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## **Palliative Sedation and Euthanasia**

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In May 2003 a young medical doctor who was during a weekend in charge in a medical hospital, is called by a nurse of the department of neurology to see a 77 years old patient who was suffering of a serious CVA (brain-infarct) and who was almost suffocating due to a high production of sputum and shortage of oxygen. In order to alleviate the suffering he decides to an intravenous ad-diction of 20 mg. Morphine and at a later stage an additional 5 mg. Dor-micum. Although he was aware that the medication might speed up the death of his patient, his main concern was to alleviate the suffering of the patient who was under a palliative care program and for whom a decision to abstain from further treatment had been taken. The aim of his treatment was pallia-tive sedation. Shortly after the treatment the patient died and the doctor filled out a registration form for a natural death.

The medical director of the hospital obviously disagreed with the treatment. He was of the opinion that the young medical doctor in fact pursued euthana-sia and informed the district public prosecutor. The prosecutor started a criminal investigation because the doctor had not complied with the rules and procedures prescribed for euthanasia as ruled in the 2001 Termination of Life Request and Assistance in Suicide (Review Procedures) Act. Because there was no previous explicit and serious request by the patient to perform a ter-mination of life and therefore the public prosecutor decided to prosecute the young doctor for murder. Additional to the criminal procedure a disciplinary procedure at the Regional Medical disciplinary Board against the doctor was started.

The discussion on the legal character of palliative sedation has been fuelled by a short observation of the Chairman of the Board of Prosecutors General in a monthly review for prosecutors called 'Opportuun'.

In the Netherlands the Dutch Board of Prosecutors General decides whether a doctor who has terminated someone's life without complying with the pro-cedures ruled in the 2001 Termination of life on Request and Assistance in Suicide (Review Procedures) Act, should be prosecuted. In his observation the Chairman of the Board wrote as follows:

'From a medical point of view it may be well founded to sedate someone who is unbearably suffering in order to lapse him into a coma. Under circum-stance it furthermore is acceptable to cease hydration and nutrition to some-one who is in coma. For doctors these are two kind of considerations. Juridi-cally, however, the situation is completely different. A doctor who brings someone in coma and who ceases the provision of food and liquid, might not have had the intention to terminate someone's life, but from a criminal law point of view there is, however, a relevant relation. If the death of the patient is a very probable cause of the performance of the doctor, criminal intention can be proved. For criminal intention its not required that the doctor intended the death of the patient.

It is absurd that a doctor who brings someone in a terminal coma, escapes a review under the 2001 Termination of life on Request and Assistance in Sui-

cide (Review Procedures) Act. Such cases are not notified and no review – by a regional review committee or the Board of Prosecutors General (PT) – takes place. What might happen is that the public prosecutor is informed directly, but this happens rather rarely. That is a problem. What way this problem will be solved – through criminal law or through a review by a review committee – is regardless. The point is that terminal sedation in its effects is equal to euthanasia. That is the reason why external control on the compliance with the criteria of due care – as expressed in the 2001 Act – shall be made possible'.<sup>1</sup>

The decision to prosecute the doctor and the opinion of the Chairman of the Board of Prosecutors General caused a lot of commotion in medical circles because palliative sedation was increasingly applied in recent years in the Netherlands and doctors were afraid that they might be prosecuted in cases of palliative sedation. That fear decreased when the Minister of Health declared that palliative sedation is to be considered as regular medical treatment and does not equal to euthanasia<sup>2</sup> and furthermore decreased by the decisions of the Courts and the Regional Medical disciplinary Board. In the criminal case the doctor was acquitted for murder both by the Court in first instance and by the Appeal Court.<sup>3</sup> The reason for the acquittal was that both Courts adopted the opinions expressed by a number of medical expert witnesses that in this case the treatment was a proper medical treatment for suffocating patients and therefore a proper palliative care.

In the disciplinary case the Regional Medical disciplinary Board<sup>4</sup> came to the conclusion that the doctor in his professional performance in this case had acted in conformity with medical insights, medical norms and standards and declared the complaint by the state medical inspector against the doctor inadmissible. Obviously both the public prosecutor and the state medical inspector were of the opinion that palliative sedation is a form of euthanasia and therefore falls under the legal regime of the 2001 Termination of Life on Request and Assistance in Suicide (Review Procedure) Act.

