
Bioethics Outlook

Plunkett Centre for Ethics

A joint centre of Australian Catholic University and St Vincents & Mater Health Sydney

Volume 24, No 2

June 2013

The use of sedatives in the care of persons who are seriously ill or dying:

Ethical distinctions and practical recommendations

The Fifth International Association of Catholic Bioethicists

The International Association of Catholic Bioethicists (IACB) was founded by a group of bioethicists from around the world in 2005 to advance thinking among Catholics on various emerging, unaddressed, or unsettled questions in bioethics. The IACB aims also to serve the common good by developing resources to promote ethical health care globally, with a concern especially for those who are marginalized or vulnerable, and to support bioethicists who contribute to discussions regarding health care policies in their various institutions and countries. The 900-year-old Order of Malta, one of two equestrian orders recognized by the Holy See, supports the IACB materially and through encouragement and promotion of the IACB's activities. The Order respects and fosters the IACB's academic independence and values the IACB's deliberations in carrying out the Order's work in health care and humanitarian aid in a manner consistent with its mission of witnessing to the Catholic faith and serving the needy (*tuitio fidei et obsequium pauperum*).

In this issue

We set out the most recent 'consensus statement' of the International Association of Catholic Bioethicists. The statement was developed at a meeting in Philadelphia in 2011 and published in the *National Catholic Bioethics Quarterly*, Vol 12, No 3, Autumn 2012. An explanatory statement by Drs William Sullivan and John Heng is followed by the statement itself. We gratefully acknowledge the permission to reprint from the National Catholic Bioethics Center.

The colloquia of the IACB

The main activity of the IACB is organizing international and regional colloquia every two years to enable bioethicists to get to know one another, exchange perspectives and ideas, and work together to identify and articulate points of agreement and questions that require further research, reflection and discussion. Such colloquia have been held in Toronto, Melbourne, London, Paris, Cologne, Philadelphia and Madrid. The next IACB international colloquium is being planned and will take place in Rome from June 9 to 14, 2013 on ethics and intellectual disability. The discussions during the IACB international colloquia are summarized in various consensus statements, which have been published and made available online at the IACB website¹. They are on the topics of care of the frail elderly in the global context², medically assisted nutrition and hydration³, the dignity of patients in health care systems that are appropriating business models of management⁴, stem research and regenerative medicine⁵, and the care of people with Alzheimer's disease and related progressive cognitive impairments⁶. What follows is the latest consensus statement on the use of sedatives in the care of persons who are seriously ill or dying.

¹ <http://www.iacbweb.org>

² *National Catholic Bioethics Quarterly* 2004; 4(1): 151-58.

³ *National Catholic Bioethics Quarterly* 2004; 4(4): 773-82.

⁴ *National Catholic Bioethics Quarterly* 2005; 5(4): 767-81.

⁵ *National Catholic Bioethics Quarterly* 2008; 8(2): 322-39.

⁶ *National Catholic Bioethics Quarterly* 2010; 10(3): 549-67.

This topic was discussed at the fifth IACB International Colloquium held in Philadelphia, U.S.A., from July 12 to 16, 2011. About 50 bioethicists from 12 countries participated, representing various clinical sciences and specialties in health care, philosophy, ethics, law, canon law, theology, thanatology, and pastoral care. Collectively participants had considerable expertise and experience in providing palliative care or reflecting on ethical and theological issues relating to the care of persons who are seriously ill or dying. The colloquium was sponsored by the American, Federal, and Western Associations of the Order of Malta in the U.S.A. and hosted by the National Catholic Bioethics Center and St. Charles Borromeo Seminary.

Process

This statement resulted from the collaboration of participants in the 5th IACB international colloquium. Those who signed the statement contributed in some manner to discussing, writing and editing various versions of it. The statement reflects their views and is not intended to represent the position of the Order of Malta, the hosting organizations in Philadelphia, or every member of the IACB.

