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Euthanasia, Assisted Suicide, and Palliative Sedation: A Brief Clarification and Reinforcement of the Moral Logic

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ABSTRACT

A persistent misunderstanding of the moral distinctions between the practices of euthanasia, assisted suicide, and palliative sedation suggests a critical need to revisit the relationship each shares with licit medical practice in the context of palliative care. To that end, this essay grounds its arguments in two, straightforward premises: (i) the licitness of medical practice is largely determined by the balance between (a) good ends, (b) proportionate means, (c) appropriate circumstances, and (d) benevolent intentions; and (ii) whereas palliative sedation employs criteria A-D (above), both euthanasia and assisted suicide fail to secure criteria A-C. Drawing from this syllogism, the aim and proposal of this essay is to examine the logic inherent to the practices of euthanasia, assisted suicide, and palliative sedation in the context of palliative care with the intention of positing the argument that while palliative sedation fulfills the requirements of morally licit medical practice – and so successfully executes the tenets of sound ethical logic – both euthanasia and assisted suicide do not.

Keywords: Euthanasia, Assisted-Suicide, Palliative Sedation, Ethical Proportionality

1. INTRODUCTION

1.1 Overview

Palliative care services are expanding rapidly around the globe.¹ Tens of millions of individuals worldwide are affected by life-threatening illnesses (such as HIV/AIDS and cancer) that cause them immense suffering and economic hardship. The majority of cases occur in the developing world, where accessibility to adequate treatment is frequently scarce.² The practice of palliative care has thus become increasingly recognized as a legitimate area of expertise in modern biomedicine, and specialists in the field continue to endeavor to establish a concrete evidence-base for their practice. Indeed, several major centers have now been dedicated to palliative care research and education, and the number of countries in which palliative care services are currently operative transcends eighty. As a result, “hospice care”³ has evolved into a global field of work concerned with dying individuals and others facing life-threatening illness.⁴

1. Henk ten Have and David Clark, “Introduction: The Work of the *Pallium* Project,” in *The Ethics of Palliative Care: European Perspectives*, ed. Henk ten Have and David Clark (Philadelphia: Open

2. Cecelia Sepúlveda, Amanda Marlin, Tokuo Yoshida, and Andreas Ullrich, “Palliative Care: The World Health Organization’s Global Perspective,” *Journal of Pain and Symptom Management* 24, no. 2 (August 2002): 91-96; see especially p. 91.

3. “Terminal care,” which began in the 1950s and 1960s, later paved way for the “hospice care” movement. See ten Have and Clark, “Introduction,” 1-12; see especially p. 1.

4. ten Have and Clark, “Introduction,” 1-12; see especially p. 1

Palliative care encompasses a broad range of activities, including pain management, the deployment of multidisciplinary medical teams, and attention to psychological, social, and spiritual concerns. While the focus of palliative care is undoubtedly grounded in some of the oldest aspects of medicine, it also constitutes a particularly modern development, which has made significant progress in a short time. Although palliative care centers on the universal human experience of suffering, the manner of its organization differs significantly from one context to another. In several of the countries that have adopted palliative care programs, some of the issues facing health care are held in common. Among these are morally ambiguous medical interventions that aim to ameliorate pain and suffering associated with the burden of chronic illness, where the possibilities of cure are slim to none.

1.2 Analytical Method

A persistent misunderstanding of the moral distinctions between the practices of euthanasia, assisted suicide, and palliative sedation suggests a critical need to revisit the relationship each shares with licit medical practice in the context of palliative care. To that end, this essay grounds its arguments in two, straightforward premises: (i) the licitness of medical practice is largely determined by the balance between (a) good ends, (b) proportionate means, (c) appropriate circumstances, and (d) benevolent intentions; and (ii) whereas palliative sedation employs criteria A-D (above), both euthanasia and assisted suicide fail to secure criteria A-C. Drawing from this syllogism, the aim and proposal of this essay is to examine the logic inherent to the practices of euthanasia, assisted suicide, and palliative sedation in the context of palliative care with the intention of positing the argument that while palliative sedation fulfills the requirements of morally licit medical practice – and so successfully executes the tenets of sound ethical logic – both euthanasia and assisted suicide do not.

