Physician Aid in Dying, Euthanasia, Palliative Sedation and the Principle of Double Effect

1. Physician aid in dying (also called physician assisted suicide and medical aid in dying) is legal in ten U.S. jurisdictions: California, Colorado, District of Columbia, Hawaii, Montana, Maine (starting January 1, 2020), New Jersey, Oregon, Vermont, and Washington.
   a. It is not legal in Georgia
   b. Those jurisdictions that to allow for the practice have requirements such as
      i. The patient requesting the aid must be capacitated and if not capacitated no surrogate may request it for the patient
      ii. The patient must be expected to die within 6 months
      iii. The patient must be screened for a treatable depression or other psychological impediment to making an informed decision
      iv. The patient in some jurisdictions must make the request two times with a period of time in between the request
      v. The patient or non-medical assistant must administer the lethal prescription and not the ordering physician
   c. The majority of persons requesting aid in dying
      i. Request it to avoid pain and suffering
      ii. Tend to be Caucasian, persons with higher income and higher education
   d. In the jurisdictions with aid in dying statutes physicians may decline participation
   e. Neither the AMA or the ACP have endorsed physician aid in dying
2. Euthanasia (mercy killing) is illegal in all jurisdictions in the U.S.
   a. Active euthanasia is the killing of a patient by active means such as a lethal injection
      i. Active euthanasia includes killing at the request of the patient or surrogate as well as without the request of the patient
   b. Passive euthanasia is the withholding of life support and letting a patient die when there is no denial or informed refusal of life support
      i. Informed consent and informed refusal (including the withdrawal of already initiated life support) are morally and legally allowed and equal
3. Palliative sedation statement by the *American Academy of Hospice and Palliative Medicine* is as follows: *Palliative care supports patients whose diseases are associated with significant burden. Distressing symptoms exist on a spectrum from the most easily*

treated to the most refractory. Although preservation of awareness at the end of life is viewed as a priority for many, for some, the relief of symptoms may outweigh the desire to be conscious. 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. (http://aahpm.org/positions/palliative-sedation)

   a. Palliative sedation must not intend to shorten the life of the patient (euthanasia)
   b. While palliative sedation may decrease respirations hastening death the Principle of Double Effect mitigates it being euthanasia

4. The Principle of Double Effect
   a. The principle of **double effect**. This principle says that if doing something morally good has a morally bad side-**effect** it's ethically OK to do it providing the bad side-**effect** wasn't intended. This is true even if you foresaw that the bad **effect** would probably happen.
   b. The principle of double effect has the following elements
      i. The action in itself is an aim for the good or at least neutral
      ii. The good effect is intended and not the bad effect
      iii. The good effect is not produced by the bad effect
      iv. There is a proportionally grave reason for risking the bad effect
   c. Examples of principle of double effect

      i. This principle if commonly seen in terminal sedation. It is used to justify the case where a doctor gives drugs to a patient to relieve distressing symptoms even though he knows doing this may shorten the patient's life.

      ii. This is because the doctor is not aiming directly at killing the patient - the bad result of the patient's death is a *side-effect* of the good result of reducing the patient's pain.

      iii. Many doctors use this doctrine to justify the use of high doses of drugs such as morphine for the purpose of relieving suffering in terminally-ill patients even though they know the drugs are likely to cause the patient to die sooner.

iv. This is not a blanket justification. The doctor's action must still be appropriate

v. In cases when saving the life of a pregnant woman causes the death of her unborn child - for example, performing an abortion when continuing the pregnancy would risk killing the mother. By this argument, the death of the fetus is the side-effect of medical treatment to save the mother's life.

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