Supportive Care COALITION
Advancing Excellence in Palliative Care

TALKING POINTS REGARDING PALLIATIVE SEDATION PRACTICES AND "STEALTH EUTHANASIA"

Prepared by Kevin Murphy, PhD, Vice President, Theology & Ethics, St. Joseph Health

in collaboration with the Supportive Care Coalition Ethics and Church Relations Committee

Executive Summary Bullet Points:

- Palliative care is,

  "specialized medical care for people with serious illness. It is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness – whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment." (Center to Advance Palliative Care)

- Palliative Sedation Practices refer to a variety of medication interventions for a variety of patient care situations.
- There is broad clinical and ethical consensus that palliative sedation practices are not to be used to hasten the death of the patient but to address patient symptoms.
- The Catholic moral tradition, utilizing the principle of double effect, supports offering palliative sedation to address the pain of the patient, even if this therapy may indirectly shorten the patient's life so long as the intent is not to hasten death.
- The discipline of palliative care continues to debate and research how to best respond to the intractable symptoms of patients and ensure they are addressing the needs and dignity of patients without hastening the death of the patient.

1. What are Palliative Sedation Practices?

Palliative sedation practices refers to a spectrum of interventions where sedation medications are used to relieve the physical pain and/or distress of a dying patient in the last hours or days of their life. Many times it is initiated at the patient's request. Sedation is usually implemented by means of an infusion of a sedative drug. . It is an option of last resort to address "intractable symptoms" (Dyspnea [gasping for breath], Nausea, vomiting, other forms of intolerable pain) A key distinction between this practice and that of euthanasia is that the direct goal of supported sedation practices in palliative care is to address the intractable symptoms of patients and not to hasten the death of the patient.

2. What is the Spectrum of Patient Situations Where this Practice is Utilized?

Palliative sedation is used in the following spectrum of patient care situations:

- **Situation A:** For short periods with the plan to awaken the patient after a given time period. In this situation the patient is sedated while symptom control is attempted for symptoms such as dyspnea (gasping for breath), nausea, vomiting and other forms of intolerable pain that have not successfully been controlled. Then the patient is awakened to see if symptom control has been achieved.

- **Situation B:** Situations where there is not a plan to reawaken the patient such as an enlarging cancer in the throat that compresses the trachea in a patient who does not want intubation or tracheostomy. Eventually, in this situation, symptom control will be impossible. Instead of experiencing death by suffocation, once symptoms are intolerable some patients will request palliative sedation to ease their symptoms as death approaches. This approach is sometimes called terminal sedation or continuous deep sedation.

- **Situation C:** Palliative sedation is not only utilized to address physical pain but also intolerable and intractable suffering. "Total pain" is the term that is well accepted in palliative care to describe pain as an experience that includes the components of the physical, psychological, spiritual and social. In these patient situations, the source of the pain may not be easily identifiable as physical or psycho/spiritual. It is clear that the pain and suffering of the patient is intolerable and intractable, all methods to address the symptoms have failed, and the patient requests (or the only peace clinicians feel they can offer the patient is) to be sedated without a plan to reawaken the patient.

3. What is Stealth Euthanasia?

This is a term coined by some authors[1] who claim the emergence of an intentional practice trend among health care clinicians in palliative and end of life care settings. In this practice trend it is claimed that health care clinicians use medications (opiates, sedatives and barbiturates) not just to treat pain and other symptoms of the patient but with the intention to kill the patient.

4. Are palliative sedation practices consistent with Catholic moral teaching?

The *Ethical and Religious Directives for Catholic Health Care Services* state,

> *60. "Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should*

1 See Ralph A. Capone, et. al., The Rise of Stealth Euthanasia: Imposed Death Disguised as Pain Relief", Ethics and Medics. Volume 38, Number 6 (June 2013) pp. 1-4. Also Ron Panzer, *Stealth Euthanasia: Healthcare Tyranny in America*. (Rockford, MI: Hospice Patients Alliance, 2011).

receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death."

61. "Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die. Since a person has the right to prepare for his or her death while fully conscious, he or she should not be deprived of consciousness without a compelling reason. Medicine capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death. Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering."

The key principle which has been utilized in understanding and making distinctions in the ethical implications of palliative sedations is the principle of double effect (PDE). The principle consists of four criteria: Simply stated the four conditions of PDE are as follows[2]:

1) That the **action in itself from its very object** be good or at least indifferent;

2) That the good effect and not the evil effect be **intended**;

3) That the good effect be **not produced by means** of the evil effect; and

4) That there be a **proportionately grave reason** for permitting the evil effect.