Experts on various areas relevant to the topic of the colloquium were invited to write background papers that participants read prior to the colloquium. Daniel P. Sulmasy (U.S.A.), Paulina Taboada (Chile), Henk ten Have (U.S.A. and the Netherlands), Fr. Tadeusz Pacholczyk (U.S.A.), Pierre Mallia (Malta), and William L. Saunders (U.S.A.) were the authors. A number of other participants in the colloquium were asked to provide a response during the colloquium to one of these papers. These respondents were Edmund Pellegrino (U.S.A.), Sr. Alice O'Shaughnessy (U.S.A.), José Pereira (Canada),

Sr. Nuala Kenny (Canada), Robert Barnet (U.S.A.), Fr. Paul Chummar (Kenya), Jos Welie (U.S.A.), and Bernadette Tobin (Australia), with input from Nicholas Tonti-Filippini (Australia).

After the author's and respondent's presentations on each paper, all the participants in the colloquium met in small discussion groups. The main points were summarized and presented by representatives of the groups during plenary sessions, and this was followed by further discussions. Fr. Joseph Tham (Italy), Ursula Sottong (Germany), Jaro Kotalik (Canada), Linda Scheirton (U.S.A.), Christine Jamieson (Canada), Bernadette Tobin (Australia), Bishop John Sherrington (U.K.) and Peter Gummere (U.S.A.) served as group representatives.

The initial draft of the statement, summarizing points of agreement among all the participants in the colloquium, was prepared by William Sullivan (Canada) and John Heng (Canada). This draft was scrutinized in small-group discussions and in two additional sessions of live editing by participants in the colloquium. Three subsequent drafts were circulated among these participants after the colloquium, and the helpful comments received from many of them were considered by a team of editorial consultants consisting of William Sullivan, Jos Welie, Bernadette Tobin, Bob Barnet, Fr. Kevin Belgrave (Italy) and Gerry Brungardt (U.S.A.). Accepted changes were incorporated into the final version of the statement by William Sullivan and John Heng.

Background of the Topic

From the beginnings of palliative care, medications with sedating effects have been used in the care of persons who are seriously ill or dying, resulting in a range in the depth and duration of sedation according to the

needs of the patient for relief or management of pain or other symptoms and distress. The use of sedatives in this context is intended to provide as much comfort as needed by the patient, for as long as it is required, and not deliberately to hasten the patient's death. While the patient might sometimes die while sedated, the proportionate use of sedatives with the intention to relieve or manage symptoms and distress is a component of providing care to the patient and is ethically distinguishable from assisted suicide and/or euthanasia.⁷

In the past 15 to 20 years, the use of sedatives in the care of persons who are seriously ill or dying has greatly expanded and diversified⁸, and is becoming increasingly specialized. Various ethical questions have arisen regarding specific practices, especially those instances in which a person is rendered and kept unresponsive and unaware until death occurs. For example, how close to a person's death is it appropriate to administer sedatives that are likely to result in continuous sedation? How closely should the sedated person's response be monitored? May

⁷ Boyle J. *Medical ethics and double effect: The case of terminal sedation.* *Theoretical Medicine* 2004; 25: 51-60.

⁸ For example, a recent study found that patients who died while under continuous deep sedation were a greater proportion of all who died in the Netherlands in 2010 (12.3%), compared to 2005 (8.2%) and 2001 (5.6%). See Onwuteaka-Philipsen BD, Brinkman-Stoppelenburg A, Penning C, de Jong-Krul GJ, van Delden JJM and van der Heide A. *Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey.* *Lancet* 2012; 380: 908-15.

feeding, hydration and other life-sustaining measures be forgone? What if a person who is capable of making decisions regarding care refuses feeding and hydration, either in an advance directive or in the present situation, but asks to be rendered unconscious to alleviate pain and other distressing symptoms?⁹ Is the use of sedatives to render a person unresponsive or unaware continuously an appropriate ethical response to what, primarily, some have called psychosocial, existential or spiritual suffering?

