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Rebecca A. McAteer

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Palliative Sedation: An ethical option of last-resort

Rebecca A. McAteer

Introduction

In the wake of extensive discussion regarding the ethics of euthanasia and physician assisted suicide, a more subtle debate has arisen around the similarly controversial topic of terminal sedation. I will begin this paper by offering a definition of what is meant by terminal (or palliative) sedation. I will then attempt to lay a foundational context in which to examine the ethics of palliative sedation, concluding with some suggested guidelines for evaluating situations in which palliative sedation may or may not be an ethically acceptable option. This paper aims to show that palliative sedation has not been made obsolete by recent advances in pain management and symptom control. Instead, it retains a vital role in the appropriate palliative care management of select patients at the end of life. Palliative sedation, rather than being merely a disguised form of euthanasia – so-called “slow euthanasia” – is a morally distinct, ethically permissible practice when exercised within appropriate limits.

There are generally three main standpoints taken in the literature on palliative sedation. The first is that it is never ethically acceptable, usually because it is seen as incompatible with the Sanctity of Life Doctrine, particularly also when stipulated that artificial hydration and nutrition be withheld or withdrawn following the initiation of sedation.¹ The other two viewpoints center around palliative sedation as either (1) a permissible last-resort measure or (2) an option to be offered among others at the request of patients.² I here advocate for the former, that palliative sedation should only be offered as a last-resort measure to address suffering directly related to a patient’s underlying physiologic illness.

Palliative Sedation: Some Definitions

Since one of the sources of greatest confusion in this debate is over the meaning of “terminal sedation,” it is necessary to clarify its definition, which I feel is better termed “palliative sedation” or “sedation in the imminently dying.”³ Palliative sedation is the administration of sedatives in order to provide relief for terminally ill patients suffering from severe, treatment-refractory symptoms specifically related to their underlying physiologic illness. There are rare occasions when the dose of sedatives required to achieve this end results in complete sedation to unconsciousness. This is distinct from the sedation that comes as a side-effect of high-dose opioid therapy for pain and dyspnea management in terminally ill patients, because sedation is directly aimed at in this definition of palliative sedation. However, I will show that these are not morally distinct practices since the need for palliative sedation should arise only in cases of last resort. In such (admittedly rare) cases, I believe that sedatives should be administered in increasing doses only until an adequate comfort level is achieved; sedation is both the effect and the means of relief in this last-resort scenario.

The language of this topic varies widely. More importantly, as Lynn Jansen and Daniel Sulmasy argue, the phrase “terminal sedation” “encompass[es] a variety of practices, some of which are morally distinct from one another in important ways.”⁴ They reject the ambiguous, potentially misleading phrase “terminal sedation” in favor of a proposed distinction between two separate practices, “sedation of the imminently dying” and “sedation toward death.”⁴ These are distinguished primarily on the basis of the clinician’s intent in administering sedative

medications (that of providing comfort without necessarily hastening death) and the medical appropriateness of symptom management (proportionality of the measures employed). Depending on how palliative sedation is defined and utilized, it can be considered a practice morally distinct from both VAE and PAS.

Sedation of the imminently dying is indicated when a patient who is close to death (hours or days) suffers from one or more severe symptoms that are refractory to standard palliative care. The patient's physician may then use vigorous, symptom-specific therapy that has a dose-dependent side effect of sedation, a foreseen but unintended consequence of trying to relieve the patient's symptoms. Overly burdensome life-sustaining treatments may also be withdrawn.⁴ While I feel that aiming at sedation is not itself inherently problematic, palliative sedation should never be initiated for the sake of sedation, in order to "treat consciousness" as the primary "refractory symptom." This practice is more consistent with sedation toward death, in which a patient who need not be imminently dying is treated with therapy intended to render him/her unconscious as a means of treating the refractory "symptom" – which is simply the consciousness that one is not yet dead – in conjunction with removal of other life-sustaining treatments to hasten death.⁴ Defined this way, sedation toward death is morally equivalent to voluntary active euthanasia (VAE) and physician-assisted suicide (PAS).

Distinguishing Between "Killing" and "Allowing to Die"

One issue that surrounds the ethics of palliative sedation is whether there is a difference between killing and allowing to die. I believe that such a distinction exists, and that it is both morally significant and relevant to this discussion. I will define killing as an act resulting in death, performed with the intention of causing death.⁵ Conversely, allowing to die can be defined as withdrawing or withholding an intervention that forestalls or ameliorates a preexisting fatal condition, an act which may or may not be done with the intention causing death.⁵ Of note, "allowing to die" may be either active or passive depending on the circumstances, and it is the intention of the doer, rather than the degree of action required to fulfill that intention, that determines its moral permissibility. Given these definitions, the traditional view of a physician's role can be stated: "All killing is wrong. Some allowing to die is also wrong, while some is not."⁵ I will only assert here that intending death is wrong, a claim that has been contested⁶ but one that I feel is well-supported.^{5,7}

Distinguishing Between "Intended" and "Foreseen" Consequences

The distinction between consequences that are foreseen from those that are intended also requires a look at intentions. This distinction underlies the vast majority of routine medical practice, in which treatments are administered with the intention of producing benefit for patients, but which come with the potential for known risks and burdensome side effects that are foreseen but unintended. Such risks are generally accepted if they are proportionate to the expected benefits. In palliative sedation, the intended effect is to relieve suffering, weighed against the foreseen but unintended potential to shorten life.

