Distinguishing Terminal Sedation from Euthanasia

A Philosophical Critique of Torbjörn Tännsjö’s Model

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Abstract. Torbjörn Tännsjö has argued that the practice of palliative, or terminal, sedation can be distinguished from the practice of euthanasia in a morally relevant way. He seeks to develop a coherent conceptual model for those who accept the sanctity-of-life doctrine, affirm the ethical permissibility of palliative/terminal sedation, and reject various forms of euthanasia. The author argues that Tännsjö has not sufficiently distinguished the practices of palliative/terminal sedation and euthanasia in a morally relevant way for those who accept sanctity-of-life values in end-of-life health care. His argument is a philosophical critique of the soundness of Tännsjö’s conceptual model. With respect to moral theology, the author claims that, in Tännsjö’s attempt to make his case, he uses the wrong conceptual tools, and the tools he does use, he uses wrongly. National Catholic Bioethics Quarterly 15.2 (Summer 2015): 287–301.

One complex ethical issue in end-of-life palliative care is the use of palliative, or terminal, sedation to manage otherwise uncontrollable pain and symptoms. Palliative/terminal sedation is thought to be an advance in palliative care that has lessened the call for physician-assisted suicide (PAS) or voluntary active euthanasia (VAE)

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in circumstances where many proponents of these procedures would deem them ethically and medically preferred. Understood broadly, palliative/terminal sedation is aggressive symptom control by the use of sedation, even to the point of deep unconsciousness if needed, in patients who are in the dying process.

The process of palliative/terminal sedation is widely recognized in law and is accepted by numerous professional health care organizations, including the Hospice and Palliative Nurses Association, the National Hospice and Palliative Care Organization, the American Academy of Hospice and Palliative Medicine, and the American Medical Association. What these organizations have in common is that they approve of palliative/terminal sedation as a legitimate form of palliative care while rejecting various forms of euthanasia.¹

Many philosophers and medical ethicists have, however, challenged the claim that terminal sedation eliminates the need for PAS and VAE as options for patients at the end of life. Some question whether the procedure is sufficiently distinct morally from euthanasia. Some claim that there is no real moral distinction between the practices of terminal sedation and euthanasia. In other words, terminal sedation is simply equivalent to “slow euthanasia” or “euthanasia in disguise.”² If it is, the implications are clear: either PAS and VAE should, like terminal sedation, be made legal and legitimate end-of-life options, or terminal/palliative sedation should be prohibited as PAS and VAE are.

¹ While I prefer the term “palliative sedation,” I use “terminal sedation” in the remainder of this essay to be consistent with the nomenclature used by Torbjörn Tännsjö. I think that a different conceptualization of the practice than what Tännsjö develops is a very welcome and important aspect of palliative care. What I have in mind here is what is known as proportionate palliative sedation. This is a monitored procedure in which sedating medicines “are progressively increased alongside other symptom-relieving measures, resulting in increasing levels of sedation during both waking and sleeping hours to help relieve suffering.” It is most often begun as a last resort in response to otherwise intractable physical symptoms, such as agitated terminal delirium, in patients whose death is imminent. There are two important qualifications that are often made about proportionate palliative sedation. The first is that it uses the “minimum amount of sedation needed to achieve its goal” with the rate of sedation increase being contingent upon “the severity of physical symptoms, usually ranging from hourly to daily.” The second is that it sometimes requires that the patient be sedated to the point of unconsciousness, “which is considered a foreseen but unintended side effect when lesser degrees of sedation [are] ineffective.” (Timothy E. Quill et al., “Last-Resort Options for Palliative Sedation,” Annals of Internal Medicine 151.6 [September 15, 2009]: 421.) It is my claim that this form of sedation at the end-of-life, proportionate palliative sedation, can be framed in a way that provides coherence for those who want to maintain traditional forms of the sanctity-of-life view, which entails an opposition to euthanasia, while also aggressively meeting the needs of dying patients who have refractory symptoms and intractable physical pain. The point of this essay is not to argue this case here. I raise this alternative for the sake of reinforcing the claim that some forms of aggressive sedation at the end of life that may even lead to unconsciousness until death nevertheless may be morally permissible and in some cases, perhaps, even obligatory.

According to this line of reasoning, a person who opposes PAS and VAE on ethical, philosophical, professional, or religious grounds should also oppose terminal sedation. One problem with this view is, of course, the fact that many medical professional organizations and legal scholars hold that terminal sedation is legitimate while rejecting PAS and euthanasia, as noted above. If the moral-equivalency arguments are cogent, that view is no longer tenable.