There are numerous frameworks and guidelines that have been developed by health care institutions or groups of clinicians in different countries, mostly to do with continuous sedation. These are not consistent in terminology or the medical and ethical guidance that they provide.¹⁰ Research has shown that patients, their families and other loved ones, health care workers and legislators are sometimes unclear about the

⁹ *This scenario has been associated with a practice called “early terminal sedation”. Cellarius V. ‘Early terminal sedation’ is a distinct entity. Bioethics 2011; 25(1): 46-54.*

¹⁰ *The background paper written by Herten Have for the colloquium noted this example: The framework of the European Association for Palliative Care (EPAC), speaking about “therapeutic sedation” includes continuous deep sedation as an exceptional treatment if the patient is in the very terminal stages of illness; it also considers such sedation appropriate for severe existential suffering. The National Hospice and Palliative Care Organization (NHPCO) in the U.S.A., on the other hand, does not specify continuous deep sedation as a separate form of palliative sedation and did not reach agreement on recommendations concerning existential suffering.*

ethical difference between euthanasia and the appropriate relief of symptoms and distress through the use of sedatives.¹¹

At the same time, legislation has been passed in various jurisdictions, e.g., Montana, Oregon and Washington states in the U.S.A., Belgium, Switzerland, the Netherlands, and Luxembourg, allowing for assisted suicide and/or euthanasia under certain conditions. In jurisdictions where this is not the case, advocates of assisted suicide and/or euthanasia often blur the ethical distinction between appropriate relief or management of distressing symptoms and distress through the use of sedatives and euthanasia. They argue that, if it is legal to allow the former, it should be legal to permit the latter.

Scope of the statement

The participants refer in this statement to the *use of sedatives* for relieving or managing symptoms and distress rather than *sedation*, which is a term that could include deliberately rendering and keeping a person unresponsive and unaware in order to hasten death, which would be euthanasia. In deciding to consider the use of sedatives generally in the care of persons who are seriously ill or dying, and not only for those who are imminently dying, participants wanted to avoid policies that are based on inexact estimates of the time of death and to place the emphasis in decision making on the aim or intention to relieve or manage symptoms and distress according to the condition and actual needs of patients.

¹¹ *For example, a Canadian survey of medical specialists in Quebec in 2010 revealed that 48% of them thought that palliative sedation “can be likened to a form of euthanasia”. Vogel L. Framework urges physicians to proceed with caution on palliative sedation. Canadian Medical Association Journal (CMAJ) 2011; 183(2): 174-5.*

They also wished to indicate that the use of sedatives is *one* of a range of options for care throughout the illness of such patients and that such care, ideally, should be holistic and relational, and take into account the desire of patients and their families and other loved ones to prepare for death.

Catholic principles

The statement proposes a framework for the ethical use of sedatives in the care of persons who are seriously ill and dying that is based on principles such as the intrinsic dignity and value of every human being, the unity of the whole person, human finitude and the limits of medicine, the centrality of relationships for human beings, and social justice. These principles were expressed first in philosophical language that engages a broad audience, and then, for Catholics, in terms of Church teachings and theological reflections that support and build upon these principles. Certain counter-positions were rejected, for example, the views that illness and dependency upon others undermine human dignity, that suffering and death lack meaning, and that care of the person who is seriously ill or dying can be reduced to a biomedical approach only.

Main conclusions

The statement maintains that there is a clear ethical distinction between euthanasia, which always involves the intention to suppress consciousness as a means to hastening death, and the appropriate use of sedatives to relieve or manage symptoms and distress.

The statement affirms that life is a gift and thus the intention in using sedatives should never be to shorten life and hasten death for whatever reason. Moreover consciousness

remains a good for people who are seriously ill or dying, to enable them to maintain relationships, discharge their responsibilities and prepare for their death as much as possible. Thus it is appropriate to use sedatives to reduce consciousness when other means of relieving or managing distressing symptoms are unavailable, ineffective, exacerbate symptoms, or are unacceptable to the patient. Efforts should be made to ensure that people who are seriously ill or dying, and their families and loved ones, have sufficient resources for holistic care, including pastoral and spiritual care.

