Is Palliative Sedation Euthanasia in Disguise?

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In assessing the notion of whether Palliative Sedation is Euthanasia in disguise, critical analyses of both their definitions and their practice need to be pursued, given the many similarities between them. It may also be reasonable for us to hold the view that a cursory investigation is likely to yield an illogical conclusion. Likewise, there will be unequal scrutiny of both practices, since one is riddled with more controversies versus the other.

Definitions and practice of both Euthanasia and Palliative Sedation will be proffered, followed by an analysis of the procedure for Euthanasia. However, because there is (seemingly) few or no controversies surrounding the practice of Euthanasia and its purpose, a less rigorous approach will be done of its practice. However, its definition (to include its variations) will be analysed, with a view to emphasize its primary functions and purposes, and how, by its sheer definition, it differs from Palliative Sedation. Equally important is the fact that since more controversies are directed towards Palliative Sedation, its definition along with arguments for and against the practice will be more-so meticulously analysed.

According to the online Medical Dictionary, “the word ‘euthanasia’ comes straight out of the Greek -- "eu", goodly or well + "thanatos", death = the good death -- and for 18th-century writers in England that was what euthanasia meant, a "good" death, a welcome way to depart quietly and well from life. The most commonly understood meaning of euthanasia today is more than the old dictionary definition of dying well -- a good and easy death. It refers, for example, to the situation when a doctor induces the death with a lethal injection, of a patient who is suffering unreliably and has persistently requested the doctor to do so. Suicide, whether irrational or rational, for unrelated reasons is not euthanasia. Nor is the forced killing of another person. Pain relief administered by a Dutch doctor may shorten a patient's life. As is the case in other countries, in this is seen as a normal medical decision in terminal care and not as euthanasia.” (MedicineNet.com; cited Nov. 11, 2010)

Given the definition of Euthanasia from the Online Medical Dictionary, there ought to be no ‘grey area’ with respect to the purpose of Euthanasia. The dictionary, like all other extant literature, has stated in no uncertain term, that the sole purpose of Euthanasia is not to assist the patient with coping with their illness, or to help them to live a meaningful life regardless of the circumstances or the situation. Euthanasia has the sole purpose and objective, to cause the death of the patient, albeit in a ‘good’ way. The motive of the practice is to cause death, with all intent for the patient to NOT survive the effect of the drug that is administered to them.

The definition also clearly stated that ‘forced killing’ i.e. killing without the consent of the patient or his/her proxy, is not euthanasia. This emphasises the point that the decision makers are aware that the intent of the practice is to cause the death of the patient. The parties will therefore have to make a decision based on the known fact of what the end result will be, after the drug is administered to the patient. Therefore, although death, in this instance, would have resulted from the administration of a drug, it is not euthanasia. Likewise, the definition has unequivocally stated that suicide, whether irrational or rational, although resulting in death, it is still not
euthanasia. Similarly, if death results from the administration of pain relief, this cannot be called
euthanasia; but rather it is seen as normal medical care.

These illustrations show that not because death results from a particular act, that it is euthanasia.
Neither is it reasonable to say that because death is the result of a practice that all of these are
still ‘forms’ of euthanasia, but only go by different names. What helps to determine whether an
act can be considered to be euthanasia, is to determine if that particular act satisfies the
definition, the intent, and the aim of euthanasia. If that act satisfies these conditions, then it is
reasonable to classify it as an act of euthanasia; but if it doesn’t satisfy these criteria, then they
cannot be reasonably classified as such.

