note 261, at 85.

289. OBSERVATORIO COLOMBIANO DE CUIDADOS PALIATIVOS [O.C.C.P.] [COLOMBIAN OBSERVATORY ON PALLIATIVE CARE], *Estado Actual de los Cuidados Paliativos en Colombia: Reporte Técnico 2021* [*Current Status of Palliative Care in Colombia: Technical Report 2021*] 37 (2021), https://cdn.prod.website-files.com/645b9ffb9c7891c118eb084b/6468ba0f421de37f676c02a2_Reporte-tecnico-2021.pdf [https://perma.cc/32HV-KX8W].

290. *Id*.

291. *Id*.

292. INT'L ASS'N FOR HOSPICE AND PALLIATIVE CARE, ATLAS DE CUIDADOS PALIATIVOS EN LATINOAMÉRICA [LATIN AMERICAN ATLAS OF PALLIATIVE CARE] (2nd ed., 2020), https://cuidadospaliativos.org/recursos/publicaciones/atlas-de-cuidados-paliativos-de-latinoamerica/ [https://perma.cc/FZS9-JT54]; COLOMBIAN OBSERVATORY ON PALLIATIVE CARE, *supra* note 289.

and (8) administrative barriers which hinder access.[293] The Colombian Association for the Study of Pain explains that "the distribution of pain medications and palliative care services in Colombia is concentrated in large capitals. Departments such as Amazonas, Vaupes, and Putumayo have very restricted access."[294]

With respect to Type 2 PSs̄ANH, there is no available data on the requests for procedures related to the modification of therapeutic efforts or the withholding of artificial nutrition and hydration. For palliative sedation, it is important to note that even if the practice is widely accepted in the clinical practice, there is no official information about the number of palliative sedations performed or requested in the country.[295]

Concerning euthanasia, from 2015 (when the procedure first started being registered in the health system) to October 31, 2022, 322 euthanasia procedures were administered in the country. [296] During 2022, the number of euthanasia procedures practiced in the country reached the highest number since 2015. [297] Most of the euthanasia procedures practiced in Colombia have been performed in urban centers and capital cities such as Bogota and Medellin.[298] All of the procedures were performed on people older than eighteen years old, with the median age being sixty-two years old.[299]

Oncological diseases give rise to the greatest number of euthanasia requests in the country.[300] 80.4% of all cases were carried out in oncological patients. This includes malignant tumors of gastrointestinal origin, which include those of the pancreas, liver, stomach and colon, and malignant tumors of the lung or bronchi, and malignant tumors of the ovary or cervix. The non-oncological diseases that raise the greatest number of euthanasia requests were amyotrophic lateral sclerosis, chronic obstructive pulmonary disease, heart failure, cardiac failure, Becker muscular dystrophy, HIV, and recurrent depressive disorder.[301] Even terminal illness is not required (89.1% of euthanasia procedures were carried out in the terminal stages of life). Only a small percentage of patients accessed the procedure with incurable diseases (10.2%) or corporal lesions (0.6%).[302]

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293. COLOMBIAN OBSERVATORY ON PALLIATIVE CARE, *supra* note 289.

294. Asociación Colombiana Para el Estudio del Dolor [Colombian Association for the Study of Pain], *Communication to Local Expert Authors in Response to Information Request* (Mar. 22, 2022).

295. LUCAS CORREA MONTOYA & CAMILA JARAMILLO SALAZAR, DE MUERTE LENTA #2: CIFRAS, BARRERAS Y LOGROS SOBRE EL DERECHO A MORIR DIGNAMENTE EN COLOMBIA [SLOW DEATH #2: FIGURES, BARRIERS, AND ACHIEVEMENTS REGARDING THE RIGHT TO DIE WITH DIGNITY IN COLOMBIA] 47 (DescLAB 2022), https://www.desclab.com/monitor/monitor07 [https://perma.cc/9H7T-ZFY2].

296. *Id.* at 24.

297. *Id.* at 25.

298. *Id.* at 31.

299. *Id.* at 36.

300. Montoya & Salazar, *supra* note 295, at 23.

301. *Id.* at 36.

302. *Id.* at 39.

The Constitutional Court has highlighted different barriers to accessing end-of-life procedures. Though the Constitutional Court has focused on euthanasia, these barriers apply more broadly in the context of palliative care. These barriers include: (1) delays in the authorization of the procedures, (2) lack of opportunity for specialized assignment, and (3) delays in the authorization of the procedures and medications not included in basic health plans. The Constitutional Court has also highlighted barriers such as: (4) complaints originating from the follow-up of information requests, (5) the non-application of standards, guidelines, or care protocols, (6) the delay or absence of authorization of surgeries or the delivery of medications excluded from basic health plans. The Constitutional Court has also drawn attention to (7) the existence of a set of complaints associated with problems of access to information and noncompliance of duties and procedures for access to a dignified death.[303] It is relevant to note that in two of the nine cases that have been analyzed by the Constitutional Court about the right to die with dignity, patients ended up accessing palliative sedation while they waited for their euthanasia decision.[304]

The general practice of palliative care in Colombia is very limited. Lack of education and training are the main limitations on this type of care. Only ten universities in the country offer palliative care graduate education. Eight medical programs include this type of knowledge in their study plans: two in graduate nursery studies, one in psychology graduate studies, and one in interdisciplinary studies. This is even more limited in the case of pediatric palliative care, with only six universities in the country including these contents in their medical carriers. Only 367 medical professionals are associated to the two existing professional associations on palliative care.[305] Rural regions in Colombia lack adequate access to palliative care. Regions with no access to palliative care are also regions predominantly occupied by rural, indigenous, and afro-Colombian communities.

3. The Netherlands

Like Australia and Colombia, Types 1 and 2 PSs̄ANH are legal and

303. Corte Constitucional [C.C.] [Constitutional Court], Julio 22, 2021, Sentencia C-233/21 (Colom.).

304. Corte Constitucional [C.C.] [Constitutional Court], Diciembre 15, 2014, Sentencia T-970/14 (Colom.); Corte Constitucional [C.C.] [Constitutional Court], Marzo 14, 2016, Sentencia T-132/16 (Colom.); Corte Constitucional [C.C.] [Constitutional Court], Mayo 12, 2017, Sentencia T-322/17 (Colom.); Corte Constitucional [C.C.] [Constitutional Court], Julio 4, 2017, Sentencia T-423/17 (Colom.); Corte Constitucional [C.C.] [Constitutional Court], Diciembre 12, 2017, Sentencia T-721/17 (Colom.); Corte Constitucional [C.C.] [Constitutional Court], Agosto 25, 2017, Sentencia T-544/17 (Colom.); Corte Constitucional [C.C.] [Constitutional Court], Febrero 18, 2020, Sentencia T-060/20 (Colom.); Corte Constitucional [C.C.] [Constitutional Court], Marzo 7, 2023, Sentencia T-048/23 (Colom.); Corte Constitucional [C.C.] [Constitutional Court], Mayo, 11, 2022, Sentencia C-164/22 (Colom.).

305. COLOMBIAN OBSERVATORY ON PALLIATIVE CARE, *supra* note 289, at 48-62.

practiced.[306] Type 3 PSs̄ANH is treated as a request for euthanasia, and thus permissible, so long as the applicable euthanasia procedures are followed.

a. Legality of PSs̄ANH in the Netherlands

The Peter Vencken case provides a clear example of the permissibility of Type 1 PSs̄ANH.[307] In 2003, physician Vencken was accused of having unjustly ended the life of a terminally ill man. Vencken claimed that his treatment had been normal medical practice for the relief of symptoms and for palliation. But the Public Prosecutor and the Medical Inspectorate filed complaints against Vencken, and he was taken into custody for nine days. Ultimately, both the Criminal Court and the Medical Disciplinary Board rejected the complaints made against Vencken. They determined that he had acted according to professional standards.[308] Vencken later recovered $50,000 for being wrongly imprisoned.[309]

Today, Type 1 PSs̄ANH is considered regular medical treatment under the Royal Dutch Medical Association (the "RDMA") Guidelines in the Netherlands and thus regarded by doctors and scholars to be relatively unproblematic.[310] Still, some scholars emphasize that by reducing the patient's consciousness, all types of PSs̄ANH (including Type 1 PSs̄ANH) "cause . . . the patient's social death."[311] In fact, Type 1 PSs̄ANH is frequently practiced when providing routine end-of-life care services. The most recent RDMA guidelines for palliative sedation were published in 2022.[312]

The primary aim of Type 2 PSs̄ANH is to reduce or remove the experience of symptoms that cannot otherwise be controlled, keeping in mind that a consequence of this could be that the patient dies. Provided that death can be expected within one to two weeks, the RDMA guidelines will apply conventionally, and the case is considered regular medical treatment. The question of when Type 2 PSs̄ANH is considered euthanasia turns on the notion of conditional intent.

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306. The local jurisdictional experts for this section were Professor Paul Mevis, Professor Agnes van der Heide, and Professor Johannes (Hans) van Delden.