On the other hand, the statement emphasizes that respecting the dignity of persons who are seriously ill or dying entails that they should have adequate care and support for relieving or managing intolerable symptoms and distress throughout their illness, including the use of sedatives. Health care workers should not be reluctant or too hesitant to use sedatives when this is appropriate under the conditions clarified in this statement. The same ethical standards should apply to the use of sedatives as to any other form of health care intervention. In particular, the means used to relieve or manage symptoms or distress should be appropriate and proportionate to the condition and response of the person, which should be monitored. Physicians who prescribe and administer sedatives should be educated in the interdisciplinary nature of palliative care and receive appropriate training to understand and maintain the proper use of sedatives in the care of persons who are seriously ill or dying.*

***William Sullivan and John Heng**

The use of sedatives in the care of persons who are seriously ill or dying¹²:

Ethical distinctions and practical recommendations

Background

1 This statement highlights the main conclusions reached by participants in a colloquium organized by the International

¹²*The term seriously ill or dying in this statement refers to all persons with a chronic or life-threatening illness, not only to those who are imminently dying. Some guidelines or protocols specify that continuous sedation for the management of refractory or intolerable suffering should be considered only for a patient in the last 2 weeks of life. See, for example, Dean MM, Cellarius V, Henry B, Oneschuk D and Librach SL. Framework for continuous palliative sedation therapy in Canada. Journal of Palliative Medicine 2012; 15(8): 870-79 and Verkerk M, van Wijlick E, Legemaate J and de Graeff A. A national guideline for palliative sedation in the Netherlands. Journal of Pain and Symptom Management 2007 34(6): 666-70. One important reason for this restriction is that the last 2 weeks of life is the most commonly cited estimate in the medical literature for when forgoing medically assisted (“artificial”) nutrition and hydration will most likely not shorten a dying patient’s life. The prognosis of when death will occur for a particular patient, however, is inexact and often unreliable. The participants in this colloquium decided not to stipulate any restriction on the use of sedatives based on estimates of the time of death, but to place the emphasis rather on the intention to relief or manage symptoms and distress and on the actual needs of individual patients.*

Association of Catholic Bioethicists (IACB) and held in Philadelphia, U.S.A., July 10-14, 2011. Although this statement is based on principles and values that are informed by the Catholic tradition, many of these are held in common with other faith traditions and are also ethically defensible through philosophical reasoning. The practical recommendations that are proposed in this statement can thus be considered and discussed by all members of society.

Introduction

2 Persons who are living with a chronic or life-threatening illness should be given the best available care in keeping with both good therapeutic standards and sound ethics. In particular, palliative care, which aims to maintain or improve their conditions of life should be provided and promoted whenever possible.¹³ Palliative care should be guided by compassion for patients and their families and other loved ones and by particular concern for those who are poor and vulnerable in society.

¹³ *Catechism of the Catholic Church. 2nd edition. Vatican City: Libreria Editrice Vaticana, 2000, no. 2279. Available online at http://www.vatican.va/archive/ccc_css/archive/catechism/ccc_toc.htm. According to the World Health Organization (1990), palliative care is “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.” For the full definition, consult <http://www.who.int/cancer/palliative/definition/en/>*

3 Sedatives¹⁴, which are medications that have the effect of reducing a person's responsiveness and awareness to varying degrees, are sometimes used in palliative care as a means to care for persons who are experiencing severe and intolerable symptoms and distress.¹⁵ There are, however, a range of different practices involving the use of sedatives that have emerged in recent years, and various terms are employed to describe these practices.¹⁶ Each of these terms implies a specific claim regarding when sedation is "appropriate" as well as a stance on the ethics of euthanasia and assisted suicide. In this statement, to