Let’s use an analogy to illustrate the point that not because death results from a particular act, that
the intentions leading up to the death were the same. If a pedestrian were to be fatally hit by a
motorist who intended to kill him, then this of course results in the pedestrian’s death
(mimicking euthanasia). On the other hand, if a motorist is pulling off the road to give a
pedestrian a ride when his vehicle accidentally kills him (the pedestrian) then this of course
results in his death (mimicking palliative sedation). The fact that this illustration shows that we
can have the same end result but with different intentions, shows that euthanasia and palliative
sedation could have the same results, but also with different intentions as well.
Although intentions are difficult to prove, it is, in my opinion, the primary element that
differentiates between euthanasia and palliative sedation. If it is, and no doubt has been the case,
that healthcare professionals perform the act of euthanasia under the guise of palliative sedation,
then the definition, meaning, and practice of palliative sedation ought not to be blamed for such
an act. Obviously, such acts are a distortion to the intent of palliative sedation. Likewise, such an
act would amount to an abuse and misdemeanor.
However, the fact that human element is involved, we will always have distortions. This does not
mean though, that we should disband all events that involve the human element, otherwise there
will be no event. Therefore, to make palliative sedation represent palliative sedation (for which it
was intended); and to not make palliative sedation be euthanasia --in disguise, (for which it was
not intended), we can only implore the relevant practitioners to follow the strict guidelines laid
down for the practice of palliative sedation.
Although a definition for euthanasia has already been mentioned, other sources give similar but
more comprehensive definitions, with variations. One of the reasons for highlighting the many
types and forms of the practice of euthanasia, is to underscore the notion that whichever type or
form of Euthanasia is applied, the INTENT is to ALWAYS cause the death of the patient. These
types and forms of practice can then be compared with other types and forms of medical
intervention, with a view to establish which practice would ‘match up’ to the definition of
euthanasia, and hence determine from this comparison, which act is or is not euthanasia.
Euthanasia has generally been defined as the intentional killing by act or omission of a dependent
human being for his or her alleged benefit. What is critical to note here is the key word “intentional”,
because if death is not intended then it is not an act of euthanasia.
Voluntary euthanasia has been defined to be an act of euthanasia carried out upon the voluntary
request of the patient. This means that the patient was fully conscious and was aware of what the request
meant and also that the act was irreversible.
Non-voluntary euthanasia is when a person who is killed by the act did not, or was not in a conscious
and autonomous state to, make a request; which would mean in essence that the patient’s wish was not
known but at the same time was killed, a decision that could have been made by care givers in consultation with the doctor.

**Involuntary euthanasia** is killing the patient against his/her wish. That is, a patient made a clear and categorical request not to be euthanized but still the act was performed on that patient, literally against their will.

**Physician assisted suicide** occurs when a patient is provided with information, guidance and means of taking his or her own life from a doctor, and the actual act is performed by the patient himself/herself.

**Active Euthanasia** is when the patient’s death is caused by performing an action such as giving a lethal injection. In other words active euthanasia is actually doing something to cause the death of the patient.

**Passive Euthanasia** is withholding necessary nutrition and hydration that would inevitably lead to the patient’s death. In other words, passive euthanasia is not doing something to cause the patient’s death.

**Indirect euthanasia** involves the assistance of a clinician, e.g. physician, clinical nurse practitioner, pharmacist) whose role is to provide the treatment for the symptoms but nonetheless is knowledgeable that one of the side effects is an early death. This is different however, from physician-assisted suicide. In a physician-assisted suicide case, the doctor prescribes the medication with a deliberate intention to cause death and not to directly treat the symptoms. (only considered as euthanasia because of its context i.e. intentions)

**Direct euthanasia** means the involvement of a clinician in actually inducing a patient’s death by administering the lethal injection, especially in cases where patients are physically incapable of performing the lethal act themselves.

In The Netherlands however, the definition of euthanasia is more precise. Based on the recommendation of the Royal Dutch Medical Association, The Dutch Parliament legislated a new act on April 10, 2001 which took effect on April 1, 2002, which made the definition of euthanasia more precise and restrictive. With the new act, Euthanasia is now defined to mean “…the termination of life by a doctor at the patient’s request, with the aim of putting an end to unbearable suffering with no prospect of improvement. It includes suicide with the assistance of a doctor” (www.justitie.nl). It is critical to note that the voluntary aspect of the definition is of utmost significance. This is so because a decision by any party to terminate the life of a patient, and an act carried out on the patient with the intention to kill and which results in the termination of the life of the patient without the voluntary request of the patient is not considered to be euthanasia, but rather homicide. Also, withdrawing or refusing from medical treatment at a patients request is not euthanasia, as the doctor is obliged to honour and respect the requests of the patient. The doctor is also at liberty to withhold or discontinue any form of medical treatment that in his/her opinion is considered medically futile, and this would not be considered euthanasia as it is viewed as a part of normal medical practice. Interestingly, the law also states that the doctor may also attempt to relieve pain using even stronger medication, even if this has the side effect of hastening death, and this would not be considered euthanasia, because it was not requested by the patient to take his/her life and neither was it the intention of the doctor to kill. This practice however is what is normally referred to as “Terminal Sedation” or “Palliative Sedation”.