This essay discusses an argument by Torbjörn Tännsjö for making a morally relevant distinction between the practice of terminal sedation and the practice of euthanasia. Tännsjö is a utilitarian with respect to ethics, and he does not necessarily subscribe to the sanctity-of-human-life view. He nevertheless seeks to develop a coherent conceptual model, seemingly as an aid for those who accept the sanctity-of-life doctrine, affirm the ethical permissibility of terminal sedation, and reject various forms of euthanasia. Many, though of course not all, Christian ethicists, moral theologians, and medical professionals are seeking a coherent approach to sedation at the end of life that upholds these various values.

Although the notions with which Tännsjö is working with can be coherently maintained, his argument does not sufficiently distinguish the practices in a morally relevant way.

**A Description of Tännsjö’s Argument**

Tännsjö seeks to develop an argument that defends the moral status of terminal sedation against the kinds of equivalency arguments described above. He understands terminal sedation as

a procedure where through heavy sedation a terminally ill patient is put into a state of coma, where the intention of the doctor is that the patient should stay comatose until he or she is dead. No extraordinary monitoring of the medical state of the patient is undertaken. Normal hydration is ignored. All this means that in some cases where patients are being terminally sedated, death is hastened; if the disease does not kill the patient, some complication in relation to the sedation, or the withdrawal of treatment and hydration, or the combination of these, does. (15)

Tännsjö positions his view between the extremes of the euthanasia debate and suggests that terminal sedation, as he describes it, provides the best compromise for resolving such a contentious issue. He writes,

Adherents of euthanasia may well argue that terminal sedation is not good enough. Some patients may want to be intentionally and actively killed by their doctors, they may claim. However, while they continue to argue their case, they should be prepared to admit that terminal sedation renders dying easier for the very patients on behalf of whom they put forward their argument for euthanasia.

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And adherents of the Sanctity-of-Life Doctrine, who oppose euthanasia, should be able to appreciate that there exists a way for them to answer the stricture that they are insensitive to human suffering. They can accept a practice of terminal sedation and yet, for all that, stick to the Sanctity-of-Life Doctrine and their opposition to euthanasia. (29)

He thinks one can hold to his understanding of terminal sedation and still identify morally relevant differences between it and euthanasia for those who reject euthanasia on the basis of the sanctity of life.

**Morally Distinguishing Features**

Tännsjö holds that euthanasia is incompatible with “two basic principles of medical ethics,” which are “the principle of acts and omissions and the principle of double effect” (17–18). He asserts moreover that terminal sedation, as he has defined it, differs from euthanasia with respect to these principles and is, in fact, compatible with them. It is on this basis that he wants to make an ethical distinction between terminal sedation, on the one hand, and euthanasia on the other.

How does Tännsjö see the relevance of these two principles at work? He holds that the distinction between acts and omissions has traditionally affirmed something like the following: “While it is always wrong actively to kill a person, it may sometimes be right to allow death to come about. Active killing is always wrong, passive killing may sometimes be right” (18). To be clear, he thinks the phrases “passive killing” and “letting nature take its course” are both apt descriptions for the same state of affairs (20). Actions that would fall under “passive killing” include, for him, the withdrawal of food from a patient who thereby starves to death and the removal of a ventilator from a patient who subsequently suffocates as a result.

He acknowledges that “all concrete actions are active under some description of them. However, some kinds of actions allow that we sort instances of them into the active or passive category, relative to the kind in question” (18). This is a key statement for Tännsjö’s appeal to these principles and the ethical work that they are supposed to do for him. So in contrast to removing a ventilator, which could constitute an instance of passive killing, “injecting an opioid, which kills the patient, is to kill actively” (18). He goes on to state that the act–omission distinction in itself is not of moral importance in the euthanasia discussion. The reason is that “in most Western countries, even active killing of severely ill patients is legally tolerated” (18). What he has in mind on this point are “cases where patients are given a sedative medication or opioids in a manner that hastens death. This is clearly a case of active killing” (18, original emphasis). For the act–omission distinction to have moral import in his discussion then, it needs to be coupled with the second medical ethical principle, namely, the principle of double effect.

