

Duquesne University

Duquesne Scholarship Collection

Graduate Student Research Symposium

2021-03-08

Catholic Terminal Sedation-A New Framework for Providing Terminal Palliative Sedation as a Requirement in Catholic Healthcare Organizations

Noah Dimas

Follow this and additional works at: <https://dsc.duq.edu/gsr>



Part of the [Applied Ethics Commons](#), [Bioethics and Medical Ethics Commons](#), [Catholic Studies Commons](#), [Health and Medical Administration Commons](#), [Health Services Administration Commons](#), and the [Palliative Care Commons](#)

Catholic Terminal Sedation-A New Framework for Providing Terminal Palliative Sedation as a Requirement in Catholic Healthcare Organizations. (2021). Retrieved from <https://dsc.duq.edu/gsr/2021/proceedings/8>

This Paper is brought to you for free and open access by Duquesne Scholarship Collection. It has been accepted for inclusion in Graduate Student Research Symposium by an authorized administrator of Duquesne Scholarship Collection.

Catholic Terminal Sedation: A New Framework for Providing Terminal Palliative
Sedation as a Requirement in Catholic Healthcare Organizations

Noah Dimas, PhD (c)

Duquesne University – Graduate Research Symposium

Advisor: Gerard Magill, PhD

Outline:

1.	Introduction – The Growing Acceptance of Assisted Death in Healthcare	1
1a.	Institutionalization of Assisted Death	1
1b.	Roman Catholic Healthcare’s Ethical Dilemma	1
2.	Roman Catholic Objections to Assisted Death	2
2a.	Objection to Assisted Suicide	3
2b.	Objection to Euthanasia	4
3.	Roman Catholic Obligations to Care	6
3a.	Foundational Obligations	6
3b.	“Ethical and Religious Directives”	7
3c.	“Evangelium Vitae”	9
4.	Palliative Sedation in Secular Healthcare	11
4a.	Distinguishing Types of Palliative Sedation	12
4b.	Forgoing Life-Sustaining Medical Interventions in CSU	13
4c.	Depriving Consciousness	14
5.	A Framework for Palliative Sedation in Catholic Healthcare Organization	15
5a.	Proportionality of Sedation	15
5b.	Intentions of Sedation	17
5c.	Moral Distress at the End of Life	19
5d.	Catholic “Assistance in Dying”	21
5e.	Obligations to Ordinary Treatment of Illness	23
6.	Conclusion	25
	Endnotes:	27
	Bibliography	32

1. Introduction – The Growing Acceptance of Assisted Death in Healthcare

Within the global medical institution, there is a large shift surrounding the ways in which patients relate with their physicians. Specifically, there is a growing desire for patients to participate in their medical decisions. Within this broader larger movement of shared decision-making, there are some groups of patients that desire a greater deal of control over the manner in which they die.¹ This group is regularly referred to as the “Death with Dignity” movement. However, amidst this movement are the tensions between the Catholic Church and the Death with Dignity movement, specifically surrounding the movement’s advocacy of assisted death.

1a. Institutionalization of Assisted Death

In particular this movement regularly is advocating for the legalization and normalization of two forms of assisted death, those known most commonly as Physician-Assisted Suicide and Active Voluntary Euthanasia, hereby collectively referred to as assisted death. These assisted death interventions have been rising in legalization most notably since the turn of the millennium. Of note are Belgium, the Netherlands, and Canada whom all have legalized one or both forms of assisted death.² This essay, however, will take a specific look at the status of assisted death within the United States. For the US, there are a number of states who have legalized assisted suicide in particular for citizens.³ However, there are no present federal laws that legalize any form of assisted death nationwide. These abilities are instead relegated to the state level and each state is independently allowed to enact laws on assisted suicide.⁴ However, active voluntary euthanasia has no legal precedent within the US at present.