¹⁴ *Opiates (e.g., morphine, oxycodone and hydromorphone), which are used in palliative care to manage pain and other symptoms, can have a sedative effect but should not be used primarily for their sedative properties. The most common classes of medications used in palliative care for their sedative properties are psychotropic medications such as benzodiazepines (e.g., Midazolam and Lorazepam), barbiturates (e.g., Phenobarbital), antipsychotic medications (e.g., Chlorpromazine and Haloperidol), and increasingly, anesthetic agents such as Propofol, Dexmedetomidine, and Ketamine.*

¹⁵ *Symptoms and distress are sometimes difficult to distinguish. For example, symptoms like dyspnea or difficulty with breathing, convulsions and delirium might result in anxiety and agitation.*

¹⁶ *Examples of such terms are palliative sedation, terminal sedation, proportionate palliative sedation (PPS), and palliative sedation to unconsciousness (PSU). See Claessens P, Menten J, Schotmans P and Broeckaert B. Palliative sedation: A review of the research literature. *Journal of Pain and Symptom Management* 2008; 36(3): 310-333.*

avoid confusion, we will refer generally to the use of sedatives in the care of persons who are seriously ill or dying and then specify conditions under which such use is ethical.

4 The ethical use of sedatives in the care of persons who are seriously ill or dying can be distinguished from euthanasia or assisted suicide. Euthanasia or assisted suicide is "an act or omission which of itself or by intention causes death, with the purpose of eliminating all suffering."¹⁷ In euthanasia or assisted suicide, therefore, the intention is to hasten death, and the chosen means involve either creating a new lethal condition that ends the patient's life or forgoing proportionate life-sustaining measures. Sedation in a manner that does not amount to euthanasia or assisted suicide is both clinically achievable and may be helpful to patients who are in distress. Of grave concern to us, however, are practices that are presented as "appropriate" sedation but belie a wrongful intention to hasten death. For example, although the term *palliative sedation to unconsciousness* (PSU) does not necessarily imply the intention to shorten a person's life, some authors have used this term to refer to sedation with precisely this intention.¹⁸

¹⁷ *John Paul II, Evangelium vitae (1995), no. 65.*

¹⁸ *"Palliative sedation to unconsciousness" is a term coined by Timothy Quill et al. See Quill, TE, Lo B, Brock DW, Meisel A. Last-resort options for palliative sedation. *Annals of Internal Medicine* 2009; 151(6):421-4, and the following response: Sulmasy DP, Brungardt GS, Cavanaugh T. Justifying different levels of palliative sedation. *Annals of Internal Medicine* 2010; 152(5): 332. Sulmasy et al. argue that PSU is better described as "sedation to death".*

Ethical Framework

The following values and principles, and their implications, should inform the use of sedatives in the care of persons who are seriously ill or dying:

5 Each human being, as such, has intrinsic dignity and worth and is a part of the human community. Each is created in the image and likeness of God and destined to live in eternal communion with God. The intrinsic dignity of persons who are seriously ill or dying and the value of their lives are not reduced by their loss of particular functions and abilities, illness, dependency or suffering. Thus they should be respected always and by everyone. Care providers should offer available means to improve the conditions of life of such persons and those of their families and other loved ones. Care providers should not intentionally hasten any patient's death, even if this is requested.

6 Every human being is a biological, psycho-affective, intellectual, social and spiritual unity. No human being is reducible to only a part or function of his or her being. Distress and suffering afflicts the person and not just his or her body.¹⁹ Thus care that is provided to persons who are seriously ill or dying should take into account and address the well being of the whole person.

