A Primer on Palliative Sedation

Rev. Kevin Belgrave and Rev. Pablo Requena, MD

Abstract: The use of sedation at the end of life is proving a difficult topic of bioethical debate. In spite of efforts to reach agreement on definitions and guidelines, the practice most commonly known as palliative, or terminal, sedation remains a source of ambiguity and confusion. The goal of this article is to offer the reader a primer on the topic of palliative sedation. Two specific objectives are proposed: first, to orient the reader to some of the principal elements of the clinical and bioethical literature on palliative sedation; and second, to describe what we believe to be some of the principal sources for a theological understanding and evaluation of the use of sedation at the end of life. National Catholic Bioethics Quarterly 12.2 (Summer 2012): 263–281.

The use of sedation to treat otherwise unmanageable symptoms at the end of life is proving a difficult topic of bioethical debate. In spite of notable efforts to reach a consensus on definitions and guidelines, the practice most commonly known as palliative, or terminal, sedation remains a source of ambiguity and confusion, both in the professional literature and in the popular media.

The basic source of this confusion and ambiguity seems clear enough: sedative medications at the end of life can serve either the legitimate and good ends of medicine (relief of pain and suffering) or can be abused as a thinly veiled form of euthanasia. The moral task is to describe and articulate the distinction between
sedation as a legitimate relief of pain and sedation as euthanasia in such a way that it can be recognized (and thus regulated) in concrete clinical cases. However, while the moral task is easy enough to state, how to accomplish the task is more challenging, and the literature reflects this challenge. Moving from article to article in the palliative sedation literature can indeed leave the reader confused and frustrated.

The goal of this article is to offer the reader a primer on the topic of palliative sedation. Two specific objectives are proposed. The first objective is to orient the reader to the main features of the clinical and bioethical literature on palliative sedation. Although we will offer brief points of analysis and commentary along the way, our focus is an exposition of the literature itself. Given the general confusion surrounding the practice of palliative sedation, we feel that such an overview of the literature is an important contribution to the overall moral discussion. The second objective is to describe what we believe to be some of the principal sources for a theological understanding and evaluation of the use of sedation at the end of life. While the topic of palliative, or terminal, sedation has appeared in the pages of both this journal as well as Ethics & Medics, the articles to date have not attempted a systematic or comprehensive treatment of the topic.1

A Brief History of the Origins of Palliative Sedation in the Clinical Literature

To understand how the use of sedation at the end of life has come to be so confused, we need to understand something of its history. The first appearance of the term “terminal sedation” in the clinical literature was in a 1991 article by Robert Enck, which was a commentary on two prior studies.2 Although it did not use the term “terminal sedation” itself, the Enck article highlighted the practice of sedation for symptom management at the end of life. One of the studies it discussed—a 1990 study by Vittorio Ventafridda and colleagues—drew attention to the fact that while treatment for severe end-of-life pain and suffering was common in practice, the most serious cases, those that could be addressed only with sedation, were “rarely discussed openly.”3 In the early and mid 1990s, a discussion emerged seeking to

---

1 See Nancy G. Valko, “Should Sedation Be Terminal?” National Catholic Bioethics Quarterly 2.4 (Winter 2002): 601–608; John Howland, “Questions about Palliative Sedation: An Act of Mercy or Mercy Killing?” Ethics & Medics 30.8 (August 2005); and Cecelia Marie Scaduto, “Terminal Sedation Can Be Licit,” Ethics & Medics 35.6 (June 2010). The most comprehensive treatment can be found in “Should Sedation Be Terminal?” However, Valko’s focus is more on drawing attention to the potential for abuse in the use of sedation than on a systematic treatment of the topic. In Ethics & Medics, Dr. John Howland offers a reflection highlighting the many moral questions arising from the use of sedation at the end of life. Sr. Cecelia Marie Scaduto articulates prerequisite conditions for a moral use of sedation, with an important focus on the need to fulfill moral and religious duties at the end of life.


clarify the nature of symptoms that might justify the use of sedation at the end of life, as well to acknowledge the possibility of abuse.  