1b. Roman Catholic Healthcare’s Ethical Dilemma

However, this is where Roman Catholic healthcare organizations have found troubles within jurisdictions that have legalized some form of assisted death. On the one hand, there are many

patients who might come to Catholic healthcare institutions and expect assisted death to be available as options if the jurisdiction has legalized them. However, given the deeply rooted moral tradition of Catholicism, there will not be any Catholic healthcare institution that will provide assisted death in its present form.⁵ This then poses a challenge to Catholic healthcare in that Catholic healthcare is considered subpar since there is no possibility for assisted death. Therefore, these proponents argue a “death with dignity” is not possible. What has been lacking in this discussion, however, is the existing intervention within palliative medicine known as palliative sedation. Broadly stated, palliative sedation exists as a last resort option for patients who are no longer responding well to standard pain management interventions.⁶ In practice, this goal of symptom control is achieved by bringing the patient to a lesser state of consciousness. However, this practice is somewhat misunderstood by some in Catholic healthcare.

This is then the purpose of this essay, to detail an ethical framework using normative sources in Catholic moral teaching to assert that Catholic healthcare can and should utilize palliative sedation as a requirement for Catholic healthcare institutions. First, this essay will lay out a clear understanding of the Roman Catholic objections to the various forms of assisted death. Second, this essay will explore the obligations to care that the Roman Catholic Church has detailed. Last, this essay will present a detailed defense on why palliative sedation ought to be a mandatory protocol in Catholic healthcare organizations based on the discussion in this essay.

2. Roman Catholic Objections to Assisted Death

In order to understand how palliative sedation is ethically distinct from assisted death, there must first be a discussion on why the Catholic church has historically been very antagonistic to assisted death. Furthermore, providing definitions specifically on what these assisted death interventions are usually practiced as will prove useful to this discussion since these definitions

provide a deeper understanding to the Roman Catholic rejection of assisted death and allows for an ethical distinction to be started between assisted death interventions and palliative sedation.

2a. Objection to Assisted Suicide

As defined by Broeckaert, assisted suicide can be defined as “intentionally assisting a person, at this person’s request, to terminate his or her life.”⁷ In practice, this is regularly achieved by a physician or other medical professional prescribing a lethal dose of medication to a patient at this patient’s request. It is then the patient’s duty to take this medication to end his or her life when the patient decides the time has come to die. This practice is what is currently legal in some states within the US, albeit with differing procedures on how a patient comes to acquire the lethal medication itself.⁸

Within the Catholic tradition, there exists a fundamental teaching that human life is a gift from God.⁹ As such, humanity is tasked with preserving and properly using this gift until God deems one’s journey has ended, and He takes this person unto Himself in natural death.¹⁰ This is where the Catholic Church has historically made the teaching that suicide is immoral and improper since humanity has a duty to self-preservation.¹¹ This also is tied to the general notion that because human life is a gift that is deserving of respect, humanity cannot willingly end human life since this is inherently disrespectful to God’s role as Divine Creator of human life.¹² Furthermore, suicide also usurps God’s role as the Alpha and Omega since the killing of oneself willingly ends life before God has deemed it one’s time.¹³

Given this understanding of the Catholic moral tradition on suicide at-large, it becomes clearer that assisted suicide is not morally permissible. If one had any hesitation on this conclusion, there is a direct mention of the impermissibility of material cooperation in suicide.¹⁴ Therefore, assisted suicide as it exists in physician-assisted suicide (PAS) is not allowable in

Catholic healthcare organizations. This is made very explicit in the Ethical and Religious Directives for Catholic Health Care Services (ERD). Specifically, ERD 60 makes a direct statement that “Catholic health care institutions may never condone or participate in...assisted suicide in any way.”¹⁵ This is a very clear statement that assisted suicide, including PAS, is never permissible within Catholic healthcare and ought to be condemned if it were to ever appear within the walls of Catholic healthcare organization.

2b. Objection to Euthanasia

A similar rationale from assisted suicide is applied to the Roman Catholic rejection of euthanasia. As defined also by Broeckaert, euthanasia is defined as “the administration of lethal drugs in order to painlessly terminate the life of a patient suffering from an incurable condition deemed unbearable by the patient, at this patient’s request.”¹⁶ It must be mentioned here that there are some ethicists who distinguish between active and passive euthanasia as well as voluntary, non-voluntary, and involuntary euthanasia.¹⁷ However, while these distinctions can be more explicitly explored elsewhere, they are not the most relevant to this discussion at-hand. The only mention that must be made that the Catholic Church has emphasized is that of active and passive that will be explored below.

