Is Palliative Sedation Simply Legalized Euthanasia?

Palliative sedation, formerly known as terminal sedation, is legal in California. The American Medical Association outlines it in “Sedation to Unconsciousness in End-of-Life Care,” and their code of ethics impress that palliative sedation is just that, the act of sedating a patient in order to relieve extreme agony in a dying patient. This procedure is an option given to painful and terminally ill patients at the end stage of their disease, when all other treatment and analgesic options have failed and it is obvious that death is very near. This type of pain relief can hasten and even sometimes unintentionally cause death, causing critics to feel that it is a form of euthanasia, which is illegal. Palliative sedation is a controversial issue because the procedure has the potential to speed up the dying process, creating a grey area that begins to resemble euthanasia and assisted suicide in its more extreme cases. There are various degrees of palliative sedation; however, the intent is always to relieve pain and suffering, allowing the patient to die with dignity. It is important to understand that palliative patients are in the final stage of their terminal illness and death is imminent, with or without medical intervention. The patient is dying and has the right to choose or reject procedures that may or may not shorten their death, while the physician has an obligation to relieve pain and agony at their patient’s request.

The American Medical Association has established strict guidelines for palliative sedation. These guidelines focus on cases where palliative sedation is warranted and reasons why in certain situations, it is not appropriate. Under current AMA protocol, palliative sedation
must only be recommended in extreme circumstances where all other treatment options have failed, death is unavoidable, and the patient experiences unbearable physical pain. Existential suffering, like mental agony and distress, are not appropriate reasons for palliative sedation. It is required for the physician to fully disclose the effects of palliative sedation, with the patient themselves or their surrogate, and to discuss any other treatment options at this stage in their death. If palliative sedation is chosen as the best option, the physician must also discuss the length and degree of sedation to be given and whether or not to remove any life sustaining support during the sedation process. Prior to palliative sedation, the physician is required to make detailed medical documentation of the reasons and the plan for palliative sedation as well as obtain written informed consent on the side of the patient.

The AMA separates palliative sedation from euthanasia or assisted suicide based on intent and proportionality. Palliative sedation is intending to induce a coma for the purpose of pain management, whereas the intent of euthanasia or physician assisted suicide is to induce death for pain management. In "Ethical Decision Making With End-Of-Life Care: Palliative Sedation and Withholding or Withdrawing Life-Sustaining Treatments," Molly Olsen, Keith Swetz, and Paul Mueller defend ethical palliative sedation practices by explaining “although the outcome of PS may include death as a product of disease, death is not a criterion for successful PS, whereas in PAS and euthanasia, death is the desired criterion for success.” The primary intent of a physician administering this end of life pain management is to relieve agony allowing the patient to be free of suffering, while allowing their preexisting terminal disease to run its natural course with as little psychological impact on that patient as possible.

The pain in a palliative patient can be extreme, so that it takes large doses of strong analgesics to achieve pain relief, and in some cases only sedation to unconsciousness will give
the desired effect. As I previously explained, the AMA distinguishes palliative sedation from euthanasia and assisted suicide practices on the basis of intent and proportionality. In “Terminal Sedation: Pulling the Sheet Over Our Eyes,” Margaret Battin finds flaws with this logic. She gives an example where this principle has potential to be abused in the medical field, and ponders how “one large dose of morphine may signify a bad intention but repeated or continuous infusions seem harmless. This is naive in the extreme. It’s the slyest courtier who poisons the emperor gradually; what could equally well be inferred is a clever attempt to cover one’s tracks.” This principle insinuates that it is only ethical when a patient is allowed to die a natural death, free from intervention of any treatments that have the potential to cause death to occur faster.

Critics would argue that while the patient is sedated, they are unable to eat or drink normally, so the need for supportive care is important and that once the supportive care is taken away, so is the sanctity of life. It could also be argued that this is not a natural death and that due to the removal of supportive care, death is hastened, and therefore the physician is inducing a slow euthanasia. In addition, one could argue that the sedation in itself is killing the patient also. In "Continuous Deep Sedation Until Death: Palliation Or Physician-Assisted Death?,” Mohamed Rady and Joseph L Verheijde indicate that “deep sleep sedation suppresses brain stem vital centers and shortens life” and that “continuous deep sedation should be distinguished from common sedation practices for palliation and characterized instead as physician-assisted death”. Rady and Verheijde also impress that continuous deep sleep sedation “contravenes the double-effect principle because: (1) it induces permanent coma (intent of action) for the contingency relief of suffering and for social isolation (desired outcomes) and (2) because of its predictable and proportional life-shortening effect.” It is easy to see why palliative sedation can easily be viewed as assisted suicide or euthanasia. It is true that removal of life sustaining support does in
fact hasten death, but most often times the patient is no longer able to eat and drink on their own, due to debilitating illness. Therefore, to say that discontinuation of supportive care is the same as euthanasia, is misleading. In these cases, if it weren’t for the supportive care, the patient would have failed to survive previously.