In the late 1990s, two United States Supreme Court decisions would mark a turning point in the debate over sedation at the end of life: *Vacco v. Quill* and *Washington v. Glucksberg*. These two decisions, delivered together on June 26, 1997, brought the ethical tension between terminal sedation and euthanasia to the forefront and acted as a catalyst to propell the debate forward for the next decade. The two cases involved a challenge to the constitutionality of a ban on physician-assisted suicide in New York State and Washington State. In *Vacco v. Quill*, the respondents (including Dr. Timothy Quill, a prominent palliative sedation commentator) argued that a patient’s legal refusal of life-sustaining medical treatment is essentially the same as assisted suicide and, thus, that the latter cannot be constitutionally withheld where the former is permitted. The Court rejected this argument, affirming the legal and moral distinction between allowing a patient to die and assisting a suicide. In *Washington v. Glucksberg*, the respondents argued that the freedom to choose the time and place of one’s death (essentially, through physician-assisted suicide) is a fundamental liberty of persons and should be granted constitutional protection under the Fourteenth Amendment. The Court again rejected this argument, appealing to a nearly unanimous history of legal and moral doctrine opposing suicide. In both cases, the Court affirmed the right of patients to refuse unwanted medical treatment, as well as the legitimacy of aggressive pain management, including “terminal sedation,” even if such treatment runs the risk of hastening the patient’s death. Thus for the most extreme cases of end-of-life pain, terminal sedation emerged as a kind of alternative that made a right to physician-assisted suicide unnecessary. Unfortunately, the meaning of “terminal sedation” was anything but clear or unproblematic. The respondents described it as “induc[ing] barbiturate coma and then starv[ing] the person to death”—essentially

---


a "covert" form of assisted suicide. Rather than clarifying the meaning of terminal sedation, the Court simply focused on the death-hastening potential of such sedation, noting its justification based on the principle of double effect.

Thus, while in both cases the Court rejected a general right to physician-assisted suicide, the overall result was an increased tension between euthanasia and the apparently legitimate practice of terminal sedation. Did this practice truly involve starving a person to death? Could a patient voluntarily exercise a right to refuse a "medical treatment" such as the assisted provision of nutrition and hydration (even if death by dehydration was certain) while at the same time asking that the symptoms of such dehydration be aggressively managed with the use of sedation? Did terminal sedation truly hasten the death of the patient?

Clinical Discussion of the Practice of Palliative Sedation

Over the next decade, attempts to clarify the practice of sedation at the end of life emerged. Various articles, including national and international consensus and guideline documents, attempted to shift terminology away from the ambiguous "terminal" sedation toward "palliative" sedation, to separate, both clinically and ethically, decisions about the use of sedation from decisions about the assisted provision of nutrition and hydration (such that a denial of food and water would not be seen as somehow part of the very meaning of terminal/palliative sedation), and to arrive at a clear definition of the practice. These documents often provide a systematic treatment of the clinical practice and ethical issues based on a substantial review of the preceding literature. As such, they can serve as a helpful starting point for the reader entering the palliative sedation discussion. A number of these documents merit particular mention:

8 For specific references to "terminal sedation" in the Court decision, see the opinion of the Court delivered by Chief Justice Rehnquist, note 11; and the concurring opinion of Justice John Paul Stevens, http://www.law.cornell.edu/supct/html/95–1858.ZC1.html.
1. European Association for Palliative Care (EAPC) Recommended Framework for the Use of Sedation in Palliative Care, Cherny and Radbruch, 2009. This consensus document is based on pre-existing guidelines, literature, and extensive peer review. The editorial introduction to this document calls it a “groundbreaking effort on behalf of the international palliative care community to agree on a structured approach to a controversial and sensitive issue.”

2. Palliative Sedation Therapy in the Last Weeks of Life: A Literature Review and Recommendations for Standards, de Graeff and Dean, 2007. This comprehensive document is a joint effort of twenty-nine palliative care clinicians from fifteen countries. Its aim was to develop internationally accepted definitions and recommendations based on the published literature.

3. Palliative Sedation: A Review of the Research Literature, Claessens et al., 2008. This extensive review of specifically empirical studies on palliative sedation was produced by a group of clinicians and philosophers from the Catholic University of Leuven, Belgium. The definition of palliative sedation provided in this document is particularly helpful.

In spite of these efforts, however, a clear and agreed understanding of the use of sedation at the end of life remains elusive. In the literature as a whole, one finds varying terminology, definitions, and descriptions. Sometimes the same terminology is used between authors to refer to what are, in fact, significantly different practices. Thus while some movement toward consensus is discernible, it is still helpful to understand the landscape of the clinical discussion on the use of sedation at the end of life.

Terminology

Consider a sample of the terms used to denote the practice of sedation for symptom management at the end of life: “terminal sedation,” “palliative sedation,” “continuous deep sedation,” “controlled sedation,” “sedation for the imminently dying,” and “total sedation, proportionate palliative sedation,” “palliative sedation therapy,” and “palliative sedation to unconsciousness.” To be sure, while varying

---

10 Nathan I. Cherny and Lukas Radbruch, “European Association for Palliative Care (EAPC) Recommended Framework for the Use of Sedation in Palliative Care,” Palliative Medicine 23.7 (October 2009): 581–593.


terms can still be seen in the literature, the trend does appear to favor the term “palliative sedation.” Of course the question remains, what exactly does this term mean?