The Catholic Church has provided rationale for why euthanasia is impermissible based on two general premises – respect to God as Creator and respect to God through neighbor. The former premise is the same as mentioned above for assisted suicide, human life is a gift from God as a result of God being the Divine Creator.¹⁸ Therefore, humanity cannot take the life of another since this is highly disrespectful to God’s creation. Furthermore, God’s role as Alpha and Omega still applies here since the ending of another human’s life is also taking the power of God

into one's own hands and disrespecting the authority of God. The second premise mentioned requires a more unique discussion on the nature of humanity as a unified body in God's Creation.

The Catholic tradition has taught that all of humanity is a unified body because God has created all that exists in the world.¹⁹ Therefore, all of Creation is deserving of respect since God has created everything. This is the same argument as presented above. However, what is unique in respecting God by respecting one's neighbor is that all of humanity is of equal dignity regardless of one's present circumstances or condition.²⁰ Therefore, one cannot take the life of another human being in particular because this severs the bonds that humanity shares as equals. In other words, the killing of another human being is asserting one's dignity as less than another and is better served dead than alive. This can be broadly applied to any and all instances of killing. But what is most relevant to this discussion is the case of euthanasia.

Consider a terminally ill patient who desires euthanasia. This patient makes a judgment that his or her life is no longer worth living. In response, a medical professional provides an assessment that the patient's suffering is intractable and intolerable.²¹ Even if not directly stated, there is a tacit agreement that this patient's life is no longer worth living and is better served as dead than alive. This is the foundation on which the Catholic Church has rejected euthanasia as a valid end-of-life intervention. Euthanasia inherently denies the dignity deserved to human beings.²² Instead of pursuing further interventions to provide the best care for a terminally ill patient, euthanasia says, even if implicit, that this patient's life is no longer meaningful, and the patient can only make meaning out of his or her life by being dead. This rejection of euthanasia and the rationale behind it can be found explicitly in ERD 60 accompanied by some recommended interventions to help the patient through this troublesome time.²³

While these discussions on the Roman Catholic rejections of assisted death are well documented, no thorough answer to assisted death has been proposed. This is largely due to a lack of explanation of the moral and ethical natures of end-of-life care as it relates to Catholic healthcare. Therefore, a discussion of the foundational Catholic obligations to care appear necessary to further understand how palliative sedation can fit into the Catholic moral tradition.

3. Roman Catholic Obligations to Care

Alongside the clear rejections of assisted death, the Catholic Church has produced a number of teachings and documents that provide guidance on how Catholic healthcare ought to provide fundamental care to individuals. Of these documents, this essay will focus on a select few that provide further understanding on how Catholic healthcare is to respond to those who desire assisted death, focusing on general, normative documents that provide a broad understanding of the foundations of Catholic healthcare.

3a. Foundational Obligations

One of the most reliable sources of guidance for Catholic healthcare can be seen in the Gospels. Many times, throughout the Gospels, Jesus is seen healing the sick. From lepers, to the blind, to the deaf, to the lame, Jesus healed all who came to him without hesitation.²⁴ This has provided a source of great inspiration for many Catholic healthcare mission statements. Furthermore, Jesus provided another direct mention of this practice in his teachings on the Final Judgement saying, “Before him will be gathered all the nations...then the King will say...’Come, O blessed of my Father, inherit the kingdom prepared for you...for I was sick and you visited me.’”²⁵ Among other things, Jesus is telling humanity what to do to gain the favor of God and attain Heaven for eternity. These teachings are regularly known as the “corporal works of mercy,” practices that can bring about God’s mercy by providing the basic needs of

humanity.²⁶ Given these foundational teachings come from the words of Jesus himself, these words become foundational teachings for all Christian believers to take to heart. They become more relevant to any Christian institution that has the continuation of the healing ministry of Jesus Christ at the heart of their mission.²⁷ Therefore, it could be reliably assumed that Catholic healthcare organizations ought to take these words to heart within their actions.

In particular, one could argue the notion that Jesus' healing ministry does not stop with simply providing a cure for ailments. This is seen in the work of mercy regarding the sick. The wording used highlighted the fact that all are called to "visit the sick."²⁸ This usage of "visit" is particularly relevant since it indicates a need to come to the sick and care for them, not "cure." In other words, there is a call to reach out to and care for the sick who are in need however you can help them.²⁹ This is reflected well in the broader tradition of palliative medicine and the broader palliative care movement.