307. Rb.'s-Breda 10 Noviembre 2004, ECLI:NL:RBBRE:2004:AR5394 (In re Vencken) (Neth.); Hof's- Hertogenbosch 19 Juli 2005, ECLI:NL:GHSHE:2005:AU0211 (In re Vencken) (Neth.). The case was not taken to the Dutch Court of Cassation.

308. J. Legemaate, *Relief of Symptoms and Palliation Versus Ending a Patient's Life: Looking Back at the Case against Vencken*, 150 NED TIJDSCHR GENEESKD [DUTCH J. MED.] 1689, 1691 (2006).

309. Tony Sheldon, *Doctor Who Was Remanded for Murder Wins Record Damages*, 332 BMJ 443 (2006).

310. The Royal Dutch Medical Association, ARTSENFEDERATIE KNMG, https://www.knmg.nl/over-knmg/about-knmg/about-knmg.htm [https://perma.cc/7SEY-XZVL].

311. Rien Janssens et al., *Palliative Sedation: Not Just Normal Medical Practice. Ethical Reflections on the Royal Dutch Medical Association's Guideline on Palliative Sedation*, 38 J. MED. ETHICS 664, 665 (2012).

312. *See Palliative Sedation Guideline*, PALLIALINE (Jun. 16, 2022), https://palliaweb.nl/richtlijnen-palliatieve-zorg/richtlijn/palliatieve-sedatie [https://perma.cc/34GA-VYSC].

Type 2 PSs̄ANH lies in the middle ground between palliative sedation and euthanasia. Provided that the goal of the treatment is to reduce or remove the experience of symptoms that cannot otherwise be controlled, Type 2 PSs̄ANH will not be viewed as euthanasia. Accepting early death of a patient as a possible consequence of palliative sedation constitutes conditional intent within the meaning of the Dutch Criminal Code.[313] However, in practice it is rarely classified or recognized as such because practitioners do not report Type 2 PSs̄ANH cases to authorities, instead death in such cases is attributed to disease.

From a legislative perspective, it was suggested that the Criminal Code should be amended to explicitly state that undertaking palliative sedation with conditional intent, but with the goal of reducing or removing the experience of symptoms should not be considered euthanasia (as defined in Article 293, para 1 of the Criminal Code). This recommendation has not been implemented. However, the 2021 Dutch Cabinet stated that the Government aims to clarify the difference between euthanasia and palliative sedation. Progress is yet to be seen. Type 3 PSs̄ANH is approached as a request for euthanasia. Therefore, the Criminal Code and Dutch Euthanasia Act 2001 applies (which permits euthanasia in specific circumstances).

b. PSs̄ANH and analogous practices in the Netherlands

Type 1 PSs̄ANH is analogous to withholding or withdrawing life-extending treatment in dying patients as well using opioids on terminally ill patients. Types 2 and 3 PSs̄ANH is considered analogous to euthanasia. In 2003, a criminal prosecution was initiated against a physician who undertook palliative sedation on a patient to reduce the experience of symptoms, but which resulted in the death of the patient soon after.[314] This case falls within the Type 2 or Type 3 category. The physician was arrested but later acquitted on the basis that conditional intent was not proved beyond reasonable doubt. On appeal, the Court of Appeal affirmed because there was no causal link between the medication used by the physician and the death of the patient. Still, while the physician was acquitted, the legal position on the boundary between Type 2 PSs̄ANH and Type 3 PSs̄ANH remains unclarified.

For Type 1 PSs̄ANH, the RDMA Guidelines on Palliative Sedation provides safeguards. For Types 2 and 3 PSs̄ANH, Article 293 of the Criminal Code, read with the Dutch Euthanasia Act 2001, delineates a safeguarding procedure. A "Review Committee" gives their opinion, and the local coroner is informed. The Dutch Supreme Court has recommended that criminal proceedings should only be pursued as a last resort. Disciplinary proceedings are the first part of call.

313. Wetboek van Strafrecht [Penal Code] art. 293, lid 1 (Neth.), https://wetten.overheid.nl/zoeken/ [https://perma.cc/Q3TG-WERA].

314. *See supra* notes 307 to 309 (discussing the Vencken case).

c. Medical Practice of PSs̄ANH in the Netherlands

Regarding Type 1 PSs̄ANH, in 2015, there were 9.2% deaths within twenty-four hours of administering palliative sedation, 8.4% deaths within the first week, 0.2% deaths within the first two weeks and 0.4% deaths over two weeks after administering palliative sedation.[315] It is noteworthy that there is a lack of evidence/research on the details of these cases, thus restricting the potential for a robust conclusion.[316]

Overall, in the Netherlands, there is no marked divergence between principle and practice regarding the use of PSs̄ANH. Instead, the prevalent medical culture, involving the use of opioids for dying patients and education (physicians were found to be administering palliative sedation largely in accordance with guidelines in a 2011 study) plays a significant role.[317]

4. Switzerland

PSs̄ANH is not explicitly covered by the Swiss Penal Code and so the status of Ps̄ANH depends on analogizing it to forms of euthanasia.[318] The determining factor between criminally punishable direct, active euthanasia on the one hand and PSs̄ANH on the other hand is the intent of the doctor and medical team. Switzerland is particularly liberal in its regulation of assisted suicide, permitting private organizations to offer their services within the framework of the law.

a. Legality of PSs̄ANH in Switzerland

The Swiss legal framework and doctrine distinguishes between four categories of euthanasia and assisted suicide: (1) direct, active euthanasia, (2) indirect, active euthanasia, (3) passive euthanasia, and (4) assisted suicide.[319]

(1) Direct, active euthanasia: This is deliberate killing to shorten the suffering of another person. The doctor or a third party deliberately administers an injection to the patient which results directly in their death.[320] This form of

315. Judith Rietjens et al., *The Rising Frequency of Continuous Deep Sedation in the Netherlands, a Repeated Cross-Sectional Survey in 2005, 2010, and 2015*, 20 J. AM. MED. DIRECTORS ASSN. 1367, 1370 (2019).

316. More recently, rates have been increasing. *See, e.g.*, Johannes J.M. van Delden et al., *Should We All Die Asleep? The Problem of the Normalization of Palliative Sedation*, 52 AGE & AGING 1 (2023); Madelon T Heijltjes et al., *Continuous Deep Sedation at the End of Life: A Qualitative Interview-Study among Health Care Providers on an Evolving Practice*, 22 BMC PALLIATIVE CARE 160 (2023).

317. Siebe J. Swart et al, *Palliatieve Sedatie Na Introductie KNMG-Richtlijn*, 155 NED TIJDSCHR GENEESKD. A2857 (2011).

318. The local jurisdiction experts for this section were Professor Sabrina Burgat and Professor Mélanie Levy.

319. FED. OFF. OF JUST., *Forms of Assisted Dying* (Jan. 01, 2023), https://www.bj.admin.ch/bj/en/home/gesellschaft/gesetzgebung/archiv/sterbehilfe/formen.html [https://perma.cc/GKG5-QU3R].

320. *Id.*

euthanasia is punishable under Article 111 (murder), Article 114 (mercy killing on request), or Article 113 (manslaughter) of the Swiss Penal Code.

(2) Indirect, active euthanasia: This is the relief of suffering (*e.g.*, via morphine) which may have the secondary effect of shortening life. The possibility that death might occur earlier than it would otherwise have done is considered.[321] While not covered explicitly by the Swiss Penal Code, this type of euthanasia is generally regarded as permissible.[322] This perspective is also reflected in the euthanasia guidelines of the Swiss Academy of Medical Sciences (the "SAMS Guidelines").[323]

(3) Passive euthanasia: This is the renunciation or discontinuation of life-prolonging measures (*e.g.*, a life-support machine being switched off).[324] There are no specific legal provisions governing this form of euthanasia either, although it is regarded as permissible. The SAMS Guidelines also define passive euthanasia in the same terms.[325]

(4) Assisted suicide: Assisted suicide involves enabling the patient to obtain the lethal substance, which the person wishing to commit suicide then takes themselves without any external assistance.[326] Provided the person providing the lethal medications cannot be accused of having any self-serving motive, assisted suicide is not punishable.[327]

Under the Swiss Penal Code, only a person motivated by self-serving ends who helps another to commit suicide (*e.g.*, by obtaining a lethal substance) will be punished by imprisonment for up to five years, or by pecuniary penalty.[328] Organizations such as EXIT offer assisted suicide within the framework of the law, based on their own criteria of eligibility (*e.g.*, terminal disease). For assisted suicide to be legal, the person who wishes to commit suicide must have the mental capacity to make that decision *and* the physical capacity to make the last gesture.[329] Intervention of an assisted suicide organization such as EXIT is possible but the players in the healthcare system are generally not involved in assisted suicide.[330]

There is relevant case law in the assisted suicide context. The Swiss Federal Court has insisted on liberty:

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321. *Id*.

322. Samia A Hurst & Alex Mauron, *Assisted Suicide and Euthanasia in Switzerland: Allowing a Role for Non-Physicians*, 326 BMJ 271 (2003).

323. Swiss Academy of Medical Sciences, *Guidelines: Management of Dying and Death*, 148 SWISS MED. WKLY. 1, 13 (2018).

324. FED. OFF. OF JUST., *supra* note 319.

325. *Id*.