Proportionate versus Continuous Deep Sedation

In general, the varying terms refer to one of two types of practices. Some physicians use the term “sedation” refers specifically, even exclusively, to the continuous use of deep sedation to unconsciousness lasting until the patient’s death. For others, the key element of the practice is a use of sedation proportionate to the symptoms being managed. Such a use of sedation need not be “to unconsciousness”; rather proportionality to the symptoms is the hallmark of the intervention they call “palliative sedation.” If sedation is needed to unconsciousness and until death, this would simply be a proportionate response to the severity of the symptoms being relieved. Because of this proportionality, it is recognized that palliative sedation can involve different levels and durations. Of course, authors do not always fall perfectly into one or the other of these two types. However, these themes of “palliative sedation as proportionate” and “palliative sedation as continuous deep sedation until death” do appear to represent an important aspect of the literature. In terms of a trend toward one or the other of these emphases, the literature appears to reveal a growing consensus in support of the centrality of proportionality in the definition of palliative sedation.


Last Resort and Refractoriness

Another important part of the clinical discussion of palliative sedation is the idea that sedation should be used only as a treatment of “last resort.” There is a sense that all other palliative care interventions must be considered before one decides to intervene in a way that will reduce patient consciousness. This “last-resort” criterion is usually addressed by some discussion of the nature of symptom refractoriness. In other words, sedation becomes an option when a patient’s symptoms prove refractory to other, treatments that are less compromising. Here, again, terminology will vary. Some speak of refractory symptoms, others of intolerable or intractable symptoms. Regardless of the terminology, there is notable debate over the exact meaning of this criterion. The debate appears to focus on two questions. First, what kinds of symptoms are included in the evaluation of refractoriness or intractability: physical symptoms alone (such as refractory dyspnea, delirium, and pain—the three principal symptoms listed as indicating the need for sedation), or psychological/existential symptoms as well? And second, who makes the judgment that a given symptom is refractory to treatment: the physician, the patient/surrogate, or both? The physician seems best suited to determine when all possible palliative treatments have been tried. Yet the patient seems best placed to determine when a treatment is intolerable.

Proximity to Death

Another general criterion for the use of sedation concerns the proximity to death of the patient. Here again, terminology can vary widely: “last phase of life,” “actively dying,” “imminent death,” and “terminal stage.” The criterion of proximity to death as a condition for the use of palliative sedation is widespread in the literature yet seldom explicitly defined. Some authors speak in general terms of “days to weeks” or “hours to days”; others refer to death “within two weeks” as the standard. Any standard is troublesome given the acknowledged difficulty and inaccuracy of life-expectancy predictions at the end of life. Clarity in the understanding of a patient’s proximity to death takes on particular importance when sedation is connected to a withdrawal of nutrition and hydration. In such scenarios, a failure to provide nutrition and hydration could, in fact, hasten death.

Descriptive versus Normative Definitions

In addition to the variations in terminology, indications, and the themes of continuous deep sedation versus proportionate sedation, the literature also reveals a certain divergence on the question of the kind of definition that is appropriate for “palliative sedation.” Some authors, advocating a purely descriptive definition, take “palliative sedation” to be almost any use of sedation in a palliative care setting. So defined, the criteria for the use of “palliative sedation” in a morally licit manner would need to be articulated in separate clinical practice guidelines that set standards

16 This fact is noted in Kirk and Mahon, “NHPCO Position Statement,” 916.
for things like refractoriness and proximity to death. Other authors, however, take
the term “palliative sedation” to include already, as part of the very definition itself,
the normative criteria that would make it morally licit.18

Given this significant variation in types and content of definitions in the clinical
literature, one must be cautious in interpreting the many empirical studies available on
the practice of sedation at the end of life, whatever the terminology used to describe
it. Without a shared understanding of what exactly the practice of sedation entails,
the studies are almost impossible to compare.19 For example, empirical estimates of
the prevalence of palliative sedation vary widely.20 Studies of the efficacy and safety
of palliative sedation are further plagued by methodological and ethical challenges
that are at times insurmountable.21 Needless to say, it is important to account for the
significant variation in definitions when trying to interpret the findings of empirical
studies. A similar counsel is required for the interpretation of media reporting related
to palliative sedation. With enough effort, one can find an article in the clinical
literature to support almost any interpretation of palliative sedation.

In conclusion, a correct moral judgment of palliative sedation requires a clear
definition that includes all morally relevant elements of the practice.22 Until such
elements can be uniformly articulated and, more importantly, agreed on in the
literature, it would seem that ambiguity and potential for abuse will remain. As the

18 For an example of this, see Judith A. Rietjens et al., “Re: Palliative Sedation: The
Need for a Descriptive Definition,” Journal of Pain and Symptom Management 37.3 (March
2009): e10–e11; and Bert Broeckaert et al., “Authors’ Reply: A Descriptive Definition of Pal­
While either approach to defining the practice could, in theory, yield a perfectly moral use
of sedation, the debate simply reveals yet another way that confusion and ambiguity can
emerge in the literature. It is worth noting that while Rietjens’ approach might, in theory,
work as a clinical definition, a moral definition of palliative sedation cannot prescind from
those morally relevant elements that are an essential part of the agent’s choice of action. This
is ultimately why we prefer and find helpful the definition offered by Claessens, Broeckaert,
and colleagues.