The discrepancy between the views of the Courts and the Regional Medical Disciplinary Board at the one side and the public prosecutor and the state medical inspector at the other side are basically caused by the fact that long time it has been not clear whether palliative sedation is a form of euthanasia or a means to alleviate the suffering of seriously ill patients. The reason that palliative sedation could be considered as a kind of euthanasia was caused by the lack of a clear definition of the phenomenon of palliative sedation and the fact that palliative sedation mainly takes place in the terminal phase of

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<sup>1</sup> J. de Wykerslooth, *Two gaps in the euthanasia regulation*, Opportuun, June 2005.

<sup>2</sup> Response on questions put by Members of Parliament 21 August 2003.

<sup>3</sup> District Court Breda, 10 November 2004, *Medisch Contact* 2004, pp. 1876-1878 and Court of Appeal 's-Hertogenbosch, 19 July 2005, *Medisch Contact* 2005, p. 1359.

<sup>4</sup> Decision 10 March 2005, *Medisch Contact* nr. 12, 25 March 2005, pp. 499-501.

someone's life. Palliative sedation is also called sedation in the terminal phase, sedation in the end of life-care or terminal sedation and belong, like euthanasia, to the spectrum of medical decisions concerning the end of life.

Palliative sedation happens rather frequently, as is shown in a recent evaluation research on the review procedure in cases of euthanasia.<sup>5</sup> This was the first study in which estimated figures on palliative sedation in the Netherlands were produced. Annually around 140.000 people die in the Netherlands. In approximately 10% of all deaths terminal sedation took place.<sup>6</sup> The study made clear that there was reason for concern on the carefulness applied when palliative sedation takes place.

This concern was not due to proof of substantial lack of carefulness when palliative sedation was applied, but due to three uncertainties:

- it is uncertain how the transparency and the reviewability of terminal sedation can be proved;
- it is uncertain under what terms and conditions terminal sedation is good medical care; and
- insight in the practice of terminal sedation is restricted.

In the case of euthanasia the 2001 Termination of life on Request and Assistance in Suicide (Review Procedures) Act prescribes review procedures to be complied with in order to make it possible for the regional review committee to review the decision making process and to check whether the doctor acted with due care and complied with the six criteria formulated in the Act in order to guarantee him from prosecution for euthanasia.<sup>7</sup>

Palliative sedation does not fall under the rules of the 2001 Termination of life on Request and Assistance in Suicide (Review Procedures) Act and can therefore not be reviewed by the regional review committee.

As long as there do not exist guidelines in which the terms and conditions for terminal sedation were formulated, it was difficult to review whether in a given case terminal sedation was good medical care or not. As long as this uncer-

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<sup>5</sup> G. van der Wal, A. van der Heide, B.D. Onwuteaka-Philipsen, *Medische besluitvorming aan het einde van het leven. De praktijk en de toetsingsprocedure euthanasie (Medical decisions at the end of life. Practice and review procedure euthanasia)*, Utrecht, De Tijdstroom, 2003, pp. 75-101 and J.A.C. Rietjens, A. van der Heide, A.M. Vrakking et al., *Physicians report of terminal sedation without hydration or nutrition for patients nearing deaths in the Netherlands*. *Annals of Internal Medicine* 2004, 141, 178-85.

<sup>6</sup> See for the discussion of these figures: [www.annals.org/cgi/content/full/141/3/178?](http://www.annals.org/cgi/content/full/141/3/178?)

<sup>7</sup> Peter J.P. Tak, *Das Niederländische Gesetz zur Kontrolle der Tötung auf Verlangen und Beihilfe zum Selbstmord.*, *ZStW* 2001, pp. 905-923 and idem *The Doshisha Hogaku* 2002, pp. 179-210. Articles on the development of euthanasia legislation and practice in the Netherlands have been published in various Japanese law reviews. See Peter J.P. Tak (Katsunori Kai), *Legal Aspects of Euthanasia in the Netherlands*, *Hiroshima Hogaku*, Vol. 19, (1), pp. 165-199, Peter J.P. Tak, *Recent Developments Concerning Euthanasia in the Netherlands*, *The Doshisha Hogaku*, no. 260, 1998, pp. 163 ff.

tainty exists a doctor who applies palliative sedation runs the risk that the palliative sedation is considered as a termination of life which does not fall within the legal scope of euthanasia, but constitutes murder or manslaughter and that he will be prosecuted for the latter. This uncertainty is unacceptable for doctors who apply palliative sedation in their process of palliative care of a patient.