He articulates this principle in the following way: “It is always wrong intentionally to kill a patient, but it may be right to provide aggressive palliative care, with the intention of relieving pain, even if it can be foreseen that the patient will die from the care in question” (18). He believes that the principle of double effect is clear enough for most people and seems reasonable to many. Here again, as with his first principle, he suggests that this distinction in itself is not of moral importance with respect to the euthanasia discussion. He also thinks that in most “Western countries . . . we do not abide by it” since “intentional killing of patients is legally tolerated” (19). What
Tännsjö has in view are situations like those classified by others as instances of passive euthanasia in the sense of “the withholding/withdrawal of medical treatment (or tube-feeding) with the intention (aim) of hastening death.” Understood in this way, he sees the refusal of treatment with the aim or intention of causing death as an instance of passive killing, and this is legally tolerated and morally permissible.

If neither of the two principles that Tännsjö takes to be part of medical ethics are, in themselves, of moral importance with respect to the discussion of euthanasia, then how does euthanasia violate them as he claims? He wants to say that it is “only a combination of the two principles (of acts and omissions and the double effect) [that] can substantiate” the moral impermissibility of euthanasia while permitting terminal sedation (19).

According to Tännsjö, then, we can sort various end-of-life medical practices and decisions into four discrete categories based on the combination of these two principles or distinctions. The first category is that of active killing where death is intended. An example here would be the practice of active euthanasia. The second category is that of active killing where death is merely foreseen. He would place terminal sedation (as he defines it) into this category, for “the point in sedating the patient is not to cause death, but to relieve suffering. So even if the sedation (actively) kills the patient, the death of the patient is merely foreseen, not intended” (20). Third is the category of passive killing where death is intended, as in the withdrawal of life-sustaining treatment with the aim of causing the death of the patient. He states, “The withdrawal of treatment is undertaken with the intention to hasten the death of the patient. However, this is a case of passive, not of active, killing” (20). And the last category is passive killing where death is merely foreseen. What he has in view here seems to be the withholding of life-sustaining treatment (in contrast to the withdrawal indicated in the third category) or the refusal to feed someone (without sedation) in a health care setting, if that is what is chosen by the patient or the patient’s proxy. In other words, this category also includes the failure even to initiate certain life-sustaining treatments.

Concerning moral evaluation of these four categories, Tännsjö claims that only the first category, that of active killing where death is intended, would be morally forbidden in a health care context. Actions in the other three categories are legally tolerated and hence, on Tännsjö’s view, morally permitted. With regard to the moral

4 John Keown, Euthanasia, Ethics and Public Policy: An Argument against Legislation (New York: Cambridge University Press, 2002), 217, original emphasis. Tännsjö does not make a distinction between passive euthanasia and withholding or withdrawing treatment. However, following John Keown and many others, I suggest here that what count as instances of euthanasia rely heavily on the notion of intent as a necessary part of the action. So when treatment is withheld or discontinued with the intention of causing death, the act is deemed passive euthanasia. However, if treatment is withheld or withdrawn because “the treatment is either futile or too burdensome, or in order to respect the patient’s refusal of treatment” (217), then the act is not considered passive euthanasia. Tännsjö does not appeal to this sort of distinction in his essay. He identifies passive euthanasia with the withholding or withdrawal of treatment regardless of the reasons for the act.
permissibility of passive killing or allowing nature to take its course, he does qualify his view:

Of course, this does not mean that all instances of passive killing are morally acceptable. Sometimes it is morally wrong to kill passively. As a matter of fact, this is wrong, and very wrong, in most cases. But when it is wrong to kill passively, this is not due to any inherent wrongness in the act, but to particular consequences of it. It may for example be wrong to allow a patient to die because of lack of treatment, if one has promised, or undertaken, to provide the treatment in question, most obviously so if the treatment would [have] saved the patient. (20, original emphasis)

It is unclear exactly how his emphasis on the consequences is supposed to be as significant as he intimates. He admits that his view “may seem strange” to some. If instances of active killing are tolerated and if intentional killing is also tolerated, then how can these all of a sudden be morally problematic when taken together? He responds to this question by noting that “it is the argument from the observation that a certain distinction lacks moral relevance in one situation to the conclusion that it lacks relevance in all situations that is fallacious” (20). This is how he explains that the two principles independently are not morally important in the euthanasia discussion, but that they do have moral significance for it when taken together. Tännsjö thinks that he has thus adequately developed an argument that distinguishes the moral permissibility of terminal sedation for those who also want to oppose PAS and VAE.