19 Efforts to draw reliable data from these studies are further hampered by differences
in care settings and patient populations across the various studies. See Patricia Claessens
et al., “Palliative Sedation, Not Slow Euthanasia: A Prospective, Longitudinal Study of
Sedation in Flemish Palliative Care Units,” Journal of Pain and Symptom Management

20 For example, one article notes a range of reported prevalence within their reviewed
studies of 3 percent to 68 percent. That is, some studies reported that palliative sedation
was used in 3 percent of studied cases, while other studies claimed that palliative sedation
was used in 68 percent of cases. See de Graeff and Dean, “Palliative Sedation Therapy,” 67.
Many other examples from the literature could be cited along these same lines.

21 For more on the methodological problems of palliative sedation research, see Claes­
sens et al., “Palliative Sedation: A Review,” 329–330; and Maltoni et al., “Palliative Seda­
tion Therapy Does Not Hasten Death,” 1168. Maltoni’s study is important as it explicitly
attempts to address and correct, as much as possible, the methodological weaknesses of
preceding studies.

22 See John Paul II, Evangelium vitae (March 25, 1995), n. 65.
literature reveals a definite trend toward proportionality in the definition of sedation use, we will end this section by offering what we believe to be a morally adequate definition of palliative sedation formulated by Patricia Claessens and colleagues in their 2008 review article and recently affirmed by one of the article’s original authors, Bert Broeckaert. According to this definition, palliative sedation is “the intentional administration of sedative drugs in dosages and combinations required to reduce the consciousness of a terminal patient as much [and as long] as necessary to adequately relieve one or more refractory symptoms.” Starting from this broad definition, further differentiations (mild/deep sedation, continuous/intermittent sedation) can be made. This definition, Broeckaert believes, stresses the “essential dynamic quality and proportional nature of palliative sedation.”

Clinical Discussion of the Ethical Issues

Admittedly, without a shared understanding of terminology and definitions, it seems difficult to proceed to any systematic discussion of the ethical dimensions of palliative sedation. However, for the sake of orienting the reader to the literature, it will be helpful to offer a brief overview of the ethical themes that emerge fairly consistently in the literature. The main ethical issues addressed in the literature are the following:

1. Distinguishing palliative sedation from euthanasia, and the question of intention.
2. Whether sedation hastens the death of the patient.
3. The role of the principle of double effect.
4. The concurrent use of assisted nutrition and hydration with palliative sedation.
5. The use of palliative sedation for existential suffering.

Palliative Sedation, Euthanasia, and Intention

Although the entire ethical discussion on ethical palliative sedation could be described as variations on the essential task of distinguishing the practice from euthanasia, this topic does get specific treatment in the literature. Palliative sedation, in its motivation and certain technical elements, can appear quite similar to euthanasia. Both are proposed as compassionate responses to suffering in a carefully defined set of seriously ill patients who are in advanced stages of disease. Palliative sedation and euthanasia appear to share the same goal of alleviating suffering, and both ultimately end with the death of the patient. In fact, the specific drugs used are often the same in both cases. Complicating matters even further is the rather nebulous concept of intention, which is often proposed as the key ethical distinction between the practices. With varying precision and elaboration, a number of authors try to articulate the ethically relevant distinctions between palliative sedation and

---

23 The “and as long” is a 2011 addition by Broeckaert. See Claessens et al., “Palliative Sedation: A Review,” 329; and Broeckaert, “Palliative Sedation,” 63.

24 Broeckaert, “Palliative Sedation,” 63.
euthanasia. Distinctions are made between the practices in areas such as intention/aim, instrument of relief, and effect/outcome.

Although intention is often proposed as a key distinction between palliative sedation and euthanasia, unfortunately the concept and terminology of “intention” get a fairly uneven and imprecise treatment in the palliative sedation literature. Intention is indeed a complex area of human action theory and a topic of much current debate, particularly regarding how, precisely, intentionality factors into the constitution of the moral object of an act. Even apart from these specific debates on the nature of the moral object, intentions can appear multi-layered and somewhat inaccessible to the outside observer, particularly in difficult clinical scenarios at the end of life. For these very reasons, authors such as Timothy Quill, himself a proponent of physician-assisted suicide, reject intention as a decisive element in the palliative sedation discussion. Rather, he argues that the ethical justification for palliative sedation should rely on informed consent, patient autonomy, and a straightforward principle of proportionality of treatment to suffering. Others, such as Joseph Boyle, show that clinical intentions need not be hopelessly complex and inaccessible but, rather, can indeed be regulated in the clinical practice of sedative use. For Boyle, and others, it is through practices such as the proportionate dosing of sedation to the severity of symptoms and adequate monitoring and documentation that a clinician’s intentions are revealed and the distinction between palliative sedation and euthanasia upheld.