To secure the justification of this thesis, the essay will move in three parts. First, it will address the ontology of palliative care, including a specific analysis of the goals of palliative care and the proposal of palliative care as a fundamental human right. Second, it will address the practices of euthanasia and assisted suicide, including a specific analysis of the definitions and clinical comparisons of each, as well as the moral arguments against the respective practices. Finally, it will address sedation to unconsciousness in palliative care, including a specific analysis of the function of palliative sedation and the ethical justification of palliative sedation as a licit medical practice.

2. THE ONTOLOGY OF PALLIATIVE CARE

2.1 The Goals of Palliative Care

While various conceptions exist regarding the best “way” to conclude life, this essay proposes that the goal of palliative care is primarily to ensure that patients are able, insofar as possible, to live their death well. When referring to a “good death” as opposed

to a “good life,” it is necessary to clarify which characteristics make for a good death, since the conception of palliative care employed herein includes some period of life. It seems obvious that “death” refers to at least one of three diverse and consecutive scenarios. Wim Dekkers and colleagues identify these scenarios as “the process of dying,” “the event of death,” and “the state of death.”⁵ Hence, procuring a good death that resonates with the aims of palliative care may refer to the whole enterprise of scenarios or to any one of them, and must therefore take into account any complications that may occur in the event of overlap.⁶

Dekkers and colleagues identify two cardinal goals of a good death (a peaceful death, and a death occurring in one’s sleep), yet the latter can be logically subsumed under the former.⁷ In this light, practicing palliative care involves ensuring that patients are able not only to live their death, but also that they are able to do so peacefully. The primary reason to focus on peacefulness as an explicit goal of palliative care practice is that, while assuredly abstract, the idea transcends time and culture. The notion of peace in the context of death has perhaps been communicated best by Daniel Callahan. For Callahan, a peaceful death is marked by acceptance rather than fear,⁸ and takes place, insofar as possible, in the presence of loved ones who are able to offer comfort, support, and compassion.⁹ In this way, the goals of palliative care blend personal, medical, and social strands of morality.¹⁰

2.2 Palliative Care as Human Right

Palliative care providers across the globe have become increasingly concerned that the expansion and support of palliative care services for patients facing diagnoses of life-threatening illnesses are not receiving adequate attention or commitment from health policy makers. This has led to a growing call for palliative care to be accepted as a fundamental human right, and for obligations that flow from that right to be fulfilled – namely, global access to palliative care services for all patients who would benefit from its availability. The rationale underlying this call has been clearly delineated by F. Brennan, who considers the foundation of the right to palliative care with regard to the International Covenant on Economic, Social and Cultural Rights (ICESR), the obligation of signatory nations, and the difficulties crossed in the promotion of palliative care as a human right to be respected.¹¹ While the promotion of palliative care as a human right is axiomatic to palliative care workers, it remains necessary to develop a further an

5. Wim Dekkers, Lars Sandman, and Pat Webb, “Good Death or Good Life as a Goal of Palliative Care,” in *The Ethics of Palliative Care: European Perspectives*, ed. Henk ten Have and David Clark (Philadelphia: Open University Press, 2002), 106-25; see especially pp. 108, 110-11.

6. Dekkers et al., “Good Death or Good Life,” 106-25; see especially p. 111.

7. Dekkers et al., “Good Death or Good Life,” 106-25; see especially p. 114-19.

8. That is, fear in the presence of excessive pain and suffering. See Dekkers et al., “Good Death or Good Life,” 106-25; see especially pp. 115-16.

9. See Dekkers et al., “Good Death or Good Life,” 106-25; see especially pp. 115-16.

10. Dekkers et al., “Good Death or Good Life,” 106-25; see especially pp. 117.

11. Liz Gwyther, Frank Brennan, Dip Obs, and Richard Harding, “Advancing Palliative Care as a Human Right,” *Journal of Pain and Symptom Management* 38, no. 5 (November 2009): 767-74; see especially p. 768.

understanding of the rights instruments whereby palliative care might become accessible at both the local and international level.¹²

Both palliative care and human rights are founded on the principles of dignity and universality, including nondiscrimination. Included in the General Comments¹³ of the ICESR is the directive to attend to and care for “chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity.”¹⁴ Hence, palliative care is already articulated as a human right within the International Bill of Rights.¹⁵ At both the local and international level, several strategies are available.¹⁶ First, discussing the aforementioned documents with government and health officials would alert them to the need to develop specific palliative care policies. Second, palliative care organizations could assist their governments to comply with their obligations to provide health care in the context of palliative care, including policy development, opioid law reform, and providing adequate palliative care education.¹⁷