326. *Id*.

327. Hurst & Mauron, *supra* note 327.

328. Schweizerisches Strafgesetzbuch [StGB] [Swiss Penal Code] art. 115 (Switz.), https://www.fedlex.admin.ch/eli/cc/54/757_781_799/en [https://perma.cc/B25F-96G6].

329. Hurst & Mauron, *supra* note 327.

330. Kalima Carrigan, *One-Way Ticket to Zürich: Presentations of 'Suicide Tourism' in European News Media*, 29 MORTALITY 817 (2023).

> It is not a right to die, but rather a freedom to die, insofar as a right relates to a benefit that can be demanded from the State while a freedom aims to respect the autonomy of the person, that is to say a choice which is guaranteed by the State.[331]

An individual thus has the freedom to choose assisted suicide as their way of dying (freedom to choose the form and timing of one's own end of life), but they do not have a right to demand from the State (or public healthcare professionals as representatives of the State) to administer the means to realize assisted suicide.

PSs̄ANH is considered indirect, active euthanasia (sedation) or passive euthanasia (absence of artificial hydration or nutrition) under Swiss law. Indirect, active euthanasia (sedation) or passive euthanasia (absence of artificial nutrition or hydration) are not covered explicitly by the Swiss Penal Code. The SAMS Guidelines apply here.

The main criteria to distinguish indirect, active euthanasia (sedation) or passive euthanasia (absence of artificial hydration or nutrition) from criminally punishable direct, active euthanasia is the question of *intent*. The intent of the doctor and the medical team is determinant. The three types of PSs̄ANH are allowed if the primary intent is not to accelerate or cause death. The primary intent must be to relieve the dying process, the suffering of a dying patient (*e.g.*, pain, feeling of suffocation, anxiety about dying, etc.)—thereby "softening death" (without intending to cause death). The intent is visible/expressed in the choice and dosage of medicines used for sedation.

The decision-making process about PSs̄ANH involves the medical team and the consent of the patient (with capacity or advance directives) or the therapeutic representative (in the case of an incapable patient), on the basis of the person's presumed will (*e.g.*, opposition against therapeutic over-treatment at the end of life) and interests (*e.g.*, interest in relieving pain).[332]

While patients can refuse artificial nutrition or hydration (right to refuse treatment), it is more difficult to conceive of a right to demand sedation as it is a positive service provided by medical professionals. Swiss law does not protect a positive right to receive specific healthcare treatments. Swiss Federal Court precedent clearly states that while the freedom to die (freedom to choose the form and timing of one's own end of life) is guaranteed, this right does not include a right to receive specific public services to do so.[333] There is no connection between PSs̄ANH and assisted suicide under Swiss law.

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331. Bundesgericht [BGer] [Federal Supreme Court] Sept. 13, 2016, 142 ENTSCHEIDUNGEN DES SCHWEIZERISCHEN BUNDESGERICHTS [BGE] I 195 (Switz.), *available at* https://www.bger.ch/de/index.htm [https://perma.cc/7LL4-4L6H].

332. Schweizerisches Zivilgesetzbuch [ZGB] [Swiss Civil Code] arts. 370 & 378 (Switz.).

333. Bundesgericht [BGer] [Federal Supreme Court] Nov. 3, 2016, 133 ENTSCHEIDUNGEN DES SCHWEIZERISCHEN BUNDESGERICHTS [BGE] I 58 (Switz.), *available at* https://www.bger.ch/de/index.htm [https://perma.cc/6V7E-WNNZ].

b. PSs̄ANH and analogous practices in Switzerland

Type 1 PSs̄ANH is not considered analogous to any existing practices. Type 2 PSs̄ANH is analogous to other means of relieving suffering, such as morphine, which may have the secondary effect of shortening life.[334] Finally, Type 3 PSs̄ANH, under Swiss law, can be characterized as the refusal of treatment (nutrition or hydration) and positive medical services (sedation). A capable patient is legally entitled to request the former but there is no legal guarantee to receive the latter.[335]

c. Medical practice of PSs̄ANH in Switzerland

No information was provided.

5. The United States of America

U.S. law generally provides that Type 3 PSs̄ANH is permissible, so long as the physician does not, consistent with the doctrine of double effect, intend to cause the patient's death.[336] Since Type 3 PSs̄ANH is permissible, Types 1 and 2 PSs̄ANH are certainly permissible. But medical guidelines typically restrict PSs̄ANH to cases where the patient is close to the end of their life, such that withholding or withdrawing artificial nutrition and hydration would probably not hasten death. So, there would be little occasion to provide Type 3 PSs̄ANH, even if it is legally permissible.

a. Legality of PSs̄ANH in the United States of America

The United States of America is a federal system with fifty-six jurisdictions. Both federal and state laws govern PSs̄ANH.

Federal Law on PSs̄ANH

There is limited applicable federal regulation of PSs̄ANH. At the turn of the century, proposed federal legislation provided that:

> (1) In the first decade of the new millennium there should be a new emphasis on pain management and palliative care. . .
>
> (4) Dispensing or distribution of certain controlled substances for the purpose of relieving pain and discomfort even if it increases the risk of

334. Michel Beauverd et al., *Palliative Sedation – Revised Recommendations*, 154 SWISS MED. WKLY. 3590 (2024).

335. *Id.*

336. The local jurisdictional experts for this section were Konstantin Tretyakov and Professor Thaddeus Mason Pope.

> death is a legitimate medical purpose and is permissible under the Controlled Substances Act. . .[337]

But since this statute was not enacted, we must turn to case law. Two seminal U.S. Supreme Court cases address the legality of Type 3 PSs̄ANH: *Washington v. Glucksberg*[338] and *Vacco v. Quill*.[339]

In *Glucksberg*, the practice of terminal sedation was not addressed directly in the majority opinion (in which five out of nine justices joined). Nevertheless, the concurring opinions, including that of Justice O'Connor (who gave the fifth vote to the Court's opinion) addressed the legality of the sedation that is certain to bring about death. Justice O'Connor made the following telling remark:

> There is no need to address the question whether suffering patients have a constitutionally cognizable interest in obtaining relief from the suffering that they may experience in the last days of their lives. *There is no dispute* that dying patients in Washington and New York can obtain palliative care, *even when doing so would hasten their deaths*.[340]

Although the reference to "last days of their lives" could be argued to limit the foregoing statement to Types 1 and 2 PSs̄ANH. Justice Souter made a similar comment in his concurrence:

> The law generally permits physicians to administer medication to patients in terminal conditions when the primary intent is to alleviate pain, *even when the medication is so powerful as to hasten death and the patient chooses to receive it with that understanding*.[341]

The final and perhaps most noteworthy statement comes from Justice Stevens, who offered an extended and more general comment on the legality of hastening death through medication at the patient's request:

> The illusory character of any differences in intent or causation is confirmed by the fact that the American Medical Association unequivocally endorses the practice of terminal sedation—the administration of sufficient dosages of pain-killing medication to terminally ill patients to protect them from excruciating pain *even when it is clear that the time of death will be advanced*. The purpose of terminal sedation is to ease the suffering of the patient and comply with their wishes, and the actual cause of death is the administration of heavy

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337. Pain Relief Promotion Act of 2000, H.R.2260, 106th Cong. (2000), https://www.congress.gov/bill/106th-congress/house-bill/2260 [https://perma.cc/KET6-VSTN].

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

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

340. Vacco, 521 U.S. at 737-38 (O'Connor, J., concurring) (emphasis added).

341. *Id.* at 780 (Souter, J., concurring) (emphasis added).

> doses of lethal sedatives. This *same intent and causation may exist when a doctor complies with a patient's request for lethal medication to hasten her death*.[342]

In *Vacco*, the Supreme Court recognized a difference between medical aid in dying and terminal sedation. Justice Rehnquist, delivering the opinion for the Court, held that:

> 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*.[343]

The permissibility of Type 3 terminal sedation necessarily entails the permissibility of Types 1 and 2 of this treatment.

In the United States of America, the Assisted Suicide Funding Restriction Act of 1997 prohibits federal funding for "items and services (including assistance) the purpose of which is to cause (or assist in causing) the suicide, euthanasia, or mercy killing of any individual."[344] Under applicable federal regulations, while "assisted suicide" is excluded from Medicare coverage, "[t]his 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."[345] Therefore, PSs̄ANH is exempted from the restrictions imposed on medical aid in dying (assisted suicide).

State Law on PSs̄ANH

All states have enacted statutes that govern living wills, health care proxies, and rights of terminally ill patients.[346] Many of these statutes contain provisions that could apply to terminal sedation. For example, the Oklahoma Advance Directive Act (the "Oklahoma Act") provides, in relevant part, that:

> Even if life-sustaining treatment or artificial administration of nutrition and hydration are withheld or withdrawn, the patient shall be provided with medication or other medical treatment to alleviate pain and will be

342. *Id.* at 751 (Stevens, J., concurring) (emphasis added).
343. *Id.* at 807 n.11 (emphasis added) (internal references omitted).
344. 42 U.S.C. §§ 14401–14407.
345. 42 C.F.R. § 411.15(q) (2023).
346. *See generally* AMERICAN BAR ASS'N COMM'N ON LAW AND AGING, *Health Care Decision-Making, AMERICAN BAR* (Nov. 8, 2023), https://www.americanbar.org/groups/law_aging/resources/health_care_decision_making/ [https://perma.cc/7BJG-VTRB] (collecting citations).