Quill’s rejection of intention as a morally useful concept in difficult clinical scenarios represents an extreme in the clinical discussion. However, even among those authors who do not reject the out of hand the role that intention plays in the


27 Joseph Boyle, “Medical Ethics and Double Effect: The Case of Terminal Sedation,” Theoretical Medicine and Bioethics 25.1 (January 2004): 51–60. Boyle acknowledges that a person’s intentions are not completely accessible to an outsider and can be difficult even for the person himself to fully articulate. However, he argues that when intentions must be accounted for in a legal or regulatory context, what is important is not the deep and inaccessible intentions of one’s heart but rather the expressions of intention that are manifest in one’s actions and subject as such to evidence.
the moral description of palliative sedation, it can happen that even fairly straightforward distinctions in intention are lacking in clarity. Most notably, for instance, authors do not always distinguish between intention as it relates to the end, or ultimate goal, of an act (the why—for example, relief of suffering) and intention as it relates to the means chosen to accomplish this end (the what—for example, death of patient in the case of euthanasia and proportionate reduction in sensation in the case of palliative sedation). Such a distinction, obviously, accounts for how two specifically and, ultimately, morally distinct actions can be performed with the same (ultimate) “intention.” Such imprecision and lack of clarity, together with the outright contentious arguments of authors such as Quill, only further exacerbate the general confusion and ambiguity surrounding palliative sedation.

**Does Sedation Hasten Death?**

Closely connected with the question of euthanasia is whether the use of sedation at the end of life might hasten the death of the patient by depressing a vital function, such as respiration. While some hastening of death can be tolerated in pain relief under double-effect reasoning, clear evidence of a death-hastening element to palliative sedation would certainly blur its distinction with euthanasia. A diversity of opinion can be observed. A number of authors suggest that the belief that palliative sedation hastens death is fairly widespread, leading to a reluctance to use sedation even in cases where there may well be a morally sound indication. In contrast to these perceptions, however, the existing empirical data appear to suggest that palliative sedation does not in fact have a life-shortening effect, and that in some cases it may even prolong life. These studies are widely noted in the major literature reviews. At the same time, however, the methodological limitations of these studies...
are also noted. The principal limitation of empirical research in palliative sedation, particularly with reference to the life-shortening effects, is phrased succinctly by one review article: “Performing a randomized study is the only way to prove that palliative sedation has no life-shortening effect, but for obvious ethical reasons, this will never be performed.”

The Role of the Principle of Double Effect

Connected with the discussion of a death-hastening effect is the place of the principle of double effect in an evaluation of sedation at the end of life. If the trend in the literature proves accurate and sedation does not in fact shorten life, it would seem that the principle of double effect is not required. However, a small but important subset of the discussion on intention and the principle of double effect concerns the question of whether or not the reduction or suppression of consciousness itself can be considered an evil effect of sedation, particularly if such suppression lasts until the patient’s death. In general, the question of the principle of double effect, like the related question of intention, is a notable element of the palliative sedation discussion. Like intention, it too receives an uneven treatment in the literature. The two concepts are often found together, usually in connection with a discussion of whether palliative sedation could be justified even if it hastened death. In much the same way as he rejects the usefulness of intention in the description and evaluation of palliative sedation, Quill rejects the usefulness of double-effect reasoning. The two are in fact closely related. He argues that double effect entails requirements about intentions that are unrealistic in a clinical setting, particularly in regard to distinguishing between what is foreseen and what is intended. He argues that in difficult cases that require sedation, it is disingenuous to suggest that death is merely foreseen but unintended.

32 Claessens et al., “Palliative Sedation: A Review,” 329. Such a study would involve randomly assigning otherwise identical terminal patients to either treatment by palliative sedation or treatment without palliative sedation. The ethical problem, however, is that such a study design would require deliberately withholding sedation from a set of patients, even when it is clearly indicated, in an attempt to measure the effect this has on survival. Such a deliberate denial of basic suffering relief at the end of life would be ethically unacceptable.