Brender et al defines Palliative Sedation as “the use of sedative medications to relieve extreme suffering by making the patient unaware and unconscious (as in a deep sleep) while the disease takes its course, eventually leading to death. The sedative medication is gradually increased until the patient is comfortable and able to relax. Palliative sedation is not intended to cause death or shorten life”. (Brender Erin et al)
This definition once again emphasises the point that although the sedative administered to the patient may cause to be unconscious, the intention is not to cause death. Also, the purpose of the drug is to allow the patient to comfortable and relax, while the underlying illness takes its course, eventually leading to death. The point here is that although death occurred, it was not caused by the drug that was administered, but rather by the underlying illness.

**Procedures for administering Euthanasia and Physician-Assisted Suicide (PAS)**

In The Netherlands, before Euthanasia or PAS can be carried out there are certain legal requirements that both patients and doctors have to follow. These requirements are the most recent in the debates of euthanasia and PAS that have been going on well in excess of thirty years. Prior to this new ruling effected by law, euthanasia and PAS were only tolerated under section 40 of the Dutch Penal Code System where a doctor was not punished for these practices because of the “defence of necessity”. These new requirements became effective on April 01, 2002 and by this new law physicians can now be exempt from punishment of performing euthanasia and PAS if the requirements are adhered to. If these guidelines are not followed then the doctor that performed the act can be charged for intentionally killing another human being (euthanasia) or assisting another human being to committing suicide (PAS).

**Motives for Palliative Sedation**

According to Roger Worthington (2005: 67), a systematic review on the indications or motives for sedation in end-of-life care found that the syndromes of delirium and agitation in an extremely ill patient were the most common indicators for sedative use in cancer palliative care, with a weighted mean of 65%. Breathlessness was the next most frequent reason with a weighted mean of 26%, followed by pain that weighed in at a mean of 14%. These reasons have been derived from many studies that have been conducted over a nine-year period (1990-1999) and by different researchers.

Broeckaert et al lends support to Worthington’s list of motives for palliative sedation and in the order of frequency as well. The article, in addition to listing delirium, dyspnoea, and pain as the most frequent motives for palliative sedation, also suggested that there are other reasons for requesting terminal sedation such as haemorrhage, nausea/vomiting, fatigue, and psychological as well. The article also noted that there can be a combination of any of these reasons from any one patient for requesting palliative sedation.

**Arguments for Palliative Sedation**

Roger Worthington argues that the aim of sedation in end of life care is not to end life, as this would be euthanasia. He posits the argument that the expected outcome from sedation in end of life care (palliative sedation) is not death but rather: rapid relief of distress; the lightest level of sedation possible; death resulting from the natural course of the disease. However, according to him, there are possible though unintentional outcomes that need to be monitored for: poor relief of symptoms and hence distress; over-dosage and risk of complications from this; sedation that is unnecessarily prolonged or at a level that is too deep; risk of dehydration or lack of nutrition. He further claims that the greatest fear of health professionals using sedation at the end of life is the risk of causing premature death, although some articles may suggest that this is an accepted practice. However, Worthington has further argued that a systematic review has disputed this claim.
In proving his point that sedation in end-of-life is not intended to cause premature death and usually doesn’t cause premature death, Worthington refers to an article published by Billings and Block in which ten studies that examined length of use of sedation before death found a weighted mean of 2.8 days before death and this could be interpreted to mean that sedation resulted in death 2-3 days after commencement or alternatively, that sedation is only employed in the last days of life and that death would have occurred at this point, regardless (Worthington 2005: 68-69).

Worthington also claimed that five studies were identified, comparing survival from admission of sedated and non-sedated patients and that none of the studies found a shorter period of survival for the sedated group. He was however cautious to say that this does not prove that sedatives used in this situation have no effect on survival and that only a controlled trial could demonstrate this, but then that would be unethical. He further notes that the findings could be explained by the fact that patients who go on to require sedation are admitted earlier, hence lengthening their survival from this point. What he claims none-the-less, is that these studies do provide reasonable evidence to dispute the claims of slow euthanasia and to counter any fears of precipitating an early death (Worthington 2005: 68-69).

According to Vissers et al. (2007, 137-142), the practice of Palliative Sedation does not necessarily have to cause death (as a double effect), but can have the effect of alleviating the patients pain and maintaining deep sleep or unconsciousness of the patient until he or she dies ‘naturally’ from the underlying illness:

As opposed to the so-called ‘double-effect’ of increasing the dose of opioids or sedative drugs with the primary intention to alleviate the symptoms but may have the unintentional consequence of hastening death; palliative sedation has the objective to induce sleep or unconsciousness until such time as death occurs as a result of the underlying illness, without accelerating the process of dying.’