> provided with oral consumption of food and water.[347]

Importantly, the Oklahoma Act goes on to provide that:

> Death resulting from the withholding or withdrawal of life-sustaining treatment in accordance with the Oklahoma Advance Directive Act shall not constitute, for any purpose, a suicide or homicide.[348]

Washington enacted a similar rule with the Washington Natural Death Act, which provides that:

> [P]hysicians and nurses should not withhold or unreasonably diminish pain medication for patients in a terminal condition where the primary intent of providing such medication is to alleviate pain and maintain or increase the patient's comfort.[349]

In Montana, the relevant statute provides that the attending physician has a "responsibility . . . to provide treatment, including nutrition and hydration, for a patient's comfort care or alleviation of pain."[350]

These statutes are based either on the Uniform Rights of Terminally Ill Act (the "URTIA") or the Uniform Health Care Decisions Act (the "UHCDA"). The URTIA provides that "[d]eath resulting from the withholding or withdrawal of life-sustaining treatment in accordance with this [URTIA] does not constitute, for any purpose, a suicide or homicide."[351] The UHCDA contains provisions that are particularly relevant to terminal sedation.[352] This can be seen, for example, in the Maine Uniform Healthcare Decisions Act, which requires that "treatment for alleviation of pain or discomfort be provided at all times, *even if it hastens my death*."[353]

In addition to the state statutes governing withdrawal and withholding of lifesaving/life-sustaining medical treatment, at least one statute that legalizes medical assistance in dying also mentions palliative sedation. The Vermont Patient Choice at End of Life Act provides that statutory constraints on medical aid in dying "shall not limit or otherwise affect the provision, administration, or receipt of palliative sedation consistent with accepted medical standards."[354]

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347. OKLA. STAT. ANN. tit. 63, § 3101.8(B).

348. *Id.* at. § 3101.12(A).

349. WASH. REV. CODE ANN. § 70.122.010.

350. *Accord* MONT. CODE ANN. § 50-9-202(2).

351. NAT'L CONF. OF COMMISSIONERS ON UNIF. STATE LAWS, UNIFORM RIGHTS OF THE TERMINALLY ILL ACT (1989) § 11(A).

352. NAT'L CONF. OF COMMISSIONERS ON UNIF. STATE LAWS, UNIFORM HEALTH CARE DECISIONS ACT (2023).

353. ME. REV. STAT. tit. 18-C, § 5-805 (emphasis added).

354. VT. STAT. ANN. tit. 18, § 5288 (2023). *See also* R.I. S.B. 2093 (2024) (section 23-4.15-8 of proposed bill providing that the preexisting practice of palliative sedation should not be affected by the legalization and regulation of medical aid in dying).

In addition to the statutes mentioned above, several statutes specifically regulate the practice of pain management and therefore could be applicable to terminal sedation. For example, a Michigan statute provides:

> [T]he use of controlled substances is appropriate in the medical treatment of certain forms of pain, and that efforts to control diversion or improper administration of controlled substances should not interfere with the legitimate, medically recognized use of those controlled substances to relieve pain and suffering.[355]

In 2023, Arkansas enacted a similar statute—the Chronic Intractable Pain Treatment Act (the "Arkansas Act"). The Arkansas Act defines "chronic intractable pain" as "a pain state for which the cause of the pain cannot be removed or otherwise treated and for which no relief or cure has been found after reasonable efforts by a physician."[356] The Arkansas Act further provides that "[a] physician shall not be subject to disciplinary action by the Arkansas State Medical Board solely for prescribing dangerous or controlled drugs for the relief of chronic intractable pain."[357] It further specifies that "[n]o physician shall be subject to criminal prosecution for prescribing or administering controlled substances under appropriate criteria in the course of treatment of a person for chronic intractable pain."[358]

State Law on Medical Aid in Dying

More than a dozen cases have considered the constitutionality of MAID prohibitions under state constitutions in California, Massachusetts, Montana, New Mexico, New York, Tennessee, and elsewhere.[359] In these cases, parties have assumed that terminal sedation is permissible. So, they focused their legal arguments on the similarities and differences between termination sedation and MAID. However, any discussion of the permissibility of terminal sedation is technically *obiter dicta* because the cases focused on the permissibility of MAID. For example, in *Morris v. Brandenburg*, the New Mexico Supreme Court held:

> The Pain Relief Act protects physicians who prescribe medication for purposes of pain relief under accepted standards of practice, even in situations where the patient's death may be hastened by the treatment . . . *[a]ccordingly, doctors may provide palliative sedation, also called*

355. MICH. COMP. LAWS ANN. § 333.16204(c)(1).
356. ARK. CODE ANN. § 17-95-703 (2024).
357. ARK. CODE ANN. § 17-95-704(a)(1) (2024).
358. ARK. CODE ANN. § 17-95-707 (2024).
359. *See* Thaddeus M. Pope, *Legal History of Medical Aid in Dying: Physician Assisted Death in U.S. Courts and Legislatures*, 48 N.M. L. REV. 267 (2018).

"terminal sedation," a practice that can hasten the patient's death.[360]

Experts at trial described the "double effect" of this practice of terminal sedation:

> Although the physician's "primary intent"—or more accurately, motive—is to eliminate pain, the physician "inevitably know[s]" that administering such high doses of consciousness-lowering medications—at times, tens or even hundreds of times the normal dosage—will lead, in close proximity, to the patient's death.[361]

In short, palliative sedation is an accepted medical practice and is permitted in New Mexico.[362] The Bernalillo County District Court's judgment in the same case provides that "palliative sedation . . . is accepted in law and medicine", even though "it is recognized and accepted that . . . palliative sedation *hastens the inevitable death of the terminally ill patient*."[363]

The New Mexico Court of Appeals affirmed that PSs̄ANH is permissible even where a physician knows that palliative sedation will shorten the patient's life (thus constituting a Type 3 PSs̄ANH situation).[364] Arguably, however, it is questionable whether this accurately reflects the state of the law (both now, and at the time that the judgment in *Morris v. Brandenburg* was handed down), given the provisions of the New Mexico Pain Relief Act (the "New Mexico Act"). On one hand, the New Mexico Act (in its original form) opens the possibility that "[a] health care provider who prescribes, dispenses or administers medical treatment for the purpose of relieving pain" may not be criminally liable.[365] On the other hand, amendments introduced to the New Mexico Act in 2012, exclude from the definition of "chronic pain" pain "associated with a terminal condition or a progressive disease that, in the normal course of progression, may reasonably be expected to result in a terminal condition."[366]

New Mexico is not the only state to address these matters. The New York Court of Appeals tacked the issue in *Myers v. Schneiderman*.[367] In her concurring judgment, Judge Rivera noted, *obiter*, that "[t]erminal sedation is . . . a slow-acting lethal process . . . that hastens the inevitable death of the

360. Morris v. Brandenburg, 376 P.3d 836, 840 (N.M. 2016) (emphasis added).

361. Morris v. Brandenburg, 356 P.3d 564, 568–69 (N.M. Ct. App. 2015).

362. *See generally* N.M. STAT. ANN. §§ 24–2D–1 to –6; N.M. Code R. § 16.12.1.7(S)(1)(iii) (2024) (defining "palliative sedation" as "the monitored use of medications at end of life intended to provide relief of intolerable and refractory symptoms but not to intentionally hasten death").

363. Morris v. Brandenburg, No. D-202-CV 2012-02909, (Bernalillo County Dist. Ct., N.M. Jan. 13, 2014) (emphasis added).

364. Morris v. Brandenburg, 376 P.3d 836, 857 (N.M. 2016).

365. N.M. STAT. ANN. § 24-2D-3(A).

366. N.M. STAT. ANN. § 24-2D-2.

367. Myers v. Schneiderman, 85 N.E.3d 57 (N.Y. 2017).

patient."[368] Nevertheless, Judge Rivera also accepted that the State of New York "recognizes [terminal sedation] as a lawful means to end life," where this is necessary "as an intervention of last resort" to manage refractory pain.[369]

Guidance from other states is less clear. For example, in *Sampson v. State*,[370] the Supreme Court of Alaska reserved opinion on whether palliative sedation fell within Alaska's ban on assisted suicide.[371] And in *Kligler v. Healey*, the Massachusetts Superior Court differentiated palliative sedation from MAID on the grounds that palliative sedation does not necessarily cause death or involve an intention to cause death.[372] The Massachusetts Supreme Judicial Court specifically observed that "competent adults who are terminally ill may elect . . . to pursue palliative sedation."[373]

In short, every state has one or more statutes authorizing living wills, durable powers of attorney for healthcare, or combined advance directives. Many of these statutes and the forms developed pursuant thereto specifically offer patients the choice of "relief from pain" and permit patients to direct "treatment to alleviate pain or discomfort . . . *even if it hastens* my death."[374] Indeed, states that have authorized medical aid in dying are careful to specify that those restrictive rules "shall not limit or otherwise affect the provision, administration, or receipt of palliative sedation."[375]

In 2022, an Ohio jury acquitted a physician accused of murdering fourteen critically ill patients with opioid overdoses. While William Husel prescribed extraordinarily high doses of fentanyl, he successfully argued that he was a caring and compassionate physician who ordered the drugs to relieve the patients' pain and discomfort during the extubation process. The prosecution was unable to prove beyond a reasonable doubt both (1) that Husel intended to kill his patients and (2) that the drugs Husel ordered are what directly caused these critically ill patients to die.[376]

Informed Consent and Medical Malpractice

In addition to laws on end-of-life decision making, statutes and case law on informed consent and medical malpractice address palliative sedation. In one case, a family sued one of the largest hospice companies in the United States of

368. *Id.* at 74.