34 Quill, Dresser and Brock, “Rule of Double Effect: A Critique.”

**Assisted Nutrition and Hydration**

The use of sedation together with assisted nutrition and hydration has occupied a prominent place in the ethical discussion since the beginning of the literature on terminal, or palliative, sedation. In early formulations of “terminal sedation,” the concurrent withdrawal of nutrition and hydration was, in fact, part of the very definition.36 In general, one can observe a trend away from this highly problematic view and toward the idea that the provision of nutrition and hydration should constitute a distinct discussion and be subject to a distinct ethical evaluation based on its own benefit–burden determination.37 However, in spite of this apparent consensus, the presumption that terminal sedation and palliative sedation necessarily include a denial of nutrition and hydration can still be found in the literature.38 It is also important to note a troubling description of palliative sedation that has persisted over the years in both the literature and the popular media. In this scenario, a patient desiring to end his life exercises a legal right to refuse “medical treatment”—in this case, the assisted provision of nutrition and hydration—with a promise from the physician that sedation would be offered to counter the effects of his autonomously chosen dehydration. This is a most troubling use of sedation, a thinly veiled form of assisted suicide. It is a practice, however, that may increasingly become the focus of the palliative sedation clinical debate.39

**Palliative Sedation for Existential Suffering**

One of the most controversial and debated elements of palliative sedation is the question of which refractory or intractable symptoms ought to be addressed by sedation—specifically, whether suffering that is existential or spiritual in origin may

---


37 For example, see Cherny and Radbruch, “EAPC Framework,” 587; de Graeff and Dean, “Palliative Sedation Therapy,” 75; Claessens et al., “Palliative Sedation,” 329; Kirk and Mahon, “NHPCO Position Statement,” 918; and Royal Dutch Medical Association, *Guideline*, 36.


be considered alongside symptoms such as dyspnea, delirium, and pain. A lack of clarity and consensus is widely acknowledged in the literature. Complicating matters further is the fact that existential suffering at the end of life most often co-exists with serious, life-threatening physical symptoms, which, by themselves, may lead a clinician to consider sedation. In the literature, one finds efforts to distinguish physical symptoms from existential ones. It is noted that existential symptoms are more difficult than physical symptoms to establish as refractory to treatment and that the progression of existential symptoms can be highly dynamic and unpredictable. Suffering that appears “refractory” one day may cease to be the next day. Adaptation and coping are common. One also finds efforts to set prerequisites for an acceptance of palliative sedation for existential suffering. Such prerequisites include a multi-disciplinary assessment of the patient and trials of respite or intermittent sedation, which are thought to break the cycle of existential distress and allow the patient to regain psychological strength. Overall, the reader of the clinical literature on palliative sedation has an impression of a cautious and qualified acceptance of sedation for existential suffering.

Notable exceptions, of course, exist. One important example is Lynn Jansen and Daniel Sulmasy. They argue that in order to know if a given treatment, such as palliative sedation, is an appropriate response to suffering in a patient, one must first determine the type of suffering. It is not enough to perform a simple proportionality calculation between a generic level of suffering and the treatment response. As Jansen and Sulmasy, they propose two general kinds of suffering: neuro-cognitive suffering, which has a direct causal relationship to a patient’s underlying physiological condition, and agent-narrative suffering, which is only indirectly related to the underlying medical condition and is more belief-dependent. They argue that even if pharmacological treatments, in some broad sense, “end” the patient’s suffering, those treatments are inappropriate for agent-narrative suffering. The reason is that such treatment ignores the physician’s commitment to what Jansen and Sulmasy call the restorative interests of the patient (the idea that the physician’s role is to “restore” a patient’s level of health). Elaborating their argument, the authors note that we more easily recognize a distinction in appropriate treatment for different types of suffering in patients who are not terminally ill. However, the distinction

43 Jansen and Sulmasy, “Proportionality.” Their argument, which is correct in our opinion, remains one of the most developed arguments against the use of sedation for existential suffering.
is often lost when treating terminally ill patients, assuming, perhaps, that they no longer have any restorative interests.

Like sedation in response to a voluntary stopping of eating and drinking, this is an area of the palliative sedation literature to watch closely in the coming years. With a general cultural fear of death and dying and increasingly better control of pain, requests for palliative sedation for existential suffering could increase. There is significant opportunity and need, both clinically and theologically, to develop a more complete moral argument against the use of palliative sedation for existential suffering. For the reader, it is likewise critically important to be familiar with the numerous clinical (but non-pharmacological) efforts to better respond to existential suffering at the end of life.\

Theological Sources for Understanding and Evaluating Palliative Sedation

Even if palliative sedation can be plausibly distinguished from euthanasia, and the additional ethical concerns be resolved, the moral challenge for Catholics would not be exhausted. Palliative sedation occurs at a decisive moment in the moral life—the time before death. It is a time marked by spiritual opportunity and serious moral duty. To interfere with a person’s level of consciousness—his use of reason—at such a decisive moment in the moral life is a serious decision that can, without exaggeration, have eternal consequences. Thus a theological context for understanding and evaluating palliative sedation is important.

The areas touched on by palliative sedation are in themselves theologically vast: pain, suffering, consciousness, and death. Because of this, one might rightly anticipate many sources of theological reflection that could in some way contribute to a clearer understanding of the use of sedation at the end of life. Historically, two sources emerge as particularly foundational: first, the Catholic tradition, both in the magisterium and theological reflection, on the morality of the suppression of pain and consciousness; and second, the Catholic tradition on preparation for death. Together these provide a properly theological context in which to understand and evaluate palliative sedation.