In brief, palliative care is an interdisciplinary movement that seeks to provide care to patients who are suffering from incurable or life-limiting illnesses beyond curative treatments.³⁰ This notion of palliative care is historically tied to the Christian tradition.³¹ As such, there is a well-established philosophy of "visiting the sick" in palliative care. Therefore, it logically follows how palliative care has adapted something like palliative sedation into its battery of intensive pain management interventions; palliative sedation can still provide care and comfort in the face of intractable symptoms. However, before this intervention is more properly discussed, further exploration of the Roman Catholic teachings surrounding obligations to care are needed.

3b. "Ethical and Religious Directives"

Arguably the most relevant normative document for Catholic healthcare is the *Ethical and Religious Directives for Catholic Health Care Services* (ERD). These are directives that are

crafted and updated by the United States Conference of Catholic Bishops (USCCB). In general, the USCCB is a representative body of Catholic bishops that helps provide guidance and interpretation of Catholic moral teaching for the US.³² The ERD, in particular, is a guiding document about how Catholic healthcare organizations are to conduct healthcare to keep themselves in line with Catholic teaching.³³ It must be mentioned that these directives are not exhaustive of Catholic moral tradition. There are many other Catholic teachings and that have the potential to challenge the current positions and developments of secular healthcare. As such, the ERD cannot cover all challenging Catholic healthcare ethics cases, nor can this essay thoroughly discuss all ERD articles relevant to Catholic healthcare ethics.

In particular, there are two articles that this essay wishes to explicate in regard to obligations to care, assisted death, and palliative sedation – ERD 60 & 61. To begin this examination, ERD 60 speaks on the topic of obligations to care in the dying by stating:

“Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so they can live with dignity until the time of natural death.”³⁴

While initially being a response to patients who request euthanasia, this directive highlights the need to provide care for patients, including those who wish to die by euthanasia, to receive more care since these patients are expressing an extreme need for higher levels of care. In other words, the ERD recognizes that patients who are dying might need more support and care in the face of death, not less. ERD 60 goes on to expand on this notion in the following directive, “Patients should be kept as free of pain as possible so that they may die comfortably and with dignity...” This portion of the directive highlights the obligation that Catholic healthcare organizations have to provide relief from pain and suffering unto death. As such, intensive pain management is not

merely an option for Catholic healthcare but an obligation if indicated. There should not be any question about *should* Catholic healthcare provide intensive pain management. Instead, there should be questions about *how* Catholic healthcare can meet these obligations.

ERD 61 takes this obligation a step further by then asserting that these intensive pain management interventions ought to be administered, even in the face of potentially life-shortening effects. This article explicitly states, “Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person’s life so long as the intent is not to hasten death.”³⁵ This further highlights the obligation to care that end-of-life medicine has in the Catholic moral tradition. These articles provide a strong emphasis on the high value of pain relief and comfort Catholic healthcare must place on the dying patient’s goals of care.

3c. “Evangelium Vitae”

One last document for Catholic healthcare that is worth exploring in this essay is the papal exhortation *Evangelium Vitae* (“Gospel of Life”). In brief, this document is addressed to the faithful to explain the notion that all of human life is sacred and deserving of respect.³⁶ One of the key teachings from this document is on the notion Pope St. John Paul II puts forward known as “the culture of death.” This idea generally states that secular society has become too lenient with allowing human life to be lost at all phases of living.³⁷ John Paul II emphasizes multiple times throughout his writing that human life has inherent dignity as a unified body of Creation and is deserving of respect as a result of this shared dignity. However, this respect is not simply a negative right, the right to not have others impose on oneself. Instead, John Paul II goes further by asserting that there is a duty to help protect life, not simply the duty to not kill.³⁸ This can be seen in his specific discussion on the topic of euthanasia.

In articles 64 & 65 of *Evangelium Vitae*, John Paul II talks about the assertion of euthanasia at the end-of-life and how it begins to infringe on the fundamental understandings about human dignity and the interpersonal duties we have to care for the sick. In particular, there is explicit mention that there is, “a moral obligation to care for oneself and to allow oneself to be cared for.”³⁹ However, John Paul II goes on to detail that this obligation is not absolute. He then goes on to explain the reality that there are times in which a patient might come to the point where there must be a burden/benefit analysis of the patient’s current care situation.⁴⁰ In other words, there will inevitably come a time when a patient is no longer obligated to pursue curative treatment, especially in the face of severe pain and suffering.