369. *Id.* at 72.

370. Sampson v. State, 31 P.3d 88 (Alaska 2001).

371. *Id.* at 99 n.75.

372. Kligler v. Healey, No. SUCV201603254F, 2020 WL 736968, at *11 (Mass. Super. Ct. Jan. 14, 2020), 36 Mass. L. Rptr. 166.

373. Kligler v. Attorney General, 491 Mass. 38, 198 N.E.3d 1229 (2022).

374. *See, e.g.*, HAW. REV. STAT. § 327E-16 (emphasis added). *See also* Frederick R. Parker Jr., *Palliative Sedation and the Louisiana Natural Death Act*, 79 LA. L. REV. 1103, 1109 (2019).

375. 18 VT. STAT. ANN. § 5288.

376. Husel v. Trinity Health Corp., No. 2:24-cv-11060-JJCG-DRG (E.D. Mich. April 22, 2024) (complaint).

America for not advising them about the option of terminal sedation.[377] The case was settled in 2014. Like California, several other states also have specialized informed consent statutes.[378] It is generally accepted that clinicians have a duty to inform patients about their right to terminal sedation.[379]

Professional Society Guidelines

In terms of non-binding soft law, several professional associations have issued statements on terminal sedation.[380] Notably, however, the case law and the guidelines do not always agree. As discussed above, the case law generally provides that Type 3 PSs̄ANH is permissible so long as the physician administering the palliative care does not, consistent with the doctrine of double effect, intend to cause the patient's death (even if the hastening of death is a certain consequence of the physician's conduct).[381] The guidelines, by contrast, often restrict PSs̄ANH to cases where the patient is close to the end of their life.[382] This would seem to largely restrict PSs̄ANH to Types 1 and 2 situations, where palliative care without artificial nutrition and hydration will not or may not hasten death.[383]

Several guidelines are worth considering in greater detail. The American Medical Association's Code of Medical Ethics Opinion 5.6: Sedation to Unconsciousness in End-of-Life Care (the "AMA Opinion) emphasizes the importance of PSs̄ANH:

> When a terminally ill patient experiences severe pain or other distressing clinical symptoms that do not respond to aggressive, symptom-specific palliation it can be appropriate to offer sedation to unconsciousness as an intervention of last resort.[384]

But the AMA Opinion also offers several cautions and qualifications:

> Sedation to unconsciousness must never be used to intentionally cause

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377. Hargett v. Vitas Healthcare Corporation, No. RG10547255 (Alameda Cty. Sup. Ct., Cal. filed 2010).

378. *See. e.g.*, N.Y. PUB. HEALTH L. § 2997-C.

379. Jun Hamano et al., *Talking about Palliative Sedation with the Family: Informed Consent vs. Assent and a Better Framework for Explaining Potential Risks*, 56 J. PAIN & SYMPTOM MGMT. Issue 3, e5 (2018).

380. *See* Gurschick et al., *supra* note 9 (but noting variability in matters such as time to death).

381. *See supra* section IV.C.5.a. (subsections on Federal Law on PSs̄ANH and State Law on PSs̄ANH).

382. *See* AMA, *infra* note 384 & AAHPM, *infra* note 386.

383. *See supra* section II.C.5.a.

384. American Medical Association, *Code of Medical Ethics Opinion 5.6: Sedation to Unconsciousness in End-of-Life Care*, https://www.ama-assn.org/delivering-care/ethics/sedation-unconsciousness-end-life-care [https://perma.cc/5FQW-JTDJ].

> a patient's death. When considering whether to offer palliative sedation to unconsciousness, physicians should: Restrict palliative sedation to unconsciousness to patients in the final stages of terminal illness.[385]

The American Academy of Hospice and Palliative Medicine (the "AAHPM") sets out four specific conditions for the permissibility of PSs̄ANH:

> Palliative sedation (PS), as defined in this statement, is the intentional lowering of awareness towards, and including, unconsciousness for patients with severe and refractory symptoms. . . Palliative sedation is ethically defensible when used 1) after careful interdisciplinary evaluation and treatment of the patient, and 2) when palliative treatments that are not intended to affect consciousness have failed or, in the judgment of the clinician, are very likely to fail, 3) where its use is not expected to shorten the patient's time to death, and 4) only for the actual or expected duration of symptoms.[386]

The AAHPM's Statement on Palliative Sedation also offers additional cautions and qualifications:

> In clinical practice, palliative sedation usually does not alter the timing or mechanism of a patient's death, as refractory symptoms are most often associated with very advanced terminal illness. Practitioners who use palliative sedation should be clear in their intent to palliate symptoms and to not shorten survival. Because patients receiving palliative sedation are typically close to death, most patients will no longer have desire to eat or drink. Artificial nutrition and hydration are not generally expected to benefit the patient receiving palliative sedation, however questions about the use of artificial nutrition and hydration should be addressed before palliative sedation is undertaken.[387]

Like the AAHPM, the National Hospice and Palliative Care Organization (the "NHPCO") sets out several specific conditions that must be met before PSs̄ANH is acceptable:

> Palliative sedation is the lowering of patient consciousness using medications for the express purpose of limiting patient awareness of suffering that is intractable and intolerable. For the limited number of imminently dying patients who have pain and suffering that is (a)

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385. *Id.*

386. American Academy of Hospice & Palliative Medicine (AAHPM), *Advocacy, Where We Stand, Statement on Palliative Sedation*, https://aahpm.org/advocacy/where-we-stand/palliative-sedation/ [https://perma.cc/6F53-ET3J] (last visited on Nov. 12, 2024).

387. *Id.*

> unresponsive to other palliative interventions less suppressive of consciousness and (b) intolerable to the patient, NHPCO believes that palliative sedation is an important option to be considered by health care providers, patients, and families.[388]

The NHPCO's Position Statement and Commentary on the Use of Palliative Sedation in Imminently Dying Terminally Ill Patients further provides:

> 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.[389]

In addition to national society guidelines, state guidelines have expressed similar views on the permissibility of PSs̄ANH. The Hospice & Palliative Care Federation of Massachusetts (the "Massachusetts HPCF"), for example, provides:

> Palliative Sedation is the monitored use of medications (sedatives, barbiturates, neuroleptics, hypnotics, benzodiazepines or anesthetic medication) to relieve refractory and unendurable physical, spiritual, and/or psychosocial distress for patients with a terminal diagnosis, by inducing varied degrees of unconsciousness. The purpose of the medication(s) is to provide comfort and relieve suffering and not to hasten death.[390]

Like the national guidelines, the Massachusetts HPCF includes cautions and qualifications in its Palliative Sedation Protocol:

> Assumptions regarding appropriateness of palliative sedation. . . 2. Generally, the patient's prognosis is hours to days. The intent of palliative sedation is control of suffering, not to hasten death. . . 11. Hospice providers will discuss the provision of hydration and nutrition as a separate intervention with the patient and family.[391]

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388. Timothy W. Kirk et al., *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 (2010).

389. *Id.*

390. Hospice & Palliative Care Federation of Massachusetts, *Palliative Sedation Protocol: A Report of the Standards and Best Practices Committee* (Apr. 2004), https://www.hospicefed.org/page/bestpractices [https://perma.cc/7M8C-924D].

391. *Id.*

In addition to the guidelines discussed above, there are national policies from the Veterans Health Administration (the largest healthcare system in the United States of America), the American College of Physicians, the American Association of Nurse Anesthesiology, the National Comprehensive Cancer Network, the Hospice and Palliative Nurses Association, and the American Thoracic Society.[392] There are many more at the regional level, such as from the North Carolina Board of Nursing.[393]

In conclusion, all three types of PSs̄ANH are generally legal in the United States of America. They key requirement is that the intent of the medical professional administering PSs̄ANH is not to hasten death, but rather to alleviate the patient's suffering.[394] In this way, causation is less central to the legality of PSs̄ANH. A medical professional may be fully aware that terminal sedation will hasten/cause the patient's death. But if this is not the intended result, then administering terminal sedation is generally not illegal. In any case, a Type 1 scenario does not hasten death and with respect to a Type 2 scenario, it would be very difficult to prove causation beyond a reasonable doubt.