Therefore, Vissers et al are suggesting that palliative sedation does not and should not have the objective of hastening death (or postponing it) but that death occur as a result of the underlying illness. This article also suggests, more critically, that the intervention does not affect the ‘natural’ course of death and therefore should not be seen as an ‘alternative’ way of dying, vis-à-vis the ‘natural’ way.

A recent study has shown that since a 2002 act regulating the ending of life by a physician at the request of a patient with unbearable suffering came in to effect in the Netherlands, there has been a modest decrease in the rates of Euthanasia and PAS (van der Heide et al 2007). These authors are attributing this decline in the rates of Euthanasia and PAS to the increase of other end-of-life interventions, such as Palliative Sedation (Ibid). This study highlights the point that Palliative Sedation is viewed as a different medical intervention than Euthanasia and PAS, one that does not inherently conceive of the practice as a deliberate intention to cause death.

Arguments against Palliative Sedation
One of the general ethical arguments against Palliative Sedation is the fear that it is a form of euthanasia, considered to be “slow euthanasia”. However, Broeckaert et.al. argue that “if the sedation that is given is indeed adequate or proportional, then it is symptom control that is
carried out, not euthanasia”. They further posit the view that in the case of palliative sedation at least three things are not present which would otherwise have been necessary for a typical case of euthanasia. These have been identified as: the subjective intention of the physician is the death of the patient; the medication and the dosages that are administered to the patient must reflect the aim of the physician; the result of this act must by definition reflect the intentional death of the patient. In elaborating on these points, Broeckaert et al argue that based on their definition of palliative sedation the physician does not intend to kill the patient but simply to control the refractory symptom(s). If however, the patient dies sooner as a result of sedation, this should only be seen as an unintended side-effect and not a deliberate intention of shortening the life of the patient.

On the next point they contend that when palliative sedation is being carried out there should be a clear match between the dosages given and the dosages needed for symptom control, and not a match between the dosages given and the dosages needed to end the life of the patient. Therefore, if this intended practice is adhered to, then a patient could not be considered to be euthanized, as only the required dosage would be given to alleviate pain and suffering, and not an excess to deliberately cause death to the patient.

On their final three-point argument on differentiating between euthanasia and palliative sedation, they make the claim that by definition palliative sedation does not have a life-shortening effect. However, in answering the question of whether in reality palliative sedation has a life-shortening effect, they claim, (based on the available empirical studies) that there is a clear suggestion that palliative sedation does not generally shorten the life of a patient.

Another argument against Palliative Sedation is the perception that the practice shortens the life of the patient, sometimes with a deliberate intent by some healthcare professionals, and sometimes with the consent of the patients’ proxy. I would argue however, that if indeed some healthcare professionals deliberately and intentionally cause the death of the patient then this practice is undoubtedly both an abuse and a misrepresentation of the intended definition and practice of Palliative Sedation. Similarly, if a proxy should consent to this abusive and misrepresented practice, then the same proxy is guilty of “mis-conduct”.

**Administration of Palliative Sedation**

Although the use of Palliative Sedation is considered to be an aspect of normal medical care, there are foreseeable instances where there could be allegations of “overdosing a patient” and hence an abuse of medical practice by the physician which can result in premature death for the patient and a legal battle for those responsible for the patient’s wellbeing. Consequently there are guidelines for healthcare professionals to follow which if followed can assist the healthcare professionals to justify both their reasoning and process when they employ sedation. The process requires a number of stages to be considered (Worthington 2005: 71-83):

- The clinical decision of a situation being refractory, including the exploration of other specialist inputs
- Specialist multidisciplinary review
- Full information given in a timely and understanding manner
- Assessment of capacity and informed consent
- Skilled drug use and review, including consideration of the depth and length of sedation
Clear aims and intention of sedation
Consideration of hydration and nutritional needs
Careful documentation of the above
Introduction of safeguards to prevent abuse

Conclusion
The burden of deciphering the fundamental difference between euthanasia and palliative sedation lies primarily in the intentions of each. While Euthanasia is solely intended to kill (or end life), palliative sedation is intended to relieve unbearable suffering, excruciating pain, discomfort etc. While the ends may seem or even be similar, the intentions are never the same. Based on the determining factor i.e. intention, it is only logical to conclude that palliative sedation is NOT euthanasia in disguise.

References
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