A Critique of Tännsjö’s Argument

The reasons Tännsjö provides for why his argument is able to justify the use of terminal sedation while euthanasia is still opposed legally, and perhaps morally, are twofold. First, terminal sedation does not violate what he calls the two basic “principles” of medical ethics, namely, the distinction between acts and omissions and the principle of double effect. Second, terminal sedation is consistent with the sanctity-of-life view. But many consider his development of these issues problematic and his conception of terminal sedation flawed. Moreover, he uses the wrong conceptual tools, and the tools he does use, he uses wrongly. The tools Tännsjö uses and the manner in which he makes his case make terminal sedation on his view a form of euthanasia, albeit perhaps in some cases slow euthanasia, which is incompatible with traditionally formulated accounts of the sanctity-of-life view. Furthermore, he misunderstands the sanctity principle and misapplies double-effect reasoning. Thus, his view does not appear to constitute an appropriate response to arguments of moral equivalence for those who oppose PAS and VAE but seek a coherent understanding of how palliative/terminal sedation could be used legitimately while maintaining a form of the sanctity-of-life principle.

Problems with the Active–Passive Distinction

Tännsjö’s use of the wrong conceptual tools can be seen in his combined appeal to the distinction between acts and omissions and the principle of double effect. The

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5 This is not to say that some form of double-effect reasoning necessarily is a wrong conceptual tool for this discussion. It is to say, instead, that the appeal Tännsjö makes to the
way Tännsjö discusses the act–omission distinction closely parallels conversations about the active–passive distinction and corresponds in many ways to the more specific killing–letting-die distinction. These close parallels seem unavoidable, given Tännsjö’s views and the general direction of the literature on the subject. Dan Brock’s description is correct when he says, “The active-passive distinction is typically understood to mirror the distinction between killing and allowing to die. . . . However, how the distinctions between active and passive and between killing and allowing to die should be drawn, as well as how they apply to these . . . practices, remains controversial”6—and ultimately, he thinks, unhelpful.

To be charitable to Tännsjö, he admits this much when he says, as noted above, “All concrete actions are active under some description of them” (18). Furthermore, he also admits that the distinction taken alone is not of moral importance to the discussion at hand. Fair enough. However, even when he combines the distinction between active and passive with the principle of double effect, he still uses the wrong tools to distinguish ethically between euthanasia and terminal sedation. How so?

Despite his denial, he needs the distinction between acts and omissions to be morally important as such in order to make his case as to why intentional active killing is morally prohibited but intentional passive killing may not be. For Tännsjö, an instance of medical killing that is morally impermissible, or forbidden (to use his term), must be both active and intentional. These are the individually necessary and jointly sufficient conditions of an immoral case of medical killing. The question for him then is, Why is intentional active killing wrong but intentional passive killing is not? The answer is not explicitly given in his essay. On the surface, he affirms that the first category of intentional active killing is not legally tolerated whereas the other categories are. But he needs to say more than this if we are to understand why instances of intentional active killing are morally wrong but instances of intentional passive killing are not. In other words, asserting that the practices in this first category are not legally tolerated does not get at the proper wrong-making properties to answer our question.

If Tännsjö were pressed on this point, his response might be based on other, more explicit comments made in his essay. Perhaps he would say that it is intentional active killing that violates the sanctity of life. But what is it about intentional active killing that makes it wrong when intentional passive killing in a health care context, ceteris paribus, is not? The only recourse he has is to appeal to the mode of the intentional killing, which under a particular concrete description is said to be active.

So while Tännsjö wants to say that the combination of the act–omission distinction and double-effect reasoning is of moral importance, it is difficult to avoid introducing the moral significance of the former, in itself, to explain why intentional active killing is wrong while intentional passive killing need not be. The notion of distinction between acts and omissions is not morally relevant in the manner in which Tännsjö needs it to be to substantiate his claim.

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intention is not synonymous with double-effect reasoning; they are not by any means coextensive.

Here is the conceptual rub. Many have pointed out that the act–omission distinction is unable to carry the moral freight often placed on it. Tännö agrees to this in principle but seemingly in practice makes an appeal to it anyway. But it is wrong-headed to put this kind of moral burden on the act-omission or the active–passive distinction while claiming that it is not sufficient to determine moral impermissibility. For Tännö, the reason why the first category of intentional active killing is morally forbidden is that it violates the sanctity of life—in a unique way, presumably. But as discussed below, when determining the wrongness of killing, the sanctity-of-life view focuses on the role of intention with respect to a course of conduct, not on the passive or active mode of agency. This then leads us to the next primary concern.