3. EUTHANASIA AND ASSISTED SUICIDE

3.1 *Definitions and Clinical Comparisons*

The practices of euthanasia and assisted suicide are complex topics that present serious moral challenges in contemporary biomedicine. In principal, however, both opponents and proponents of each practice agree that requests for euthanasia and assisted suicide are frequently the result of tragic situations. Hence, the prevention of these requests has become of interest, and this has allowed palliative care to play a critical role in the solution. However, even in hospices and palliative care units, requests for euthanasia and assisted suicide remain. With regard to the former, since there is much confusion in the palliative care literature surrounding the concept of euthanasia, a critical distinction can be made to uncover the ethical aspects of the practice.¹⁸ The distinction concerns “passive” versus “active” forms of euthanasia. The passive form indicates the positive action of allowing a patient die by foregoing necessary life-sustaining

12. Gwyther et al., “Advancing Palliative Care,” 767-74; see especially pp. 767-68.

13. The specific Comment is no. 14, in the section concerning the care of older persons. See Gwyther et al., “Advancing Palliative Care,” 767-74; see especially pp. 769-70.

14. Gwyther et al., “Advancing Palliative Care,” 767-74; see especially pp. 769-70. Quotation from p. 770.

15. However, these articulations – powerful as they are – do not prevent barriers to access, including availability, acceptability, and quality. Several factors can be identified as the underlying source of these barriers: lack of political support and awareness, sociocultural issues, “opiophobia” and “opioignorance,” entrenched attitudes within the medical profession, and low prioritization of palliative care among policy makers. See Gwyther et al., “Advancing Palliative Care,” 767-74; see especially pp. 770-71.

16. For a comprehensive overview of these strategies, see Gwyther et al., “Advancing Palliative Care,” 767-74.

17. Gwyther et al., “Advancing Palliative Care,” 767-74; see especially pp. 770-71.

18. Other significant distinctions concern direct versus indirect, and voluntary, involuntary, and nonvoluntary forms of euthanasia. See Bert Gordijn, Ben Crul, and Zbigniew Zylicz, “Euthanasia and Physician-Assisted Suicide,” in *The Ethics of Palliative Care: European Perspectives*, ed. Henk ten Have and David Clark (Philadelphia: Open University Press, 2002), 181-97; see especially p. 182.

treatment.¹⁹ On the other hand, active euthanasia indicates causing the death of a patient by giving a certain life-shortening treatment.²⁰ This essay will therefore define euthanasia as a medically contraindicated action or omission that directly and intentionally causes death in the effort to indirectly and unintentionally address, control, and eliminate suffering in full.

In contrast to euthanasia, assisted suicide typically indicates the action of a licensed clinician – most frequently a physician – who provides to a legally competent person the means – often in the form of a prescription for a lethal dose of drugs – to commit suicide.²¹ While not formally part of the definition, the context of terminal illness is often assumed and has been part of the prerequisite conditions in all proposed laws in the United States thus far. Yet this is not a formal part of the definition of assisted suicide as such, since physicians might be permitted to offer such aid to those who wish to terminate their lives for other reasons.²² In this sense, assisted suicide is different from the medically indicated withholding or withdrawing of treatment, on the one hand, and from the actual killing of the patient by the physician, on the other.²³

3.2 Arguments Against Euthanasia and Assisted Suicide

Suffering can have various causes, including pain, other physiological symptoms, and clinical depression.²⁴ To that extent that these factors play a positive role as motives for requesting euthanasia, adequately addressing them with the provision of palliative care is likely to remove most of those requests. However, while even the best palliative care would not necessarily prevent the dependency and loss of control that are inherently connected with the process of dying from chronic illness, the existential angst experienced over dependency or loss of control does not suffice as a persuasive argument in favor of euthanasia.²⁵ Medicine inherently possesses particular goals, but the direct and intentional killing of patients has never been one of them. Since clinicians are bound to save life and not take it, it follows that clinicians should not kill in principle. Therefore, within the context of palliative care, euthanasia proves to be a morally illicit option.²⁶

19. Examples of this form would include would involve removing life-support equipment or not delivering CPR when so doing medically contraindicated.