The PDE does support offering high doses of sedation, with the intention to address the pain of the patient. This is true even if the doses of sedation are known to have the secondary and foreseen, indirect, effect of suppressing the respiratory system of the patient and potentially hastening the death of the patient. Such action is supported because it is differentiated from the prohibition against the intentional killing innocent human life. First, the **action** of giving sedation to address pain is considered good palliative care. Second, the **intention** of offering the sedation to relieve the pain of the patient is good. Third, when using high doses of analgesics to address more severe levels of pain, although the hastening of the death of the patient is foreseen, such hastening of death is an **indirect** outcome of the giving of sedation because the intention is to offer relief from pain. Fourth, the **reason** for the evil effect of hastening the death of the patient is **proportionate** since the sedation used is in accordance with the

[2] The *New Catholic Encyclopedia* (1967*)*, articulates the four conditions of the principle of double effect as follows: "1) the act itself must be morally good or at least indifferent. 2) The agent may not positively will the bad effect but may merely permit it. If he could obtain the good effect without the bad effect, he should do so. The bad effect is sometimes said to be indirectly voluntary. 3) The good effect must be produced directly by the action, not by the bad effect. Otherwise, the agent would be using a bad means to a good end, which is never allowed. 4) The good effect must be sufficiently desirable to compensate for the allowing of the bad effect." *New Catholic Encyclopedia*, Vol. 4, (New York: McGraw-Hill, 1967), p. 1020. The version used within the main text above is articulated more simply and is similar if not identical to versions used by: Joseph T. MANGAN, "An Historical Analysis of the Principle of Double Effect." *Theological Studies*, 10 (1949), p. 43.; Germaine GRISEZ, *Abortion* (New York: Corpus Books, 1970), p. 329.; Charles CURRAN, "The Principle of Double Effect: Some Historical and Contemporary Observations." In *Congresso Internazionale Tommaso D'Aquino Nel Suo Settimo Centenario*, Roma – Napoli, (1974). Liagire Morale. Napoli, Edizioni Domenicane Italiane, (1977), p. 426.

reasonable practice of what is needed to address the intractable pain experienced by such terminally ill patients

5. Why do some health care professionals have concerns about these sedation practices?

Many palliative care clinicians support offering palliative sedation in all three of the above noted situations with the expectation that the goal or direct intent of any of these sedation practices is to address the intractable symptoms of the patient and not to hasten the death of the patient.

- **Concern 1**: Some clinicians have the concern that while the doses of sedation do address the intractable patient symptoms, they are concerned that the sedation used may have the second indirect outcome of suppressing the patient's respiratory system and hasten the death of the patient. In these situations some clinicians feel that they are inappropriately participating in the death of the patient. They may believe that the principle of double effect is not a reasonable or effective distinction.
- **Concern 2**: Some clinicians believe it is appropriate to address physical pain symptoms with sedation but not symptoms of intolerable and intractable suffering. The concern is that sedation only masks these symptoms of "suffering" as opposed to truly addressing them.[3]
- **Concern 3**: Some clinicians are concerned that in some instances the direct intent of utilizing sedation is to hasten the death of the patient even though the voiced goal of clinicians in those instances is to address the intolerable existential suffering of the patient. This last concern has been articulated as "stealth euthanasia".[4]

6. What might be appropriate responses to the 3 concerns noted above?

- **Concern 1:** Here the concern is based on the assertion that the principle of double effect is not an effective or accurate distinction. A clinician may feel that when they give sedation at high doses, they feel they are inappropriately participating in the death of the patient. However, the principle of double effect is a relevant moral distinction that has had strong support with the Catholic moral tradition and the international medical discipline of palliative care. As well, current research is attempting to discover whether sedation practices properly implemented do in fact hasten death.[5]
- **Concern 2:** Here the concern is that our current response of sedation to address intolerable existential suffering may not be as full or complete response as we would like. The question then becomes in this debate whether the alternative response of having patients consciously experience intolerable suffering, after all our best methods to address this situation have failed, is an adequate response. Palliative care research in this area is ongoing and welcome.

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3 See Anemona Hartocolus, "Hard Choice for a Comfortable Death: Sedation." New York Times December 27, 2009.

4 See Ralph A. Capone, et. al., The Rise of Stealth Euthanasia", Ethics and Medics. Volume 38, Number 6 (June 2013) pp. 1-4. Also Ron Panzer, *Stealth Euthanasia: Healthcare Tyranny in America*. (Rockford, MI: Hospice Patients Alliance, 2011)

5 See M. Maltoni, et. Al., "Palliative Sedation Therapy Does Not Hasten Death: Results from a Prospective Multicenter Study." Annals of Oncology 20: 1163-1169, 2009.

- **<u>Concern 3</u>**: Here the assertion is that the practice of palliative sedation is being used in particular instances to covertly hasten death. There is broad consensus that within this discipline of palliative care that this type of utilization of palliative sedation is inappropriate and contrary to international palliative care standards. The question that arises from this assertion is what criteria are being used and verified as evidence for this proposed trend?

The discipline of palliative care continues to debate and research how to best respond to the intractable symptoms of patients. The goal has consistently been to ensure palliative care is addressing the needs and dignity of patients without hastening the death of the patient.