**Tännö’s View Is Incompatible with the Sanctity-of-Life Principle**

Most traditional formulations of the sanctity-of-life view exclude all modes, whether active or passive, of intentionally killing innocents. To see the problem, it is helpful to follow a line of thinking developed by Luke Gormally. The prohibition of intentionally killing innocents entailed by the principle of the sanctity-of-life bears not on “physical causation as such but on chosen courses of conduct, i.e., courses of conduct specified by the reasons for which they were chosen.” Gormally describes a course of conduct as being “identifiable as intentional precisely by reference to
the practical reasoning of the agent.”

This notion is an important component of the sanctity-of-life view. Gormally shows its relevance to the discussions surrounding PAS and VAE. He writes, “Thus a course of conduct is a case of intentional killing if what results in the killing was brought about, or allowed to happen (when it might have been prevented) because an agent chose that course of conduct in order to bring about the death of another. The purpose of securing the other person’s death was the reason for the agent’s action.”

So proponents of the sanctity-of-life view do not have conceptual space for a “distinction between acts and omissions,” even if the distinction is coupled with double-effect reasoning in the way that Tännö jö thinks morally relevant. It is difficult to avoid the conclusion that his conception of terminal sedation and intentional passive killing entails a course of conduct meant to bring about the death of another person. Terminal sedation then, as he understands it, does involve intending death, though I would argue that it ought not. He appeals to, uses, and applies the sanctity-of-life view in the wrong way.

Misapplication of Double-Effect Reasoning

Does the appeal to the rule of double effect get Tännö jö off the hook, so to speak? I do not think so. This is another area where he employs a potentially appropriate conceptual tool in the wrong way. The rule of double effect is invoked typically as a last resort when most other feasible options have been exhausted. Simply stated, the rule is that under certain conditions “an action is morally permissible, even if it results in something one would deem wrong if done intentionally,” as long as the following conditions are met:

1. That one’s action has two effects [one good, one bad], that follow from it immediately (“immediate” not in a temporal sense but in the sense that there are no other intended intervening states or agents).
2. That one’s action not be intrinsically wrong.
3. That one foresees but does not intend the bad effect; one only intends the good effect.
4. That the bad effect not be the cause of the good effect that one does claim to intend.

9 Ibid. (original emphasis). To be clear, many of those who do embrace a sanctity-of-life view think it is morally permissible in certain circumstances to withdraw or withhold life-sustaining treatment. They posit different reasons for doing so other than simply bringing about the death of the patient. They usually appeal to some form of proportionality of benefits and burdens. For proponents of the sanctity view, the death of the patient cannot be the aim of the action.
5. That one’s act is proportionate: that is, that the means are proportionate to the end, and that the good to be expected outweighs the bad in the particular situation.\textsuperscript{12}

Tännö seems to be advocating a form of terminal sedation known as “palliative sedation to unconsciousness,” where unconsciousness is the intended goal of the sedation rather than a foreseen consequence.\textsuperscript{13} This recalls the first line of Tännö’s description of terminal sedation noted above, where he states that terminal sedation is “a procedure where through heavy sedation a terminally ill patient is put into a state of coma, where the intention of the doctor is that the patient should stay comatose until he or she is dead” (15). In palliative sedation to unconsciousness, the aim of the sedated state is used “as a means of dissociating patients from their symptoms.”\textsuperscript{14} Its advocates claim that it is distinguished from euthanasia in practice in that death is foreseen but not intended. However, some astute practitioners and ethicists hold that “palliative sedation to unconsciousness cannot be justified under the rule of double effect.”\textsuperscript{15}

The problem is that palliative sedation to unconsciousness does not satisfy all the double-effect criteria. It does not meet the first criterion, since the action in question produces only one effect, not two. The first criterion, “that one’s action have two effects that follow from it immediately,” has often been rightly and reasonably presupposed but not explicitly stated. Yet it is obvious that “if one is to employ double-effect reasoning, there need to be two distinct effects.”\textsuperscript{16}

To illustrate the criticism, consider the following: It is often claimed that aggressive use of morphine can be justified under the rule of double effect because it meets all the criteria, including the first one. Morphine, as an opiate, causes both pain relief and respiratory depression. In other words, with respect to the relationship between the brain’s receptors and subsequent physiological functions that result from its use, morphine produces these two effects in the form of a \textit{causal fork}, that is, in the form of “\textit{a} causes both \textit{b} and \textit{c}.” The effects do not fit into a \textit{causal chain} of the form “\textit{a} causes \textit{b} which causes \textit{c}.”\textsuperscript{17} To meet the first criterion of the rule of double effect, one action must produce two effects in the form of a causal fork.