20. Examples of this form would involve injecting controlled substances into the patient, thereby causing death.

21. Hence, like euthanasia, assisted suicide is also medically contraindicated.

22. In fact, many advocates include conditions which are not terminal in the sense law traditionally assigns to the term – that is, a condition that is likely to cause death within six months, regardless of what treatments are implemented. See David F. Kelly, *Medical Care at the End of Life: A Catholic Perspective* (Washington, DC: Georgetown University Press, 2006), 118-32; see especially pp. 121-22.

23. Kelly, *Medical Care at the End of Life*, 118-32; see especially pp. 118-22.

24. Hence, these causes can lead to requests for euthanasia. See Gordijn et al., “Euthanasia and Physician-Assisted Suicide,” 181-97; see especially p. 194.

25. For a robust analysis of the argument justifying euthanasia, see Henk ten Have and Jos Welie, *Death and Medical Power: An Ethical Analysis of Dutch Euthanasia Practice* (New York: McGraw-Hill Publishing, 2005), 144-79.

26. Gordijn et al., “Euthanasia and Physician-Assisted Suicide,” 181-97; see especially pp. 194-95.

Even with the appropriate foregoing of life-sustaining treatment and adequate pain control, there remain some reasons why chronically ill patients may request assisted suicide. For assisted suicide proponents, there is little, if any, discernable difference between providing sedation enough to keep terminally ill patients unconscious while they die and simply assisting them to terminate their lives while they still possess the capacity to do so.²⁷ However, this essay contends that there is indeed a moral difference, and should be a legal difference, between killing and allowing to die. As with euthanasia, the illicitness of assisted suicide lies primarily in the intentions of the agents involved – the intentional termination of life in the effort to relieve suffering – and the means employed – the prescription for an overdose a drugs that will directly cause death.²⁸ It is doubtlessly true that the existential anxiety that comes with the dying process will tempt individuals to request an end that they themselves control. Yet even such neuropsychological suffering can be alleviated with the promise of pain management, coupled with the care and compassion of clinicians, family members, and others.²⁹ By abstaining from assisted suicide, palliative care takes a substantive stance toward this disputable social development.³⁰

4. SEDATION TO UNCONSCIOUSNESS IN PALLIATIVE CARE

4.1 The Function of Palliative Sedation

Patients suffering from terminal illness, with or without malignancy, often face severe symptoms during the final phases of life. In the majority of cases, these symptoms can be treated successfully. However, in some cases, patients experience symptoms that are largely uncontrollable.³¹ Refractory symptoms differ from difficult-to-treat symptoms in that, despite the many efforts of clinicians, they cannot be sufficiently treated without compromising the consciousness of the patient. Such acute suffering has a disproportionate impact on patient functioning and well-being, often intensifies as the patient approaches the end of life, and ultimately interferes with a peaceful dying process. Palliative sedation has thus been identified as a moral option of last resort when patients are confronted by refractory suffering. As such, sedation to unconsciousness is increasingly implemented by palliative care programs.³²

The practice of palliative sedation is herein understood as “the use of sedative medications to relieve intolerable suffering from refractory symptoms through a

27. The appropriate moral response to suffering, the argument goes, is to assist the sufferer in terminating suffering – whatever the means. See Kelly, *Medical Care at the End of Life*, 118-32; see especially pp. 123-24.

28. Kelly, *Medical Care at the End of Life*, 118-32; see especially pp. 123.

29. Kelly, *Medical Care at the End of Life*, 118-32; see especially pp. 123-24.

30. Gordijn et al., “Euthanasia and Physician-Assisted Suicide,” 181-97; see especially p. 195.

31. Patricia Classens, Johan Menten, Paul Schotsmans, and Bert Broeckaert, “Palliative Sedation: A Review of the Research Literature,” *Journal of Pain and Symptom Management* 36, no. 3 (September 2008): 310-33; see especially pp. 310-11.