In support of palliative sedation, the AMA mentions the principle of double effect: a situation where it is impossible to avoid all harmful actions. The double effect of palliative sedation says that the good effect must outweigh the bad effect, and that the bad effect may not be the means of achieving the good effect. For instance, the outcome of the relief of severe suffering has the potential to unintentionally hasten or cause death, ending the patient’s life; but the ending of the patient’s life cannot be the means for relieving the suffering. In addition, proportionality must also be used and the level of sedation must be directly proportionate to the patient’s level of unacceptable suffering. However, the more intense the pain, the greater the moral obligation of the physician to reduce or alleviate the patient’s pain, but the physician has a legal obligation to sedate only until unconsciousness and not further.

Palliative sedation is intended to solely treat physical symptoms like pain, delirium and dyspnea (severe shortness of breath) but several studies have shown cases where it has been used to treat existential suffering such as fatigue, malaise and psychosis. Eric Cassell and Ben Rich in "Intractable End-Of-Life Suffering And The Ethics Of Palliative Sedation," disagree with the AMA, and suggest that palliative sedation should be considered for severe mental anguish symptoms during the last stages of death. Cassell and Rich explain that “their suffering, as suffering, is no different than the suffering that comes about because of pain and suffering in patients in the terminal stage of illness deserves consideration for PS depending on the patient’s needs and wishes without regard to what is believed to be the originating source of the
suffering.” Patients experience existential suffering when their terminal illness threatens to destroy the person they have known themselves to be and they begin to suffer emotionally.

There is a method that is quite similar to Cassell and Rich’s beliefs, called Early Terminal Sedation. Victor Cellarius tells of this method in “Early Terminal Sedation Is a Distinct Entity,” and contends that it should be considered separate from routine terminal sedation. He describes it as “a particularly contentious practice concerning deep continuous sedation given to patients who are not imminently dying and given without provision of hydration or nutrition, with the end result that death is hastened.” Cellarius explains how “the ethics are composed of two legally accepted treatment options: A patient has a right to refuse life-sustaining supportive care, while also having the right to sedation as a method to ease intolerable pain and suffering.” Early terminal sedation and existential palliative sedation are rare and go against the AMA’s code of ethics at the present time; however, Cellarius suggests that the present changing nature of palliative medicine will increase the use of early terminal sedation and reassures that it falls well within the ethical guidelines of palliative sedation.

In addition to the controversial gray-area of ethics and intent, there are other stigmas attached to palliative sedation. Cassell and Rich speculate that “one reason palliative sedation generates a level of controversy may be that early on it was saddled with the misleading labels of terminal sedation and slow euthanasia.” Olsen, Swetz and Mueller agree that there is a lot of controversy regarding this type of end-of-life care and claims it is also due to the negative attention of some medications by the media. For instance, Propofol was the drug that killed Michael Jackson, which is commonly used in human and veterinary medicine for routine sedation and is used for palliative sedation as well. His doctor was attempting to relieve the pain and malaise (existential suffering) of his extreme insomnia by giving him a continuous infusion
to sedate him enough to allow him to sleep. Ketamine, more commonly known by the media as the date-rape-drug, is also commonly used for palliative sedation and is one of the most widely used injectable anesthesias by veterinarians to produce sedation in animals. Barbiturates are a wide range of sedatives that are used in palliative sedation and can be given to treat an array of disorders, such as epilepsy or pain; but they are also the drugs given to end life in the situations like capital punishment, physician assisted suicide and veterinary euthanasia.

A patient has a natural right to refuse any and all lifesaving procedures such as CPR, IV fluids, blood transfusions, assisted breathing and diagnostic tests; and they have the right to discontinue any or all of these at any time during the course of their treatment. This is not suicide, nor is the physician acting to discontinue these treatments performing euthanasia. In the issue of discontinuation of supportive care, the reason the patient is alive is dependent upon these invasive procedures in the first place. The physician is merely discontinuing the medical aspect of the fight for the patient’s life, at the request of the patient or surrogate. The sedation aspect of this comes into play with the physician’s ethical duty to effectively manage pain and agony in their patients, healthy or not.

The end result of palliative sedation, euthanasia and suicide are the same; the person ceases to live. However, palliative sedation differs in many ways from euthanasia and suicide. Palliative sedation allows a person to die with dignity and free of pain and/or agony. It does not cause them to die any sooner than they would have without medical intervention. The sole purpose is to disconnect a terminally suffering patient from their painful reality, when they and their family are ready, to allow them to die without misery. The intention is not to cause death, but ease the dying process. In a situation where the patient is in excruciating pain and is on the brink of death, it is the right of the patient to choose to withdraw from supportive care, and
allowed to die while sedated, even to the point of unconsciousness, to prevent further unbearable anguish.
Works Cited