Palliative medicine presents a still more complex challenge, because cases arise in which the unintended side effect – sedation, or even the hastening of death – may in fact be desired by both the patient and healthcare team. Given the significant role of intentions in

evaluating both an action and its consequences, I will examine the complexity surrounding intentions in greater detail.

The Role of Intentions

Critical to each of these distinctions is the presupposition that intentions are both knowable and morally significant. However, those who reject this distinction frequently assert that intentions can be subjective and difficult to discern at best, if not entirely irrelevant.^{8,9,10} Citing Timothy Quill, Johannes van Delden states that “the intention of the physician is rather irrelevant in these cases...Intentions are to a large extent reconstructions of what one felt at the time of decision-making and they are hard to verify.”¹⁰ Nevertheless, this is an assertion, and one not necessarily borne out in reality. It is at least sometimes possible to gain insight into one’s intentions from the objective conditions surrounding the particular situation.¹² For example, a clinician would be hard-pressed to defend injecting a 100 mEq bolus of potassium chloride into a patient for reasons other than to cause death, given the fact that there is no conceivable diagnostic or therapeutic value in such a measure. In clear-cut scenarios like this, intentions are readily discernable.

Yet in situations where intentions may be hard to know, even to the clinician him/herself, some questions may be useful in defining one’s intentions. If an action is taken to remove an overly-burdensome medical intervention, “What would be the clinician’s feeling if the patient did not die as a result?” Similarly, one might ask a physician, “If you could have relieved the pain in another way that had not hastened death, would you have done so?”¹¹ If the answer here is no, then the physician most probably intended death by that action. This process of examining motives essentially seeks to delineate the condition of fulfillment of the intention.⁵ If an intention is fulfilled by completion of the action – and not necessarily by the death of the patient – then the intention is likely to be morally sound. In situations of extreme suffering at the end of life, palliation of that suffering may also have an effect of hastening death. This may be expected and even desired, but it should never be intended by means of palliative measures.

The Roles of Proportionality and Double Effect

Proportionality is a premise that underlies the rule of double effect, a concept frequently invoked as a basis for palliative sedation. Despite arguments against its viability, the rule of double effect (RDE) continues to be an important, defensible guide for making sound ethical decisions in palliative care medicine.⁴ In the present context, the RDE states that if an action (palliative sedation) has two effects, one bad (sedation or hastened death) and the other good (symptom relief), then as long as the bad effect is not the cause of the good, there is proportionate reason to perform the action provided the agent foresees the bad but intends only the good.⁴

In discussing the relevance of intentions to ethics, one might argue that proportionality alone is sufficient to determine what is proper, and that talk of intentions is unnecessary.¹⁰ Yet we must note that proportionality alone cannot determine the moral soundness of an action. For instance, withdrawing futile treatment may arguably be the most proportionate action for a given patient, regardless of the clinician’s motive in doing so. Yet such a utilitarian view fails to address the moral implications of a decision that may be proportionate but is nevertheless driven by motives that are inherently unethical. Dan Brock’s hypothetical case of a greedy son who

disconnects his terminally ill mother's ventilator in order to hasten her death and collect on insurance is a good illustration of this point.⁶ The greedy son's action is clearly a grave wrongdoing, even though the action itself may be identical to that of the physician's, who, being aware of her desire to be removed from the ventilator, intends to do so in accordance with the patient's own informed decision. These two actions are morally distinguishable only by the intention of the agent. Death is foreseen in both situations; only in the former case is death necessarily intended, being itself the condition of fulfillment of the greedy son's action.

A Proposed Role for Palliative Sedation

Based upon the ethical principles outlined above, several brief guidelines can be suggested for the appropriate use of palliative sedation in the clinical setting:

- The patient must have intense, intractable suffering that is directly and causally related to his or her underlying physiological illness, for which the full extent of standard palliative care measures have been tried and found insufficient.¹³
- The patient must have a terminal illness without reasonable hope of present or future curative intervention.¹³
- The patient must have given explicit, informed consent. If incompetent to do so, the patient's wishes (as ascertained by knowledge of advance directives, substituted judgment and best interest) should dictate the decision.¹⁴
- Family input should be encouraged in reaching a consensus decision.
- The second opinion of a palliative care expert may be warranted, particularly in cases where it is unclear whether last-resort measures are indicated.

Conclusion

A saying attributed to the medieval medical tradition describes the role of the physician as one called upon to "cure sometimes, relieve often, and comfort always." Over the course of this discussion I have argued in favor of the claim that when relief is impossible, palliative sedation is one ethically-acceptable means of providing comfort to dying patients in extremis. The definition of this practice is itself controversial, but I have outlined what I feel is an ethically proper way to consider and employ it. Arguments based on theories of intentionality, the principle of proportionality, and two significant ethical distinctions – that between killing and allowing to die and between foreseen and intended consequences – underlie the ethical basis for this assertion.

References

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