7 Human beings are finite and mortal. Pain, the limitations and losses of illness, suffering, and dying are a part of the lives of every human being. Nevertheless persons who are seriously ill or dying can often find hope in suffering through the solidarity and love that is offered to them by the community. In addition, for Christians,

suffering is not something entirely negative.²⁰ Christians believe that sharing in the mystery of Christ's suffering on the cross enables the person who suffers to participate in Christ's redemptive work.²¹ Death, for Christians, is not annihilation but has meaning in light of the hope of eternal life that Christ's resurrection offers.²² Thus care providers should be respectful of the mystery of suffering and death. Providing care to persons who are seriously ill or dying always involves acknowledging the presence of distress and suffering in patients and their families and other loved ones, recognizing the importance of the meaning that they give to suffering and death, and offering hope and help when appropriate.

8 Consciousness is integral to human flourishing and remains a good for persons

²⁰ Pius XII, *Address to the Ninth National Congress of the Italian Society of the Science of Anesthetics (February 24, 1957)*

²¹ John Paul II taught, however, that, "while praise may be due to the person who voluntarily accepts suffering by forgoing treatment with pain-killers in order to remain fully lucid and, if a believer, to share consciously in the Lord's Passion, such 'heroic' behaviour cannot be considered the duty of everyone." *Evangelium vitae*, no. 65. The teaching of the Catholic Christian tradition on suffering is succinctly presented in the encyclical *Salvifici doloris* (1984). See also Pius XII, *Address, February 24, 1957, and Congregation for the Doctrine of Faith's Declaration on Euthanasia (May 5, 1980)*.

²² Pius XII, *Address, February 24, 1957*. See also John Paul II, *Evangelium vitae*, no. 65, and the *Congregation for the Doctrine of Faith's Declaration on Euthanasia (May 5, 1980)*, part III.

¹⁹ Cassell EJ. *Diagnosing suffering: A perspective. Annals of Internal Medicine* 1999; 131: 531-34, p. 531.

who are seriously ill or dying. Thus care providers should protect and promote unclouded consciousness in patients whenever possible, especially to allow them to prepare for death. Care providers should suppress consciousness beyond the natural wake-sleep cycles only for very serious reasons.

9 Therapeutic decisions for persons who are seriously ill or dying should be guided by the same standards of good therapeutic practice that inform other areas of health care.²³

²³ Daniel P. Sulmasy, in his paper for the 5th IACB International Colloquium, proposed the following therapeutic principles that guide all of health care:

Restoration: Interventions should aim to restore a patient as much as possible to a state of comfort and functioning.

Proportionality: Interventions should be assessed both in proportion to the goals of care being sought, such as to extend life, restore or maintain function, mitigate pain, relieve symptoms and distress, as well as to whether a given intervention is better suited to and more beneficial to the intended goal than other possible interventions. Decisions about such interventions should take into account both the expected likely benefits and risks of harm and burdens for the patient.

Parsimony: Only as much of an intervention as is needed to achieve the desired response in the patient should be used.

Totality: Decisions regarding interventions should aim at the total good of the patient

Practical Recommendations

The relational basis of care

10 Competent and ethical care of persons who are seriously ill or dying is enhanced when health care professionals engender a relationship of trust and benevolence with them, are attentive to the sources of their distress and suffering, and commit to accompany them in solidarity and love throughout their journey. This entails, among other things, promoting good communication with patients and their families and other loved ones, such as disclosing the terminal nature of illnesses, helping to identify goals of care, offering early provision of palliative care, supporting informed participation in decision making to the extent of their capacity, involving their community when appropriate, and addressing spiritual and religious issues.

Conditions for the ethical use of sedatives in the care of people who are seriously ill or dying

11 Persons who are seriously ill or dying should be offered adequate care and assistance throughout their illness for symptoms and the distress due to these symptoms. The use of sedatives may be offered when the patient's symptoms or distress are refractory and intolerable. In this context, "refractory" means that no adequate relief or management that does not reduce the patient's responsiveness and awareness

rather than at the functioning only of a specific part of his or her body.

