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The Scholl Institute of Bioethics is a nonprofit, Judeo-Christian organization that addresses bioethical issues including euthanasia, physician-assisted-suicide, the withholding or withdrawing of food and water from non-dying patients, brain death, organ transplantation, genetic engineering, and the rights of disabled or mentally ill persons.

Is It Terminal? Is It Palliative?

by Elizabeth Hanink RN

Just as the English use the word "tea" in a variety of ways, so the medical and ethics professionals use the word palliative or terminal in a variety of ways. The only one sure thing to say about this particular area of end of life discussion is that no three people use the same terminology for the same thing.

But without a common definition, how can we draw any conclusions about the rightness of our actions? We really can't if we rely just on the words: terminal sedation, palliative sedation, total sedation, sedation therapy, controlled sedation, deep sedation, and sedation in imminently dying patients. Any and all of these can mean the same thing or something different.

Deep sedation is often administered to patients who for whatever reason (sometimes psycho) the difference is in intent. When doctors order aggressive pain relief or palliative sedation in the truest sense, the intent must be only to ease the patient's suffering

So what we have to do is look at the actions themselves and our intentions: what we are doing and why. One identical action, such as giving extraordinarily high doses of morphine, can be perfectly legitimate or morally wrong. How we give that morphine and why tells us the morality of the matter.

In one case, say, we are faced with a person who is very, very ill, close to the end of his life and in severe, unremitting pain. Pain medication has been given in steadily increasing doses, but relief has become elusive. It takes a long time and is not adequate. If the medication is now given in even higher doses, what ordinarily might be fatal will, in most cases, not be. People become accustomed to the drug, and it requires more and more to achieve the same level of relief. It might be that the higher dose that now seems necessary will lead not only to relief of the pain, but also might make the person somnolent, unresponsive for a while. It might even, in rare cases, hasten the death of the person, an unfortunate, but unintended result. This type of event is what classically would be called "palliative sedation."

Now take a different scenario. A person is in the same pain and requiring the same heavy regimen of medication. Caregivers decide or the person decides that all of this has become too much to bear. They decide to bring the whole process of dying to an end, because now the patient, to his way of thinking or theirs, no longer has a life worth living. In their effort to orchestrate a "peaceful death," more and more of the medication is given over a short period of time without regard to the patient's respirations, level of consciousness, or other measurements of safe administration. There is no intention for the person ever to regain consciousness. The intent here is to hasten, even cause death. Unlike in our first scenario, there is no interruption when the person has periods of less sleepiness and inability to communicate. The whole process is one continuous one without reversal: enough medication to secure coma and then death.

Many clinicians see this method as preferable to physician-assisted suicide and the Hospice Patients Alliance notes that it is becoming more and more common in hospice situations. Outwardly, this scenario of "terminal sedation" may appear to be a peaceful death, and yet be without the patient's consent or knowledge.

Depending on your viewpoint, either course of action may seem compassionate or callous. But those designations have nothing to do with moral actions. In some circles to rely on the principle of double effect invites

charges of hypocrisy or claims that an argument is based on a specific religious belief. And while Thomas Aquinas did articulate the principle quite clearly, perhaps earlier than any other, its application really reflects a common sense approach to moral reasoning and is by no means limited to any particular faith.

To use an analogy that is frequently cited in these discussions, consider this. When General Eisenhower gave the order for Operation Overlord, D-Day, he knew many soldiers would die. Did he murder them? No. When King David ordered Uriah the Hittite to the front line of battle, and then called back his other men so Uriah would surely be killed, did David murder Uriah? Yes. The difference is in intent. When doctors order aggressive pain relief or palliative sedation in the truest sense, the intent must be only to ease the patient's suffering. That the patient might inadvertently die in the process is regrettable. But a physician who assists a patient to receive medication so that death will necessarily and undoubtedly occur, has killed the patient, not the pain, and this is never acceptable.

Now most people and families will want a person who is close to death to remain lucid, able to eat and drink, able in other words, still to interact with his surroundings. If, as with some levels of sedation a person can no longer swallow safely, it is vital to ascertain whether or not such levels of sedation are really necessary. In those cases where it is, if death is not imminent, every effort still is made to be sure the patient is hydrated and fed, even if artificially, and every effort must be made that overdose does not occur. Any unresponsiveness should be carefully monitored and reversible.

If a person is within hours of death (and this is very difficult to determine accurately), he might naturally refuse food and water. This is very different from rendering the person incapable of swallowing. True, on rare occasions, pain relief is not possible without compromising the patient's ability to do certain things. If a deep level of unconsciousness is necessary to achieve pain relief or to assist with delirium in a patient who is actively dying, that degree of pain relief and sedation is appropriate, but it does not cause death.

1. Deep sedation is often administered to patients who for whatever reason (sometimes psycho) The difference is in intent. When doctors order aggressive pain relief or palliative sedation in the truest sense, the intent must be only to ease the patient's suffering. That the patient might inadvertently die in the process is regrettable. But a physician who assists a patient to receive medication so that death will necessarily and undoubtedly occur, has killed the patient, not the pain, and this is never acceptable some cases, are having nutrition and hydration withdrawn. The aim is to lessen the pain that starvation and thirst provoke if carried out for an extended period, say two weeks. This type of sedation, often called "comfort care," which serves to mitigate the painful side-effects of slow euthanasia or suicide is not acceptable, at any level.
2. To refuse medical care that is extraordinary or to refuse to allow its continuation is within the rights of everyone. But the same process of determining intent applies. If a patient is to be removed from a respirator, he may be given medication to relieve the symptoms of air hunger, restlessness, and so forth. But he cannot be sedated to an irreversible state of unconsciousness in order to hasten even an inevitable death. Nor should any weaning be so rushed as to guarantee failure.

End of Life decisions can be fraught with difficulty. Not all of us are graced with a peaceful death at home surrounded by family and friends. Our last days and those of our loved ones should not be clouded by suspicion or unnecessary suffering. For all these reasons, it is vital to establish before the time of need a person who can speak for you, understands your beliefs, and whose hands are not tied by demands regarding specific interventions.

Elizabeth Hanink is a nurse with forty years experience in hospitals and the community. She is a member of the Scholl Institute of Bioethics board and she is also on the board of California Nurses for Ethical Standards. Elizabeth is the Scholl Speakers Bureau coordinator. To arrange for a speaker call: 310-671-4412 or 310-365-9220.

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ADVANCE HEALTH CARE DIRECTIVES

Please check our website for information on a variety of AHCD forms for different denominations. Remember that although a lawyer or notary are usually not required, each state has specific requirements for documents to be binding.

Scholl discourages the use of the POLST form and reminds everyone that in most states,including California, its use is not mandatory.

Scholl Institute of Bioethics has made availabe for $2 an Advance Health Care Directive from the Archdiocese of Los Angeles.

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