Background: Clinicians who care for seriously ill patients must be able to distinguish commonly referred terms in the published medical literature and lay press that aim to define end-of-life care practices. This Fast Fact offers a concise review of these terms and practices.

Withholding or withdrawing life-sustaining interventions: A patient with decision-making capacity may choose to withhold or withdraw life-sustaining therapies such as mechanical ventilation, hemodialysis, medically assisted nutrition and hydration (MANH), a pacemaker, etc. if such therapies are not meeting an agreed upon medical goal of care, even if doing so is anticipated to lead to a shorter survival (1). A surrogate decision maker can also make this request ethically if it aligns with the incapacitated patient’s best interest or substituted judgment (1). The ability of a surrogate to withdraw MANH (colloquially referred to as artificial hydration and nutrition) in an incapacitated patient, can be more nuanced, however. For example, in some states, there must be clear evidence MANH is not wanted anymore if the surrogate was not designated as power of attorney by the patient (2,3). It is important that clinicians be aware of their institutional and state legal precedence regarding MANH.

Use of opioids in terminally ill patients: Since pain and dyspnea are common as patients near the end of life, the use of appropriately dosed opioids is legal and supported by bioethicists. The principle of double-effect has been utilized to justify the use of opioids at the end of life, since the primary aim (relief of pain or dyspnea) outweighs or is proportional to any unintended potential adverse effects (decreased consciousness or respiratory drive). Some question whether the principle of double effect is even needed to justify the use of opioids for symptomatic patients nearing the end of life, since published evidence suggests that appropriately dosed opioids do not shorten survival in these patients (4).

Palliative Sedation (PS) commonly refers to the use of medications to relieve suffering by decreasing patient alertness for refractory symptoms in a terminally ill patient (5). Within this definition, deliberate deep sedation often describes the use of a continuous infusion to induce a level of unconsciousness which patients cannot be easily aroused from, and proportionate sedation describes the use of sedatives which are progressively increased according to symptom burden, resulting in unconsciousness in some cases and retention of awareness in others (6). Agitated delirium, severe dyspnea, and uncontrolled pain are common indications for PS (7,8). Midazolam, lorazepam, pentobarbital, and propofol are commonly utilized agents (7,8). See Fast Facts #106 and 107.

Voluntary Stopping of Eating and Drinking (VSED): A deliberate decision to avoid hydration and nutrition, including parenteral fluids or feeding tubes (9). This is an ethically and legally acceptable process in decisional patients with a terminal illness. It offers the option of resuming eating and drinking at any point. Questions about decision-making capacity as care evolves, symptom management, and acceptability in care settings such as long-term care facilities can make requests for VSED complex. VSED in non-decisional patients is more controversial but has been described. See Fast Fact #379.

Medical assisted death/medically assisted suicide/physician assisted suicide/physician aid in dying (death): The process in which a terminally ill individual with decision-making capacity works with their clinician to be prescribed a life-ending medication, which the person self-administers at the time of their choosing. While a variety of terms are used to describe this practice, there is not clear consensus on the preferred phrasing. In general, there is broad public support in many states and countries as it enables a sense of autonomy, perhaps even enables psychological comfort for some patients even if the medication is not used. It is legal in many states and Canada, but bioethical concerns about whether the intended effect of death is proportional to the intended benefit of relief of suffering makes it controversial. AHPM has expressed “studied neutrality” (11); the IAHPC expressed it should only be legalized in countries/regions with universal access to appropriate palliative care services and medications (12).
Euthanasia: The intentional act of a third-party, usually a physician, to administer a life-ending medication to a patient. Euthanasia may be subdivided into voluntary, non-voluntary, and involuntary forms, which are ethically distinct, as is the controversial application of “voluntary euthanasia” to mentally capable, informed patients who do not suffer from a terminal illness. Most major medical groups such as the AMA and AAHPM do not support euthanasia due to bioethical concerns about proportionality and the appropriate role of clinicians. Voluntary euthanasia for patients with intractable suffering from a terminal illness, is legal in many countries such as the Netherlands, Colombia, Belgium, Australia, Luxembourg, Canada, and Spain (13). In Canada, both lethal prescription for self-ingestion and direct administration by a clinician for a decisional patient are referred to as Medical Aid in Dying (14).

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*Table adapted from Olsen et al. (15)*

References


Authors’ Affiliations: Saint Joseph Hospital, Denver, CO

Conflicts of Interest: None

Version History: originally edited by Sean Marks MD; first electronically published June 11, 2021. Based on reader feedback a revised version was published June 25, 2021 to better reflect the lack of consensus in terminology and the distinctions between voluntary and involuntary euthanasia.

Fast Facts and Concepts are edited by Sean Marks MD (Medical College of Wisconsin) and associate editor Drew A Rosielle MD (University of Minnesota Medical School), with the generous support of a volunteer peer-review editorial board, and are made available online by the Palliative Care Network of Wisconsin (PCNOW); the authors of each individual Fast Fact are solely responsible for that Fast Fact’s content. The full set of Fast Facts are available at Palliative Care Network of Wisconsin with contact information, and how to reference Fast Facts.

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