Discretion: Clinicians should recognize and observe both the limits of their own expertise and the limits of medical interventions.

can be achieved for the patient's symptoms or distress by any reasonable alternatives because they are unavailable, ineffective within the necessary timeframe, exacerbate symptoms or are unacceptable to the patient. Alternatives include non-sedating medications, and social, environmental, psychological and spiritual interventions.

12 Some requests for the use of sedatives are made in the context of a seriously ill or dying person's intense anxiety and distress over a loss of a sense of the meaning of his or her life, illness, and death, and the conviction that his or her life is no longer worthwhile. This is often referred to as "existential" or "spiritual" suffering. It can sometimes be experienced together with somatic or psychiatric symptoms, or without them. Such distress should be recognized and addressed, employing holistic interventions that are appropriate for the human dimensions of this sort of distress. Mild to moderate levels of sedation might, however, be appropriate in some instances when existential and spiritual distress is refractory and could sometimes play a secondary role in enabling holistic interventions.

Depth and duration of sedation

13 The depth and duration of sedation should be proportionate to the demands required by the patient's symptoms and distress, and to the condition and response of the patient. For example, a low level of persisting symptoms or distress calls for a low level and episodic duration of sedation.

a. Decisions regarding the depth and duration of sedation must take into account the wishes of patients and their family and other loved ones to maintain awareness and lucidity.

- b. The administration of sedatives should be guided by the intention to relieve suffering and **not** by the intention to render the patient unaware and unresponsive. The severity and refractoriness of the patient's symptoms and distress, and the waning of his or her physical, mental and spiritual resources to bear such distress, however, might justify ever deeper and longer levels of sedation, even though the patient might be rendered unaware and unresponsive as a result of such sedation, and might die while in that state.
- c. The patient's informed consent for sedation is required or, if he or she is no longer capable of giving such consent then this should be obtained from an appropriate substitute decision maker.
- d. There should be adequate documentation and monitoring of the administration of medications and their outcomes for patients.

Distinguishing the appropriate use of sedatives from euthanasia and assisted suicide

14 A clear and ethically significant distinction can be made between the use of sedatives to relieve refractory symptoms and distress, and the use of sedatives to hasten death deliberately. When the goals of treatment and care are discussed with the patient and his or her appropriate substitute decision maker, this difference should be clarified.

15 If medications are deliberately given in higher dosages than are necessary for relief of the patient's symptoms or distress, this would indicate either a medically injudicious practice or an intention to hasten the patient's death.

Life-sustaining treatments or other interventions

16 Decisions regarding the withdrawal of life-sustaining treatments or other interventions, such as medically assisted nutrition and hydration, should be based on the patient's condition and ability to tolerate such interventions.²⁴ Forgoing such life-sustaining treatments should not be a condition of deep, continuous sedation.

²⁴ *The Congregation for the Doctrine of the Faith's document, Responses to Certain Questions of the United States Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration (2007), clarified that medically assisted nutrition and hydration are in principle "ordinary" and proportionate, while not excluding the possibility that such an intervention might become "extraordinary" and disproportionate if it were "excessively burdensome for the patient" or when it might "cause significant physical discomfort." The bishops of the U.S.A. approved an ethical directive that states: "In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the 'persistent vegetative state') who can reasonably be expected to live indefinitely if given such care. Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be 'excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed.' For instance, as a patient draws close to inevitable death from an underlying progressive and fatal condition, certain measures to provide nutrition and hydration may become excessively burdensome and therefore not obligatory in light of their very limited ability to prolong life or provide comfort." (revision to United States Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care Services, Fourth Edition, 2001, no. 58, approved in November, 2009).*

Resources and education

17 In decisions regarding the use of sedatives, the determination of when a patient's distress is "refractory" depends, in part, on the availability of reasonable alternative options for care. In policies and decisions regarding the allocation of resources, therefore, priority should be given to ensuring that persons who are seriously ill or dying, and their families and other loved ones, have sufficient resources for holistic care, such as those to enhance living environments, psychological and psychiatric support, social support, and pastoral and spiritual care.