Suppression of Pain and Consciousness

The Catholic tradition on the suppression of pain and consciousness has a significant historical heritage. Moral reflection on the topic developed in connection both with medical practices such as amputation as well as theological reflection on

inebriation and the virtue of sobriety. In many ways, the tradition reaches its zenith in the pontificate of Pius XII, who, with his characteristic wisdom and common sense, took up the topic directly in a February 24, 1957, discourse to the Italian Society of Anesthesiology. It is difficult to overstate the importance of this discourse for Catholic reflection on palliative sedation. Magisterial sources and documents of pontifical organizations after Pius XII explicitly refer back to the teaching of this discourse. Unfortunately, too often only a few select passages are cited from the discourse leaving much of its content unexplored.

Pius XII's moral commentary in the discourse is structured around three questions submitted to him by the Italian Society of Anesthesiology. First, the physicians asked whether there is a general moral obligation to refuse analgesia and to accept physical pain in a spirit of faith. Second, they asked if the total or partial deprivation of consciousness (and thus the loss of the use of man's higher faculties) is compatible with the spirit of the Gospel. Finally, they asked if analgesics that suppress consciousness may be used when clinically indicated, even for the dying, and even when such use may shorten life.

On the moral obligation to accept physical pain, Pius XII is clear. There exists no general moral obligation. A specific obligation may exist, but only when the acceptance of the pain is required to avoid sin. Physical pain as a mortification may indeed be fruitful for the spiritual life, but it cannot, in such a case, be considered a duty. In fact, in many cases, pain can prevent the attaining of superior goods and interests. Thus the Christian duty of self-denial and interior purification does not entail a general duty to accept pain. In the spiritual life, pain is only a means, not an end to be desired in itself. Such acceptance of pain in the spiritual life, he notes, must be discerned in each case with prudence and the help of an experienced spiritual director. As Pius XII wisely notes, the outward acceptance of pain is not a sure sign of Christian heroism, nor is heroism lacking in those who do not accept pain. The acceptance of pain, rather, is simply one expression of what is essential: the desire to love God and serve him in all things. Heroism consists in the voluntary perfection of this disposition. Thus analgesics can be used without anxiety and do not conflict with our Christian duty to seek perfection.

Pius XII sets the question of the total or partial suppression of consciousness in the biblical context of Christ's own full and conscious acceptance of his suffering.

---

45 Pius XII, “Le IXe congrès” (February 24, 1957) AAS 49 (1957): 129–147. The discourse was given in French. For an English translation, see Pius XII, “Anesthesia: Three Moral Questions: An Address of Pope Pius XII to a Symposium of the Italian Society of Anesthesiology,” The Pope Speaks 4 (1957): 33–49.

on the cross, and refusal to attenuate it by drinking the “wine mixed with gall” (Matthew 27:34). In light of Christ’s actions, can man accept the reduction in consciousness brought on by some uses of analgesia? From Our Lord’s example on the cross, Pius XII argues, we are indeed bound to accept the “chalice of pain” every time God wills it. However, he continues, one must not believe that God wills such acceptance every time some suffering presents itself to us. Pius XII arrives at the central point: rational action, freely ordered toward an end, is a fundamental quality of man. There is thus a moral obligation not to be deprived of consciousness without a true necessity. However, there is nothing in the suppression of consciousness itself that violates the natural law or spirit of the Gospel.

On the use of analgesia for the dying, Pius XII acknowledges that the dying have a special motive to accept the spiritual value of suffering and reaffirms that the acceptance of pain cannot be considered an obligation even at death. In fact, the truly central dispositions at the end of life—love of God and abandonment to his will—can be strengthened if one’s sufferings are attenuated. Severe pain and physical exhaustion can undermine one’s moral courage, impede prayer, and prevent a generous self-giving. On this, Pius XII is clear: at the end of life, a person should not be deprived of consciousness unless a serious reason exists. In imitation of Our Lord, death should be faced with full knowledge for as long as possible. Consciousness should not be suppressed solely to avoid a conscious experience of death. Rather, Pius XII highlights, help should be given by family and the Church such that the person may die well. The dying person may not allow or ask for unconsciousness if there remain serious moral duties to fulfill (for example, a final confession). Furthermore, a doctor, before agreeing to the use of narcosis, must ensure that a patient has been invited to fulfill his moral duties. However, if the patient obstinately refuses to fulfill these duties, the doctor may give the narcosis without guilt of formal cooperation. In such a case, the fault lies not in the narcosis but in the will of the patient. Suppression of consciousness is permitted if there is no other means and it does not impede the fulfillment of religious and moral duties. Moral evaluation of suppression of consciousness thus depends on the concrete circumstances.

47 This point connects back to the discussion of whether suppression of consciousness itself may be considered an evil effect of sedation, thus requiring the use of the principle of double effect in the evaluation of palliative sedation.