In another essay, Sulmasy develops this point in greater detail. He writes,

\begin{itemize}
\item \textsuperscript{12} William Joseph Buckley et. al., “Ethics of Palliative Sedation and Medical Disasters: Four Traditions Advance Public Consensus on Three Issues,” \textit{Ethics and Medicine: An International Journal of Bioethics} 28.1 (Spring 2012): 41. This formulation of the rule of double effect is given in Daniel P. Sulmasy’s section of the essay.
\item \textsuperscript{13} See the distinctions and descriptions of this and other forms of palliative sedation in Quill et al., “Last-Resort Options for Palliative Sedation,” 421.
\item \textsuperscript{14} Sulmasy and Coyle, “Palliative Sedation and Double Effect,” 114.
\item \textsuperscript{15} Ibid. This is not to say that palliative sedation to unconsciousness may not be morally justified in some other manner. Instead the claim here is that double effect reasoning is not the appropriate tool to be appealed to for justification of this particular form of palliative sedation.
\item \textsuperscript{16} Ibid.,114–115.
\item \textsuperscript{17} Ibid., 115.
\end{itemize}
Although in such a case it might not seem immediately obvious, there are, in fact, two separable events, distinct in time and space: pain relief (intended) and respiratory depression (unintended). To see why these really are two distinct events, making the application of the [rule of double effect] plausible, it is perhaps best to think about this case on a molecular level. The analgesic and respiratory depressant effects of morphine occur by the binding of morphine molecules at different subtypes of morphine receptors, populating different locations in the nervous system. The chemistry for each effect has a different time course (kinetics). Morphine achieves pain relief via $\mu_1$ receptors and respiratory depression via $\mu_2$ receptors. These molecular differences are manifested in the response of the patient to the drug. Pain relief occurs at lower doses and more rapidly than respiratory depression. Thus, while the effects are scattered throughout the body, conceptually this is still a Causal Forks Scenario. So the claim that one intended pain relief and not respiratory depression is plausible and coherent.\(^{18}\)

On the other hand, “if one is using benzodiazepines to induce sedation, one cannot claim that there are two distinct effects that both follow from the administration of the drug, sedation and hastened death. The benzodiazepines would be used to cause unconsciousness, and unconsciousness, in turn hastens death.”\(^ {19}\) This is a causal chain of the form “a causes b which causes c.” And in a causal chain there is “really only one effect and so ‘double’ effect does not apply.”\(^{20}\) So if palliative sedation to unconsciousness is morally justifiable at all, it cannot be on the basis of the rule of double effect. It would need to be justifiable on some other basis.

**Problems with Shifting the Aim of Double-Effect Reasoning**

Perhaps Tännsjö would reply that his understanding of terminal sedation is justified by double-effect reasoning because relief of suffering is the aim (not unconsciousness). He does, in fact, make a move in this direction in the middle of his essay, where he makes a decisive shift from what he stated previously. When he moves to identify what sort of practices fall within the four categories developed by the combination of the act–omission distinction and the principle of double effect, he writes of the second category that “the point in sedating the patient is not to cause death, but to relieve suffering. So even if the sedation (actively) kills the patient, the death of the patient is merely foreseen, not intended” (20).

However this may be, the question remains: Does this shift from aiming at unconsciousness to aiming at the relief of suffering entitle Tännsjö to use the rule of double-effect to justify terminal sedation? His overall purpose, once again, is to distinguish terminal sedation from euthanasia in a morally relevant way. He would seem to have a singular intention, which is to relieve suffering, and two effects, namely, (1) relief of suffering, the intended effect, and (2) unconsciousness leading


\(^{19}\) Sulmasy and Coyle, “Palliative Sedation and Double Effect,” 115.

\(^{20}\) Ibid.
to death, the foreseen but unintended effect. On the assumption that the rule of double effect is defensible, what then is the problem with this version of Tännö’s view?