Palliative care affirms life and regards dying as a normal process. It intends neither to hasten nor postpone death.<sup>8</sup> Palliative sedation may be part of palliative care when it becomes clear that the medical treatment has insufficient effect and that the symptoms are no longer treatable.

Palliative sedation is defined as: the intentional reduction of the consciousness of a patient in his terminal phase of life.

The objective of palliative sedation is the alleviation of pain by means of reduction of consciousness. The objective of palliative sedation is not to hasten or postpone death.

A reduction of consciousness as the *side-effect* of a treatment – f.e. the application of a normal dose of Anxiolyticum in order to restrict fear or the administration of Morphine for pain-reduction – is not considered to be palliative sedation.

#### *The guidelines*

In December 2005 the Royal Dutch Medical Association has issued a guideline for palliative sedation.<sup>9</sup> The guideline only refers to the situation of continuous palliative sedation until the moment of death. In the guideline the indication and conditions for palliative sedation are formulated.

The indication for palliative sedation is that one or more medically incurable or intractable symptoms of a disease, the so-called refractory symptoms, exist which leads to unbearable suffering of the patient. A symptom is refractory when none of the conventional treatments are effective for symptom relief or these treatments have unacceptable side effects.<sup>10</sup> The indication is primarily a medical decision, but the opinion of the patient is of major importance. When a patient does not accept a treatment for his incurable disease because the treatment for him is too burdensome or not effective this may influence the decision of the doctor that an indication for palliative sedation exists. The most relevant refractory symptoms are pain, dyspnoea and intractable distress or delirium or a combination of symptoms like serious nausea or shortness of breath combined with serious psychological distress. Without a refractory symptom there is no indication for palliative sedation.<sup>11</sup>

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<sup>8</sup> See about palliative care the WHO definition: [www.who.int/cancer/palliative/definition/en/](http://www.who.int/cancer/palliative/definition/en/)

<sup>9</sup> KNMG – *richtlijn palliatieve sedatie (Guideline palliative sedation)*, Utrecht, December 2005.

<sup>10</sup> T. Morita, S. Tsuneto, Y. Shima, *Definition of sedation for symptom relief: a systematic literature review and a proposal of operational criteria*, *Journal of Pain and Symptom Management*, 2002 (24), pp. 447-453.

<sup>11</sup> KNMG richtlijn p. 15.

The conditions for palliative sedation are that the death of the patient shall be expected within one or two weeks. In case of palliative sedation it is assumed that no artificial hydration or nutrition will take place. The majority of patients do not eat and drink anymore at the moment palliative sedation starts and die within a few days<sup>12)</sup> (85% within three days and 98% within seven days).

Patients who continue to drink as a rule die much later. Artificial hydration for patients who are under palliative sedation is considered as senseless medical treatment<sup>13)</sup>, because the hydration prolongs the suffering and may increase the suffering due to an increased oedema, pain, bronchial secretion, increased urine production or incontinence. There does not exist anymore a reasonable proportionality between the objective of the medical treatment and the applied means. Therefore non-hydration is considered to be a proper medical treatment.<sup>14)</sup>

As far as the patient is able to understand that non-hydration is part of the palliative sedation, he must be informed. When he refuses, only palliative sedation for a short time or with intervals is allowed.

In cases in which there refractory symptoms like muscle dystrophy or cardiac insufficiency exist but no immanent death expectation a short time palliative sedation or a sedation with intervals is a more appropriate medical decision.

The decision to apply palliative sedation must be taken carefully and asks for serious consideration of the indication taking into consideration the information provided by the medical staff (nurses), the patient himself and his next of kin.

Preferably palliative sedation takes place on the basis of informed consent by the patient taking into consideration his explicit wishes – when to start, where to die, farewell visits, et cetera. When the patient is not able (anymore) to express his will, his legal representative must be approached in the decision making process. His refusal can be overruled in the benefit of the patient.

In urgent cases when consultation is impossible, the doctor may take the decision without prior consultation.

Palliative sedation requires a careful preparation (information to the patient, his family and the medical staff) and may as a rule only be started by a doctor. The means applied for sedation must be adequate and proportional to

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<sup>12)</sup> J.A.C. Rietjens, A. van der Heide, A.M. Vrakking et al., *Physicians report of terminal sedation without hydration or nutrition for patients nearing deaths in the Netherlands*. *Annals of Internal Medicine* 2004, 141, 178-85.