32. Classens et al., “Palliative Sedation,” 310-33; see especially pp. 310-11.

reduction in patient consciousness.”³³ Many clinicians argue that palliative sedation does not necessarily require sedation to total unconsciousness and suggest that palliative sedation therapy can vary in terms of level (mild, intermediate, or deep), duration (intermittent or continuous), and pharmacological characteristics (primary, by drugs not proven to be effective in relieving the underlying symptoms, or secondary, by medications pharmacologically effective for immediate relief of underlying distress). Others classify sedation as sudden or proportional on the basis of whether it is established rapidly (“emergency sedation”) in preterminal patients who experience overwhelming symptoms for catastrophic events such as massive bleeding, severe dyspnea, agitated delirium, or pain.³⁴ It is therefore clear that deep, continuous sedation is but one of several forms of palliative sedation therapy.³⁵

4.2 *The Ethical Justification of Palliative Sedation*

Unlike euthanasia and assisted suicide, this essay contends that the practice of palliative sedation is morally justifiable. Some authors have hypothesized a negative impact of palliative sedation therapy on survival.³⁶ However, even if such impact were present, the use of palliative sedation therapy could nevertheless be ethically justified on the basis of its fulfillment of the four criteria inherent to the principle of double effect. The principle indicates that if doing something morally right has an indirect and unintentional morally wrong effect, it may be ethically permissible to pursue the particular course of action.³⁷ Moreover, current empirical studies suggest that palliative sedation therapy does not actually hasten death whatsoever, thus rendering the morally “wrong effect” inherent to the application of the principle of double effect nonexistent.³⁸

Unlike the practices of euthanasia and assisted suicide, the practice of palliative sedation clarifies that death is not the means by which palliation is achieved. Typically, sedation to unconsciousness is directly administered intravenously. Once the patient has been made comfortable, the medication is titrated.³⁹ Whereas euthanasia and assisted suicide break the link between the patient’s condition and medical treatment for particular

33. M. Maltoni, C. Pittureri, E. Scarpi, L. Piccinini, F. Martini, P. Turci, L. Montanari, O. Nanni, and D. Amadori, “Palliative Sedation Therapy Does Not Hasten Death: Results from a Prospective Multicenter Study,” *Annals of Oncology* 20 (2009): 1163-69; see especially p. 1163.

34. A further, more specific subtype of palliative sedation therapy is “respite sedation,” a procedure involving temporary and time-limited sedation. Finally, the possibility of using “routine,” “infrequent,” or “extraordinary” sedation has also been proposed. See Maltoni et al., “Palliative Sedation Therapy,” 1163-69; see especially p. 1163.

35. Maltoni et al., “Palliative Sedation Therapy,” 1163-69; see especially p. 1163.

36. Some have termed its approach “slow euthanasia” or, more frequently, “terminal sedation.” See Maltoni et al., “Palliative Sedation Therapy,” 1163-69; see especially p. 1164.

37. Hence, this is true even if the foreseen bad effect is likely to occur. See Maltoni et al., “Palliative Sedation Therapy,” 1163-69; see especially p. 1164.

38. Studies range from displaying that no difference exists in survival rates between patients who do and do not receive varying doses of sedatives at the end of life to multiple regression models concluding that the use of sedatives in the final forty-eight hours of life renders no increase in survival predictability. See Maltoni et al., “Palliative Sedation Therapy,” 1163-69.

39. If for no other reason than the chronological order of events, one can identify the direct and intended effect of the actions involved as being palliative, inasmuch as they occur first.

symptom management, palliative sedation maintains this essential moral link, thereby retaining its identity as a medical treatment in the traditional sense. Thus, unlike euthanasia and assisted suicide, palliation is the means to symptom management, not death. In this way, the direct and intended effect of achieving palliation by means of sedation to unconsciousness is ethically justifiable, even if the result is death.

5. CONCLUSION

The aim and proposal of this essay has been to examine the logic inherent to the practices of euthanasia, assisted suicide, and palliative sedation in the context of palliative care with the intention of positing the argument that while palliative sedation fulfills the requirements of morally licit medical practice – and so successfully executes the tenets of sound ethical logic – both euthanasia and assisted suicide do not. To secure the justification of this thesis, it has drawn from the twofold premises that (i) the licitness of medical practice is largely determined by the balance between (a) good ends, (b) proportionate means, (c) appropriate circumstances, and (d) benevolent intentions; and (ii) whereas palliative sedation employs criteria A-D (above), both euthanasia and assisted suicide fail to secure criteria A-C.

The implications here are significant. To be sure, the growing misunderstanding of the moral distinctions between the practices of euthanasia, assisted suicide, and palliative sedation are a genuine and growing concern. But rather than allowing it to terminate progress, it may instead serve to remind that while suffering is part and parcel of the human condition, it will never be eliminated by eliminating the individual who endures it.

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