48 The same idea is expressed by John Paul II: “as they approach death people ought to be able to satisfy their moral and family duties, and above all they ought to be able to prepare in a fully conscious way for their definitive meeting with God.” Evangelium vitae (March 25, 1995), n. 65. Rev. Romanus Cessario, commenting on the importance of a fully conscious preparation for death, writes, “The theological history of this provision is long and reflects a view of the Christian life that appreciates the moment of death as one of eschatological fulfillment. At the time of death, the person who has loved Christ throughout a whole lifetime should meet the Bridegroom in a condition that reflects the dignity of a rational creature. To reduce a human person to a permanent slumber does not honor this lodestar of classical Christian spirituality.” See his “Catholic Considerations on Palliative Care,” National Catholic Bioethics Quarterly 6.4 (Winter 2006): 647. See also Congregation for the Doctrine of the Faith, Declaration on Euthanasia (May 5, 1980), III.
The discourse is rich and has the potential to reacquaint us with ideas that too easily slip from the awareness of Catholics today. The importance of the end of life—this moment of eschatological fulfillment—brings with it serious moral duties that must be addressed before decisions are made to suppress consciousness.49

Preparation for death

A second theological source for reflection on palliative sedation comes to us in the late medieval *ars moriendi* tradition.50 These manuals of dying well—through text and art—presented the dying person with a clear means for understanding and resisting the temptations of the devil specific to the time before death. The tradition also spoke of the corresponding inspirations provided to the dying person to support and encourage him, as well as counsel on how to pattern one’s death after Christ’s, and how family and friends were to respond to the dying. From this tradition (as well as the biblical witness of Christ’s own dying moments) we see that the time before death can indeed be a particularly focused time of spiritual activity. The account of the good thief (Luke 23:39–43) reveals that it is also a time of immense spiritual opportunity, even in the midst of great pain.

Of course, the *ars moriendi* tradition is simply one aspect of a much more extensive Catholic tradition surrounding one’s preparation for death.51 Catholic tradition recognizes the importance of a “good death,” both asking the prayers of Our Lady “at the hour of our death” and invoking St. Joseph as the patron of a good death. The grace of “final perseverance” at the moment of death is well recognized in the tradition. We could further elaborate this point by examining the end-of-life experiences of the saints as well as the extensive liturgical rites surrounding the dying. Here we are thinking of the texts from the *Ordo commendationis animae*, as well as the prayers of the Sacraments of Anointing and Viaticum. In sum, the Catholic tradition acknowledges the reality of a suffering and conflict at the end of life that is properly spiritual in origin, as well as the importance of facing death consciously.

49 Cessario, “Catholic Considerations on Palliative Care,” 647.
Catholic traditions on the suppression of pain and consciousness and good preparation for death help to elicit and clarify the theological goods at stake in decisions to begin palliative sedation. They also clarify those goods that should inform conversations about end-of-life care long before the need for palliative sedation arises.52

**Need for Guidelines**

As one recent Canadian report noted, “The use of sedation as a modality of care at the end of life appears to be increasing without concurrent increasing clarity on the appropriateness of various kinds of sedation in various circumstances. There is a pressing need for a set of national consensus guidelines.”53 For a practice that has many names and is a source of notable confusion, efforts to untangle the ambiguity surrounding the use of sedation at the end of life are timely and important. This article has tried to orient the reader to the main features of the clinical discussion on palliative sedation as well as the key theological sources for understanding and evaluating its use.

With a general cultural fear of death, pressure to constrain health care budgets (especially for end-of-life care), and dying an increasingly aging population, it is reasonable to predict a significant push for expedient and economic options at the end of life. In such a cultural setting, the use of sedation, if not carefully defined, may, like euthanasia, appear as a compassionate and economic means of controlling both suffering and costs at the end of life. The beginnings of this tension can already be seen in the debates surrounding euthanasia happening in jurisdictions around the world.

A use of sedation strictly proportionate to the relief of refractory and intolerable physical symptoms is a part of good pain relief in palliative care. We do not stand by and watch a dying person gasp for air in distress or suffer under severe pain, in spite of our best clinical efforts, when the means to relieve such suffering are within our reach. On the other hand, in spite of the intuitive sense that sedation at the end of life can serve a good purpose, the practice is open to significant abuse. So long as a shared understanding of what precisely the practice of palliative sedation entails remains elusive, this potential for abuse will remain.

---

52 This point should be stressed. Often, by the time a need for palliative sedation arises, a person's cognitive and volitional function has already seriously degenerated. It may seem misplaced to discuss issues such as conscious preparation for death when the person is in such a state. However, understanding well the moral theological considerations surrounding the suppression of consciousness at the end of life can, as we note, serve the critical task of shaping and informing the entire remote process of preparation for death, as well as highlighting those goods most to be valued in the final moments of life.