<sup>13)</sup> Gezondheidsraad, *Patiënten in een vegetatieve toestand (Vegetative patients)*, Den Haag, 1994/2 and Commissie Aanvaardbaarheid Levensbeëindigend handelen KNMG, *Medisch handelen rond het levenseinde bij wilsonbekwame patiënten (Medical decisions concerning the end of life regarding mental unable patients)*, Houten/Diegem, Bohn Stafleu Van Loghum, 1997.

<sup>14)</sup> KNMG richtlijn (Guideline for palliative sedation), p. 23.

control the symptoms. Morphine as such is not considered to be adequate. Midazolam seems to be the most appropriate means.<sup>15</sup>

Palliative sedation requests for a proper reporting and evaluation which means that in a report the start and the continuation of palliative sedation must be reasoned on the basis of the actual status of the patient so that the use of palliative sedation is made transparent and reviewable in case discussion on the application of palliative sedation may arise.

The guidelines, furthermore, give a number of instructions to the team who is in charge of providing palliative care, so that the team is able to inform the next of kin on what happens during the palliative sedation, to assist the next of kin in their bereavement (counselling and support) and to provide them with aftercare.

Not only the next of kin must be informed, assisted and supported, also the palliative care team shall be informed on the applied palliative sedation and must be provided with clinical and practical support as well as emotional help.<sup>16</sup>

The definition of palliative sedation, the indication and conditions for palliative care, as well as the standpoints of the Royal Dutch Medical Association concerning the decision making process, the non-provision of liquor, the careful application of palliative sedation, the reporting and evaluation and the support system, are based on findings in (inter-)national literature and expert opinions.<sup>17</sup>

### *Conclusion*

Palliative sedation as part of medical palliative care is a professional medical treatment according to the rules of art (*lege artis*) and does not hasten death when properly applied. Palliative sedation wrongly has been considered as a kind of termination of life and therefore wrongly considered as an act that should be brought under the legal regime of the 2001 Termination of Life and Assistance to Suicide (Review Procedures) Act.

Palliative sedation does not make termination of life on request redundant since palliative sedation and euthanasia are completely different acts with different objectives. However, since palliative sedation can be the ultimate medical response on unbearable physical suffering in someone's terminal phase of life, the requests for euthanasia might become more exceptional.<sup>18</sup>

For psychological suffering – the so-called existential reasons like the fear for physical humiliation – palliative sedation is not an option. In those cases euthanasia might be an option, but the Supreme Court's ruling in the

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<sup>15</sup> KNMG richtlijn, p. 26.

<sup>16</sup> KNMG richtlijn, pp. 33-38.

<sup>17</sup> KNMG richtlijn, pp. 39-46.

<sup>18</sup> B.J.P. Crul, *Euthanasie moet uitzondering zijn (Euthanasia shall be exceptional)*, NRC 7 December 2005, p. 7.

Brongersma-case<sup>19</sup> has made doctors very reluctant to positively respond in such a case at a request for euthanasia.

What will be the effect of the guidelines on palliative sedation on the prosecution policy? The main reason that palliative sedation gave rise to the prosecution of the young doctor was the lack of transparency and the lack of clear rules so that palliative sedation could be considered by public prosecutors as something happening in the grey zones of medical decision concerning the end of life. Through this guideline palliative sedation decisions will become transparent and reviewable by peers. This might be a reason for the Dutch prosecution service to restrict its juridical interference to merely those cases which give rise to the suspicion that palliative sedation did not take place *lege artis* and give rise to a criminal case. Due to the transparency and clear rules for palliative sedation caused by the guidelines these will be only exceptional cases.

The Royal Dutch Medical Association has consulted the Board of Prosecutors General about the guideline and the prosecution service will use the guideline as basis for its prosecution policy. The Board of Prosecutors General has recently issued its standpoint that no prosecution will take place provided that the requirements as set in the guidelines on palliative sedation have been met.<sup>20</sup>

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<sup>19</sup> Supreme Court 24 December 2002, NJ 2003, 167.

<sup>20</sup> Directive of the Board of Prosecutors General on prosecution decisions related to termination of life on request, 15 March 2007, Staatscourant 2007, 46.