Protocols for administering terminal sedation (and pain management generally) appear to rely on the guidelines issued by professional associations. At the same time, some states have instituted committees that review pain management practices, which conceivably include terminal sedation. A helpful example can be found in the Arkansas Act.[395] It creates the Pain Management Review Committee, appointed by the Arkansas State Medical Board.[396] Pursuant to the Arkansas Act, this committee "shall . . . [r]eview complaints on an individual patient-needs basis regarding physicians treating chronic intractable pain in violation of this subchapter."[397]

b. PSs̄ANH and analogous practices in the United States of America

Type 1 PSs̄ANH is analogous to standard pain management protocols.[398] Accordingly, it does not raise distinct ethical or legal concerns. There is no clear analogous procedure for Type 2 PSs̄ANH. If one accepts the intent-based

392. Alexander de Graeff & Mervyn Dean**,** *Palliative Sedation Therapy in the Last Weeks of Life: A Literature Review and Recommendations for Standards*, 10 J. PALLIATIVE MED. 67 (2007).

393. North Carolina Board of Nursing, *Palliative Sedation for End-Of-Life Care: Position Statement for RN and LPN Practice* (Sept. 2022), https://www.ncbon.com/sites/default/files/documents/2024-03/ps-palliative-sedation-for-end-of-life-care.pdf [https://perma.cc/HG6H-3Y4E].

394. *See supra* section IV.C.5.a.

395. ARK. CODE ANN. § 17-95-705(a) & (c).

396. *Id*.

397. *Id*.; *See also* the statements by professional medical associations discussed above on the steps medical professionals need to undertake when administering terminal sedation. *See generally*, David A. Gruenewald & Gregg Vandekieft, *Options of Last Resort: Palliative Sedation, Physician Aid in Dying, and Voluntary Cessation of Eating and Drinking*, 104 MED. CLINICS N. AM. 539, 541-44 (2020) (discussing clinical practice guidelines regarding the administration of terminal sedation).

398. *See supra* section II.

distinction between terminal sedation and voluntary active euthanasia (alleviating suffering versus causing death), then terminal sedation is different from voluntary active euthanasia. However, as the patient's death becomes more causally proximate to a doctor's act, the doctor's intent becomes less and less relevant.[399] In other words, in a situation where a doctor, who knows that withdrawal and withholding of artificial nutrition and hydration is guaranteed to cause the sedated patient's death, the doctor's intent only to alleviate the suffering and not to cause death is irrelevant, at least for purposes of ethical analysis. In the literature, Type 3 PSs̄ANH and voluntary active euthanasia have generally been equated.[400]

c. Medical practice of PSs̄ANH in the United States of America

There is limited data on the administration of palliative sedation in the United States of America.[401] But available evidence suggests that use is highly variable.[402]

D. The European Supranational Dimension

Seven of the twelve examined jurisdictions are in Europe (Belgium, England & Wales, France, Germany, Ireland, Netherlands, and Switzerland). While we have assessed the legal status of PSs̄ANH within each of these jurisdictions above, analysis of the legal status of PSs̄ANH in Europe must consider the case law of the European Court of Human Rights (the "ECtHR"), applying the European Convention on Human Rights (the "ECHR").

Much of this case law involves balancing Article 2 ECHR (the right to life) and Article 8 ECHR (the right to respect for private and family life, home, and

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399. *See, e.g.*, David Orentlicher, *The Supreme Court and Physician-Assisted Suicide: Rejecting Assisted Suicide but Embracing Euthanasia*, 337 NEW ENG. J. MED. 1236 (1997); Robert Burt, *The Supreme Court Speaks: Not Assisted Suicide but a Constitutional Right to Palliative Care*, 337 NEW ENG. J. MED. 1234 (1997).

400. *See, e.g.*, David Orentlicher, *The Supreme Court, and Terminal Sedation: Rejecting Assisted Suicide, Embracing Euthanasia*, 24 HASTINGS CONST. L.Q. 947, 956 (1997) ("In many cases, terminal sedation amounts to euthanasia because the sedated patient often dies from the combination of two intentional acts by the physician—the induction of stupor or unconsciousness and the withholding of food and water. Without these two acts, the patient would live longer before eventually succumbing to illness. In other words, if the sedation step and the withholding of nutrition and hydration step are viewed as a total package, we have a situation in which a patient's life is ended by the active intervention of a physician.").

401. *See* Nathan Cherney, *Palliative Sedation*, UPTODATE (2022) (Table 1). The Hemlock Society of San Diego, an American right-to-die and assisted suicide advocacy non-profit organization, raised awareness for terminal sedation by holding a public meeting on September 18, 2022, titled *Terminal Sedation: A Better Way to Care for the Dying?* The email invitation included the following statement that the meeting would be informative for "caregivers and all who desire a peaceful death, particularly when medical aid in dying is not an option."

402. Andrea Cuviello et al., *Palliative Sedation Therapy Practice Comparison – A Survey of Pediatric Palliative Care and Pain Management Specialists*, 40 AM. J. HOSPICE & PALLIATIVE MED. 977 (2023).

correspondence).[403] In this respect, the Council of Europe's Member States are given a wide margin of appreciation, due to the lack of "consensus exist[ing] among the . . . member states", as highlighted in *Lambert v. France*.[404]

Whether the ECHR Prohibits PSs̄ANH. A Member State permitting Type 1 PSs̄ANH likely does not violate the ECHR, as it cannot constitute a "deprivation of life." It does not shorten the patient's lifespan. Similarly, it is likely that permitting Types 2 and 3 PSs̄ANH does not contravene the ECHR. The ECtHR emphasized in *Haas v. Switzerland* "the individual's right to decide" when and how to end his or their life.[405] This language references a "right," rather than a "choice," as had previously been the case, in decisions such as *Pretty v. UK*.[406] This appears to reflect an increase in the weight the ECtHR gives to the personal autonomy of patients, and, in turn, to the importance of Article 8 ECHR.[407]

Whether the ECHR Prohibits a Ban on PSs̄ANH. The ECtHR's case law suggests that any national ban on Type 3 PSs̄ANH would not necessarily be prohibited by the ECHR.[408] This is evident from the ECtHR's repeated emphasis on Member States' margin of appreciation.[409] It is also evident from the status of Article 2 ECHR as "one of the most fundamental provisions in the Convention."[410] This phrase is reiterated throughout *Lambert*.[411] Conversely, it remains to be seen whether a national ban on either Type 1 or Type 2 PSs̄ANH would contravene the ECHR. It is difficult to draw any conclusions from cases such as *Pretty*, *Haas*, or *Lambert*, given that these judgments touch upon situations where the patient's life expectancy will inevitably be shortened by the procedures in question, and which are therefore more analogous to Type 3 PSs̄ANH.

E. Summary Table

We can summarize the status of PSs̄ANH in the twelve jurisdictions.[412]

403. *See* ECHR Press Unit, *End of Life and the European Convention on Human Rights* (June 2024), *https://www.echr.coe.int/documents/d/echr/fs_euthanasia_eng* [https://perma.cc/C986-Z84Z].

404. Lambert v. France, App. No. 46043/14, ¶ 72 (25 Jun. 2015), https://hudoc.echr.coe.int/eng#{%22itemid%22:[%22001-155352%22]} [https://perma.cc/7CAQ-YEG6].

405. Haas v. Switzerland, 53 E.H.R.R. 33 (2011).

406. Pretty v. United Kingdom, 35 E.H.R.R. 1 (2002).

407. *See* Haas *supra* note 405.

408. *See Lambert*, *supra* note 404.

409. *See* Haas *supra* note 405.

410. *See Lambert*, *supra* note 404.

411. *Id.*

412. *See supra* sections IV.A, IV.B, and IV.C.

Jurisdiction	Type 1	Type 2	Type 3
Australia	Y	Y	Y
Belgium	Y	Y	Y/N
Canada	Y	Y	Y/N
Colombia	Y	Y	Y
England & Wales	Y	Y	Y/N
France	Y	Y	N
Germany	Y	Y	N
India	Y	Y	N
Ireland	Y	Y	N
Netherlands	Y	Y	Y
Switzerland	Y	Y	Y
United States of America	Y	Y	Y

V. THEMES FROM THE INTERNATIONAL REVIEW

Despite the diversity of jurisdictions that were surveyed, several common themes emerge.

Theme One: Type 1 and Type 2 PSs̄ANH. Types 1 and 2 PSs̄ANH are or are likely legally permissible in all the jurisdictions.

Theme Two: Type 3 PSs̄ANH and Analogous Practices. The fact that there were jurisdictions in each category (restrictive, moderate, permissive) reflects the wide variety of legal positions taken regarding Type 3 PSs̄ANH. One strong indication as to the legality (or lack thereof) of a given type of PSs̄ANH is often provided by the legality of practices viewed as analogous to that type.[413]

For instance, in Australia, Colombia, the Netherlands, and Switzerland,

413. *Cf.* Gurschick et al., *supra* note 9 ("Physicians in the Netherlands and Switzerland are more likely to discuss nontreatment options with patients at the end of life than physicians in Italy, Belgium, Denmark, and Sweden.").