18 Health care professionals and other caregivers who support persons who are seriously ill or dying should receive adequate training in palliative care, including the interdisciplinary nature of palliative care, which requires collaboration among various health professionals and caregivers to address the holistic needs of patients and their family and other loved ones. They should receive appropriate education and training for understanding and maintaining the proper use of sedatives in the care of persons who are seriously ill or dying.

Conclusion

In decisions regarding the use of sedatives in the care of persons who are seriously ill or dying, two extremes must be avoided: (a) providing inadequate relief for the person's symptoms and distress; (b) administering sedatives when non-sedating alternatives have not been tried or in a deliberate attempt to hasten death.

Sedation should always be a proportionate response to symptoms and distress. Decisions regarding the use of sedatives for persons who are seriously ill or dying should consider

each individual's overall good. Such decisions should be guided by a holistic approach to care giving, a commitment lovingly to accompany the person and his or her family and other loved ones throughout the illness, and a regard for their desire for an adequate preparation for death.

There is a clear ethical distinction between the appropriate use of sedatives and euthanasia or assisted suicide. This distinction is important and should be maintained. Euthanasia or assisted suicide always involves the intention to hasten a person's death. The appropriate use of sedatives aims to provide comfort to persons who are seriously ill or dying and can be achieved clinically in an ethically sound manner.

We urge society to collaborate in providing and promoting the best possible holistic care of persons who are seriously ill or dying and their families and other loved ones, so that their physical, psychological, existential, social and spiritual needs can be appropriately addressed.

Signatories and countries of residence

Fr. Mark Aita	U.S.A.
Robert Barnet	U.S.A.
Fr. Kevin Belgrave	Italy
Albrecht von Boeselager	Germany
Fr. Scott Borgman	Italy
Michelle Bowe	U.S.A.
Gerard Brungardt	U.S.A.

Fr. Paul Chummar	Kenya
Sr. Rosemary Donley	U.S.A.
Josef Dou	U.S.A.
Richard Egan	Australia
Thompson Faller	U.S.A.
Simon Grenfell	U.K.
Peter Gummere	U.S.A.
John M. Haas	U.S.A.
Henk ten Have	U.S.A. and Netherlands
John Heng	Canada
Sarah Hill	U.S.A.
Christine Jamieson	Canada
Fr. Brian Johnstone	U.S.A.
Sr. Nuala Kenny	Canada
Anthony Kerigan	Canada
Jaroslav Kotalik	Canada
Erica Laethem	U.S.A.
Pierre Mallia	Malta
Cecilia May	U.S.A.
Sr. Alice O'Shaughnessy	U.S.A.
Fr. Tadeusz Pacholczyk	U.S.A.
Maria Louisa Pedri	Canada
Edmund Pellegrino	U.S.A.
Joseph Piccione	U.S.A.
Cecilia Quade	U.S.A.
Joseph Raho	U.S.A.
Wieslaw Reglinski	Switzerland
Christoph von Ritter	Germany
Lynn M. Robbin	U.S.A.
William L. Saunders, Jr.	U.S.A.
Robert Sawicki	U.S.A.
Alex Schadenberg	Canada
Linda Scheirton	U.S.A.
Michael Skoch	U.S.A.
Ursula Sottong	Germany
William F. Sullivan	Canada
Daniel P. Sulmasy	U.S.A.
Paulina Taboada	Chile
Fr. Joseph Tham	Italy
Bernadette Tobin	Australia
Jos Welie	U.S.A.
Neil Weir	U.K.

Bioethics Outlook

A quarterly bulletin of the Plunkett Centre for Ethics

The Plunkett Centre is a centre of Australian Catholic University and St Vincents & Mater Health

www.acu.edu.au/plunkettcentre/

Tel: +61 2 8382 2869; Fax: +61 2 9361 0975; Email: plunkett@plunkett.acu.edu.au

Subscriptions: \$99 Institutions; \$55 Individuals; \$27.50 Pensioners & Student