The Shift Lacks Specification

The shift by Tännö to say that the intended aim is “the relief of suffering” lacks specification. It is simply too vague to be useful for double-effect reasoning. The rule of double effect does not have conceptual space for affirming simply that the ends justify the means. So the means by which the goal of suffering relief is accomplished must be evaluated. This is a central concern for appealing to the rule of double effect in the first place. For example, while the goal of alleviating child abuse is certainly worthwhile and morally praiseworthy, there are ways of accomplishing the goal that are obviously morally unacceptable. Killing all the children in a city to alleviate urban abuse is obviously one of them.

The question must therefore be asked, How is the goal of relieving suffering to be attained for Tännö? This has to be specified in a concrete way in order to judge whether it meets the other stated criteria of the rule of double effect. He does offer a more concrete description of terminal sedation as a medical procedure, as mentioned above, that is, as

a procedure where through heavy sedation a terminally ill patient is put into a state of coma, where the intention of the doctor is that the patient should stay comatose until he or she is dead. No extraordinary monitoring of the medical state of the patient is undertaken. Normal hydration is ignored. All this means that in some cases where patients are being terminally sedated, death is hastened; if the disease does not kill the patient, some complication in relation to the sedation, or the withdrawal of treatment and hydration, or the combination of these, does. (15)

If so, then the criticisms from the previous section return to the fore. Specifically, one wonders if this way of depicting the procedure involves a causal chain (rendering one effect) rather than a causal fork (which renders two effects). As has been argued, the causal fork with its two effects is what is needed for a legitimate appeal to the rule of double effect.

The Shift Reduces Terminal Sedation to Slow Euthanasia

Tännö does not provide any philosophical reflection on when terminal sedation is to begin in a patients’ trajectory toward death. Nor does he provide any philosophical reflection on circumstances, if any, in which the withholding or withdrawal of life-sustaining treatment would affect the moral assessment of the practice. Both of these considerations—when terminal sedation should begin and how the removal of life-sustaining treatment may affect its legitimacy—which are apparently not seen as relevant by Tännö, need to be evaluated with care in the practice of terminal sedation in order for it to be adequately distinguished morally from euthanasia, that is, if this is what Tännö is setting out to do in his model. Without such clarification, some procedures performed as terminal sedation may be in essence the same as procedures performed in euthanasia, namely, the intentional introduction of a known lethal agent into the covenantal physician–patient relationship. Sulmasy and Coyle rightly identify the problem when those who oppose euthanasia claim that it
is morally justified via double-effect reasoning to aim for or intend unconsciousness to relieve suffering. Sulmasy and Coyle write,

To justify palliative sedation to unconsciousness, in which one aims at unconsciousness until death, one would thus be required to argue that it is better for the dying patient to be unconscious than conscious. And if that is the case, it becomes hard to say how the justification for palliative sedation to unconsciousness differs from the justification for euthanasia. . . . The justification in both cases must be that it is better for the patient to be rendered permanently unable to speak, think, eat, pray, love, or interact with others, whether this is brought about through induced coma or death.  

The further danger with Tännsjö not including reflection on the timing and context of terminal sedation is that it makes criticisms of moral equivalency arguments much more salient. For example, Margaret Battin thinks that abuse and deception are more likely to occur in the practice of terminal sedation to unconsciousness and death than in physician-assisted suicide (PAS). She also thinks that terminal sedation does not fare any better with respect to two primary concerns about possible abuse that often arise with PAS. They are “(1) concern that the integrity of the medical profession will be undercut, and (2) concern that various familial, institutional, or social pressures will maneuver the patient into death when that would have been neither [the patient’s] choice nor in accord with her interests.”

According to Battin, terminal sedation is just as susceptible as PAS to abuse in these areas. The same issues of overworked physicians, biased health care providers, difficult and exasperating patients, and so on that may lead to premature and involuntary use of PAS—and that alarm many of its opponents—are no less real with terminal sedation. In fact, she thinks that on this score PAS may actually fare better than terminal sedation. She observes that in those states where PAS is legal, such as Oregon, there are safeguards in place—which are missing with respect to terminal sedation—that mitigate the possibility of abuse. According to Battin, terminal sedation is more easily influenced negatively because it obscures what the patient is agreeing to.