Type 3 PSāANH is perceived as a form of euthanasia.[414] Generally, because euthanasia is legally permissible in those jurisdictions, so is Type 3 PSāANH. But in Belgium, Type 3 PSāANH is not seen as being equivalent, or even analogous, to euthanasia. So, while euthanasia is permissible, the legality of Type 3 PSāANH remains unclear.[415] In Ireland, Type 3 PSāANH is seen as broadly analogous to assisted suicide. Because assisted suicide is not permissible in Ireland, neither is Type 3 PSāANH.[416]

However, in certain jurisdictions, there is incoherence between, on the one hand, the legality of certain types of PSāANH, and, on the other hand, their respective analogous practices (arising from a potential situation whereby one is legally permissible, whilst the other is not). For example, if Type 3 PSāANH could be lawful in England & Wales, this might raise questions about the consistency of the underlying legal system, given that euthanasia is currently subject to a mandatory life sentence. The same could arguably be said for Canada, where MAID is permissible, yet doubts remain regarding the legality of Type 3 PSāANH.

We caution the reader to remember that any analysis of the respective stances taken by the jurisdictions towards PSāANH may have produced different results if overlaid with a first principles analysis of corresponding criminal law. But, for the most part, we have not sought to delve into first principles criminal law analysis.

Moreover, our findings should be overlaid with the relevance of the European supranational dimension to several of the jurisdictions evaluated in this Article (*i.e.*, France, Germany, Ireland, Belgium, England & Wales, Switzerland, and the Netherlands), due to the importance of considering the boundaries within which European countries' freedom to regulate PSāANH are constrained.

Theme Three: Intention vs. Foresight. The legality of PSāANH is linked to a distinction between intention and foresight. This is especially true regarding the legality of Type 3 PSāANH (the legality of Types 1 and 2 PSāANH generally being less controversial). A study of palliative care practitioners shows that the intention-foresight distinction matters.[417] While the three types of PSāANH referred into in this Article are differentiated based on causation of the hastening of death (and, connectedly, the patient's prognosis), the following analysis demonstrates that we could have categorized PSāANH depending on the intention of the health practitioner tasked with carrying out PSāANH:

(1) France uses the double effect doctrine. But Type 3 PSāANH is nonetheless not permitted. This is because of other limitations in French law (particularly the requirement that "the [patient's] vital prognostic is

414. *See supra* sections IV.C.1, IV.C.2, IV.C.3 and IV.C.4.

415. *See supra* section IV.B.1.

416. *See supra* section IV.A.4.

417. C.D. Douglas et al., *Narratives of 'Terminal Sedation' and the Importance of the Intention-Foresight Distinction in Palliative Care Practice*, 27 BIOETHICS 1 (2013).

engaged in the short term").[418]

(2) Germany also uses a doctrine like double effect. This appears in Section 216 of its Criminal Code. But Germany is a restrictive jurisdiction where there is no support for the legality of Type 3 PSs̄ANH.[419]
(3) Australia, Switzerland, and the United States of America use the double effect doctrine. Consequently, Type 3 PSs̄ANH is probably permissible when there is no intention to cause death.[420] This contrasts with Germany where the double effect doctrine may be applied in practice such that foreseen consequences of actions are equated with intention.[421]
(4) In Colombia, which is a permissive jurisdiction, Type 3 PSs̄ANH is recognized as a practice that aims to hasten death. Accordingly, there is no reliance on the doctrine of double effect in this jurisdiction.[422] The double effect doctrine appears to have a similar lack of effect in the Netherlands (another permissive jurisdiction). There, Type 3 PSs̄ANH appears interchangeable with the concept of euthanasia in the jurisdiction.[423]
(5) Belgium and Canada also appear to reject the double effect doctrine. Therefore, the permissibility of Type 3 PSs̄ANH in those jurisdictions does not appear to rely on the double effect doctrine.[424]

Theme Four: Intra-jurisdictional Variation. In some jurisdictions, an analysis of the legal status of PSs̄ANH requires an understanding of the varying legal positions taken in various regions. For instance, an analysis of the law on PSs̄ANH in Canada requires an understanding of the interaction among: (1) the country's provincial authorities, which have jurisdiction over health law (*see, e.g.*, the Québec Act), (2) Canada's federal government, which has jurisdiction over criminal law, and (3) Canada's constitutional protections (*see, e.g.*, the *Rodriguez* and *Carter* judgments of the Supreme Court of Canada).[425]

Meanwhile, in the United States of America, there is a complex patchwork of legislation and case law touching upon PSs̄ANH at the state level.[426] While this was largely consistent, it differed at the margins, as was evident from the potential lack of coherence between New Mexico's Pain Relief Act and the case of *Morris v. Brandenburg*.[427] This complexity is exacerbated by federal case law—namely Supreme Court cases (including *Washington v. Glucksberg* and

418. *See supra* section IV.A.1.
419. *See supra* section IV.A.2.
420. *See supra* sections IV.C.1, IV.C.4, and IV.C.5.
421. See *supra* section IV.A.2.
422. See *supra* section IV.C.2.
423. See *supra* section IV.C.3.
424. See *supra* sections IV.B.1 and IV.B.2.
425. *See supra* section IV.B.2.
426. *See supra* section IV.C.5.
427. *Id.*

Vacco v. Quill)—exploring constitutional rights.[428]

Furthermore, in Australia, there are important divergences amongst the country's states and territories, created by a mixture of legislation on health law and criminal law. For instance—crucially for the analysis of Type 3 PSs̄ANH—Queensland, South Australia, and Western Australia (but, seemingly, no other states) specifically exclude palliative care from criminal liability.[429] At the same time, the Australian Capital Territory and Victoria have legislated for a general right to palliative care, without any explicit reference to criminal liability.[430]

Theme Five: Under-researched. The legality of all three types of PSs̄ANH, especially Type 3 PSs̄ANH, has historically been under-researched in most of the jurisdictions. Consequently, the permissibility of PSs̄ANH in these jurisdictions remains largely unclear. This is illustrated by the state of the law in Ireland as regards Type 3 PSs̄ANH. Not only is there no legislation directly touching upon Type 3, but moreover, there is no case law specific to Type 3 (or, for that matter, any type of PSs̄ANH). To analyze Type 3 PSs̄ANH, we need to reason by analogy (and not a particularly strong analogy) through linking PSs̄ANH with assisted suicide via the case of *Fleming v. Ireland*.[431]

Theme Six: Palliative Sedation vs. Artificial Nutrition and Hydration. Palliative sedation may—by itself—be clearly legally permissible in a particular jurisdiction, whilst refusing artificial nutrition and hydration remains similarly permissible in that jurisdiction, yet when the two practices combine to form PSs̄ANH, the legal position is less clear. It is often the case that the guidelines on palliative sedation consider sedation in isolation from the circumstances in which artificial nutrition or hydration can or should be withdrawn or withheld.[432]

Theme Seven: Act vs. Omission. In some instances, a legal dichotomy between acts and omissions is relevant to the legality of PSs̄ANH. For example, in India, the legality of Type 3 PSs̄ANH seems to turn on whether it is characterized as a positive act in much the same way as a lethal injection—at least, this is indicated in the Supreme Court's judgment in *Common Cause v. Union of India*.[433] The distinction between acts and omissions appears to be similarly relevant in Switzerland. Here, the law draws a dichotomy between the omission of the provision of artificial nutrition and hydration (something which capable patients can demand) and the supply of positive state services in the form of deep and continuous palliative sedation (which capable patients cannot demand).[434]

Theme Eight: Constitutional Rights. A distinction can also be drawn between jurisdictions where there is a constitutional right to end-of-life

428. *Id*.

429. *See supra* section IV.C.1.

430. *Id*.

431. *See supra* section IV.A.4.

432. *See, e.g.*, BC Centre for Palliative Care, *supra* note 191 (Canadian context); Dean et al., *supra* note 191 (Canadian context).

433. *See supra* note 121.

434. *See supra* section IV.C.4.

practices, which could encapsulate PSs̄ANH, and jurisdictions without such a right. Both Canada and Colombia recognize a constitutional right to medical aid in dying. In Canada this was in the Supreme Court's decision in *Carter v. Canada (Attorney General)* and the ensuing set up of the MAID framework.[435] In Colombia the right to euthanasia was determined by the Constitutional Court in Judgment C-164/22.[436] Conversely, in Switzerland, the courts have characterized assisted suicide as a mere "freedom" which is legally permissible, but which citizens have no right to request assistance on from the state.[437]

Theme Nine: Medical Practice. We have little clinical data and information concerning the practical application of PSs̄ANH (as demonstrated by the comparatively brief nature of the responses to Part Three of our questionnaire). But there were some suggestions of divergences in how PSs̄ANH was being applied within jurisdictions.

Differences were often due to factors such as regional differences (as in France and Colombia), socioeconomic inequalities, resource limitations (as in France and Colombia), and differences between urban and rural areas. More information is needed to reach conclusive findings about most of our jurisdictions.

(1) In France, it appears that there are sometimes differences between the availability of PSs̄ANH in urban and rural areas, due to the occasional unavailability in rural regions of critical care beds required to offer sedation to all patients in need.[438] There are also suggestions that resource limitations have undermined the usefulness of France's Claeys–Leonetti Act on end-of-life care; whilst, in theory, the Claeys–Leonetti Act creates the possibility for patients to access PSs̄ANH at home (or, if applicable, at nursing homes for the elderly), this is often unfeasible in practice due to a lack of necessary funds.

(2) Limitations and inequalities in resources were similarly highlighted as a cause for concern in Colombia and India. In India nutrition and hydration are often withheld simply because patients from poorer socioeconomic backgrounds are unable to afford the costs of life-sustaining treatment. Meanwhile, in Colombia, the long travel distances required to access PSs̄ANH create difficulties for less well-off patients. This results from regional inequalities in the country, with the distribution of pain medications and palliative care services being concentrated disproportionately in large capitals, and therefore largely unavailable in Colombia's more rural departments.

In Canada, there is a divergence between the law in theory, and how it operates

435. *See supra* section IV.B.2.
436. *See supra* section IV.C.3.
437. *See supra* section IV.C.4.
438. *See supra* section IV.A.1.

in practice. While Type 3 PSāANH is possibly or arguably legally permissible, it does not seem to be perceived by physicians in the country as constituting an ethically appropriate standard of care.[439]

Theme Ten: Safeguards. In jurisdictions where Type 3 PSāANH is—or may be—legally permissible (*i.e.*, covering the range of permissive and moderate jurisdictions), but where the relevant regulatory framework is inchoate, there could be a situation where Type 3 PSāANH is allowed in the absence of the safeguards usually associated with euthanasia. This, in turn, could create a potential "back door" to euthanasia, accessible to patients who could not otherwise access euthanasia. It is surely not desirable that this be the case. In this respect, the state of the law on end-of-life practices in Belgium is relevant, especially given that euthanasia is permissible; the imprecise and unclear nature of the law on PSāANH presents an unfortunate opportunity to circumvent the requirements imposed by Belgian law on patients looking to access euthanasia.

Theme Eleven: Guidelines vs. Law. There is also a risk of physicians delegating their decision-making to guidelines produced by medical associations in the jurisdictions in which the physicians work, without adequately considering their position under the substantive "hard law" of the relevant jurisdiction.[440] In jurisdictions in which medical guidelines take a more liberal position than "hard law" on PSāANH, following guidance from medical associations is a defense to certain offenses, including negligence. However, it is usually not a defense to offenses such as homicide or assisted suicide. In jurisdictions where medical guidelines generally take a more conservative position on PSāANH than is the case throughout relevant "hard law," such guidelines may unduly hinder the practice of PSāANH (particularly Type 3 PSāANH). Health practitioners may adhere to the guidelines, when a more flexible approach to the guidelines would better facilitate the role of PSāANH as an alternative end-of-life practice.

Theme Twelve: Religion. The respective religious outlooks of jurisdictions were not a principal factor for the legality of PSāANH. For instance, France, Belgium, and Colombia all fall into different categories (restrictive, moderate, and permissive respectively), even though all three countries contain a relatively large number of Catholics.[441] It is also interesting to note that Germany and India both fall into the same category (restrictive jurisdictions), even though Germany is a relatively secular country whereas India is a relatively religious country.[442]

Theme Thirteen: Developing vs. Developed Countries. Similarly, there

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439. *See supra* section IV.B.2.

440. *See* Thaddeus M. Pope, *Physicians and Safe Harbor Legal Immunity*, 21 ANNALS HEALTH L. 121 (2012).

441. Catholic Hierarchy, *Statistics by Country by Catholic Population*, https://www.catholic-hierarchy.org/country/sc1.html [https://perma.cc/S7EP-PZ22].

442. Pew Research Center, *How Religious Commitment Varies by Country among People of All Ages*, https://www.pewresearch.org/religion/2018/06/13/how-religious-commitment-varies-by-country-among-people-of-all-ages/ [https://perma.cc/8NHH-569J].

appears to be no link between the category into which a jurisdiction falls, and its status as a developing or developed country according to the UN.[443] This is reflected by the Netherlands (a developed country) and Colombia (a developing country) are both permissive, whilst India (a developing country) and Ireland (a developed country) are both restrictive.

One also might have thought that a developing country like Colombia would have a relatively inchoate legal framework on end-of-life practices, due to the country's relative lack of resources. However, Colombia's framework is significantly more advanced than many more developed jurisdictions, including Ireland (where there is a lack of case law and legislation directly relevant to PSs̄ANH).

VI. CONCLUSION: FRAMEWORK FOR FUTURE WORK

In this Article, we have generally avoided asking the experts for a first-principles analysis of relevant criminal law. We instead asked for applicable legislation, case law, and guidance. Such analysis is inherently complex and is unlikely to substantially shed light on the legality of PSs̄ANH. A comprehensive example of this analysis in respect of Canada can be found in Downie and Liu's paper.[444]

We have focused on the question of "what *is* the law?" We have, through that process, been able to consolidate various themes. Future work can now be aimed at determining what *should be* the law. In determining this, one possible approach is to use analogy-based reasoning (see e.g., Downie and Liu's paper) on the basis that the legality of the three types of PSs̄ANH should reflect the legality of permissible or impermissible analogous practices in a specific jurisdiction.[445] In Downie and Liu's paper in the Canadian context, it was argued that:

(1) Type 1 PSs̄ANH, which (by definition) does not shorten life, clearly *should* be lawful. Type 1 PSs̄ANH is analogous to all sorts of routine medical procedures that do not shorten life and are clearly lawful.
(2) Type 2 PSs̄ANH *should* be lawful because it is analogous to the use of potentially life-shortening opioids and other pain medications which are clearly lawful.
(3) Type 3 PSs̄ANH *should* be lawful when all the eligibility criteria and

443. *World Economic Situation and Prospects (WESP)*, ECONOMIC ANALYSIS AND POLICY DIVISION (EAPD) OF THE DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS OF THE UNITED NATIONS SECRETARIAT (UN DESA), at 153-85 (2022), https://www.un.org/development/desa/dpad/wp-content/uploads/sites/45/WESP2022_ANNEX.pdf/ [https://perma.cc/5DLD-Q64A].

444. Downie & Liu, *supra* note 1.

445. Laura Gilbertson et al., *Expanded Terminal Sedation in End-of-Life Care*, 49 J. MED. ETHICS 252 (2023) (offering a similar reasoning-by-analogy approach in respect of assisted dying, and ultimately supporting the possibility of "expanded terminal sedation" where the patient has an estimated life expectancy of up to six months).

> procedural safeguards for access to MAID set out by the federal legislation are satisfied.[446] This is because Type 3 PSs̄ANH is arguably analogous to voluntary euthanasia and assisted suicide.

An analogy-based approach also has the advantage of emphasizing that conditions and safeguards are required for access to each type of PSs̄ANH (assuming the practice analogous to that type of PSs̄ANH is permissible in the first place). Applying the same conditions and safeguards as the analogous practice would be a good starting point. But policymakers should carefully consider whether modifications to these conditions and safeguards are appropriate. For example, the rules governing access to MAID typically require capacitated patient requests (not permitting the use of advance requests or substitute decision-makers).[447] Should these restrictions also apply to Type 3 PSs̄ANH?

There are certain challenges with an analogy-based approach. The strength of the analogies would be fundamental to the reasoning. Different experts (even in the same jurisdiction) may have different conceptions of what constitutes an analogous practice. And, ultimately, the analogy-based approach only says that each type of PSs̄ANH should be treated similarly to its analogous practice.[448] It does not tell us whether those analogous practices should be legal (*e.g.*, whether a jurisdiction should permit MAID).

Our Article has attempted to include perspectives not only from leading legal academics, but also from medical practitioners. Several of the legal experts that we approached said that they lacked sufficient information/background to address the medical/clinical section, while the medical experts we approached were not usually comfortable discussing the legal framework. This illustrates that there could be more cross-disciplinary training and interaction in the palliative care sphere, and perhaps in the whole field of health law.

Any future examination into the application of PSs̄ANH could be improved through using clinical data concerning factors such as age, race, and socioeconomic status. Such data was not generally available to our experts (with exceptions for certain jurisdictions).

The lack of clarity in respect of PSs̄ANH is highly prejudicial to patients and health practitioners alike. Patients who want to access the practice should not be denied it if analogous practices are legal. Health practitioners should not need to operate with the risk of serious legal liability (including criminal liability) overhanging them and hampering their ability to provide effective end-

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446. The eligibility criteria are enumerated in MAID Act § 3, amending Canadian Criminal Code § 241.2.

447. Thaddeus M. Pope, *Medical Aid in Dying: Key Variations among U.S. State Laws*, 14(1) J. HEALTH & LIFE SCIENCES L. 25 (2020).

448. *See* Lucchi et al., *supra* note 41 (showing some clinicians think PSs̄ANH is euthanasia).

of-life care. Lawmakers around the world should examine their existing laws on PSs̄ANH (if any), assess what they believe the laws should be, and enact laws to clearly reflect these positions.

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