So the inevitable conclusion is that terminal sedation might be even more liable to abuse than PAS, or perhaps at least equally so. Therefore, terminal sedation provides no greater protection against abuse than PAS does. On the account of terminal sedation with which Tännsjö is working and the manner in which he employs the conceptual tools in question, it seems that Battin’s worries are legitimate when one aims to relieve suffering by palliative sedation to unconsciousness and death. If so, then it is not surprising that “there have been reports of those who, failing to see the

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21 Sulmasy and Coyle, “Palliative Sedation and Double Effect,” 116. It is possible that there could be other ways this state of affairs could be morally justified. But it does not appear that it can be done by appeal to double-effect reasoning which is the mode of justification in question in this section.

distinction between the justification for euthanasia and the justification for palliative sedation to unconsciousness, have titrated up the sedating drug far past the doses needed to dissociate the patient from his or her symptoms, explicitly in order to hasten death. It is a violation of transparency to ‘cloak’ these latter practices deceptively under the guise of palliative sedation.”

It appears that once deep sedation to unconsciousness and death becomes the aim in order to relieve suffering, as Tännsjö claims, “the distinction between justifiable and unjustifiable doses becomes easier to blur and the distinction between symptom control and euthanasia becomes more difficult to defend logically.”

Moreover, if there is no discussion as to the timing of terminal sedation and the circumstances under which artificial nutrition and hydration should be withheld or continued, then it becomes difficult to determine when terminal sedation is clinically indicated. Further, if double-effect reasoning is to be employed to justify an action one is considering undertaking, then the action should be seen as last resort. The basis for these claims is two-fold. First, given the “ethical and legal controversy about the acceptability of physician-assisted suicide and voluntary active euthanasia,” terminal sedation has been proposed as an ethically superior response “of last resort that [does] not require changes in professional standards or the law.” The very procedure of terminal/palliative sedation itself is considered appropriate when all other attempts at managing pain or treating symptoms have failed. This is why terminal sedation is often associated with or discussed in the context of dealing with intractable pain (i.e., pain that is resistant to relief) or refractory symptoms (i.e., symptoms that are not responsive to standard treatments). If standard treatments had been successful, there would be no need to employ such an extreme measure as terminal sedation. If terminal sedation were proposed when other, less radical treatments were available and reasonably thought to be effective, then one would have a difficult time justifying its use professionally.

Furthermore, appeal to the rule of double effect would not be appropriate in these situations, since it would not meet the proportionality requirement. This is because the good effect (the relief of suffering) could be achieved with a less invasive means that does not in the first instance aim for unconsciousness. Here is the two-fold basis for my claim that both terminal sedation and double-effect reasoning should be employed in palliative care when options of last resort are considered—and it is another indication that Tännsjö uses otherwise helpful conceptual tools in the wrong way.

24 Ibid.
Double-Effect Reasoning Does Not Help Tännsjö’s Model

All of this suggests that palliative sedation to unconsciousness as Tännsjö describes it does not meet the necessary criteria for a morally justifiable medical practice under traditional formulations of the rule of double effect. Thus, the claim that Tännsjö uses a potentially helpful conceptual tool in the wrong way is reinforced. To be sure, double-effect reasoning can be notoriously complex and controversial in theory and practice. We nevertheless need to tread carefully here. Certainly, much of what is said and believed in applied ethics, as well as in philosophy more generally, is controversial. The mere fact that there may be deep and widespread disagreement as to the moral importance of a distinction or form of reasoning does not in any way automatically make the controversial point irrelevant to the discussion. Some have sought to develop a robust version of double-effect reasoning that makes good sense for particular kinds of cases.26 However, a growing body of literature suggests that when sedation at the end of life is done appropriately, using proportionate means, there is no need to appeal to the rule of double effect, since death is not precipitated by the procedure.27

For the purposes of this essay, however, it is enough to affirm that regardless of what one thinks about double-effect reasoning, we simply cannot appeal to it to justify morally any or every situation in which some acts have unintended but foreseen consequences. One of the problems with double-effect reasoning is that, in practice, some have attempted to apply it too widely.

Conclusion

In light of the discussion here, those who hold to traditional formulations of both the sanctity of human life and double-effect reasoning should see terminal sedation, as formulated by Tännsjö, and euthanasia as morally equivalent. In fact, Tännsjö’s formulation is dangerously close to being a form of slow euthanasia. His arguments should not be considered an effective rebuttal to the charge that the two practices are morally equivalent.

26 See Sulmasy, “‘Reinventing’ the Rule of Double Effect,” 114–149.