John Paul II then goes on to explain that while it is admirable that a patient might wish to suffer and unite this suffering to that of Christ, this kind of suffering is not the obligation of the faithful.⁴¹ Instead, he argues that it is entirely acceptable to receive palliative care measures to provide support and ensure suffering is minimized at the end-of-life. He clarifies that these methods of care are entirely acceptable since they are aimed at pain-relief and nothing else. While it is possible to have the patient’s death in mind and foreseen, it is entirely acceptable in the Catholic tradition to provide these intensive pain management interventions.⁴² Where these interventions cross the line is when the intent of the interventions no longer becomes pain-relief but the hastening of death. This is well understood in secular ethics with the notions of proportionality and intentionality.

Regularly, secular ethics argues intensive pain management can easily bridge into the realm of euthanasia if the medications provided exceed the indicated dosages.⁴³ These fears exist precisely because these medications for intensive pain management can easily end the life of a patient if there is an overdose of medication.⁴⁴ Therefore, many secular ethicists argue that there

ought to be strict protocols in healthcare organizations to prevent these sorts of abuse to exist as a sort of “covert euthanasia.” As such, the argument is that there should only be levels of medication that correlate to the proportion of medication that is necessary to achieve the desired results.⁴⁵ This is what John Paul II had at heart when he wrote, “It needs to be determined whether the means of treatment available are objectively proportionate to the prospects for improvement.”⁴⁶ There ought to be a response from the medical team with interventions that are proportionate to the levels of pain and suffering indicated by the patient.⁴⁷

The second notion secular ethics utilizes is the notion of intentionality. Somewhat amusingly, this notion is rooted within the Catholic moral principle of double effect (PDE). In general, PDE allows for interventions that have the risk of evil effects so long as the intervention is not inherently evil, the good effects are intended, and the intervention is not a means to the evil effects.⁴⁸ Both secular ethics and Catholic ethics have determined that intensive pain management is generally ethically permissible since the intentions are pain relief.⁴⁹ The challenge that is often posed by opponents is that the potentially evil effects is the hastening of death. As such, many have question if this potential hastening of death is permissible. However, as secular ethics and John Paul II argue, PDE rationalizes that this life-shortening effect is ethically permissible since the intentions for receiving such pain-reliving measures are simply for symptom management, not hastening of death.⁵⁰ Furthermore, there is data that strongly disproves the argument that intensive pain management is life-shortening.⁵¹ This is arguably the position that palliative sedation finds itself in secular healthcare, an intensive pain management.

4. Palliative Sedation in Secular Healthcare

As defined by Broeckaert, palliative sedation is “the intentional administration of sedative drugs in dosages and combinations required to reduce the consciousness of a terminal patient as

much as necessary to adequately relieve one or more refractory symptoms.”⁵² Simply put, palliative sedation is the action of sedating a terminally ill patient when pain and suffering has become intolerable for the patient despite all feasible pain-relief interventions being exhausted. However, despite this rather simple understanding of palliative sedation, secular ethics has still tried to reason through specific ethical dilemmas present in palliative sedation. These dilemmas are also present for Catholic healthcare and as such contain very valuable discussion. However, these discussions have a great deal of depth in and of themselves. As such, this essay will only provide a cursory explication of these dilemmas to provide the context for how Catholic healthcare ethics ought to approach palliative sedation in Catholic healthcare organizations.

4a. Distinguishing Types of Palliative Sedation

Some distinctions that will be useful before discussing these dilemmas are those made in the types of palliative sedation itself. The former, length, is often divided into intermittent and continuous.⁵³ Intermittent sedation is often used in two situations. One situation is in emergent situations when the patient is extremely distressed from pain and suffering. This form of palliative sedation, often called “emergency sedation” is regularly employed when patients need critical symptoms managed and their pain and suffering causes immense distress that prevents proper symptom management. The second form of intermittent sedation is what is commonly referred to as “respite sedation.” This type of sedation is regularly employed when a patient is extremely distressed from pain and suffering and needs a small period of relief and returns prepared to continue treatment. After the set period of time has elapsed, the patient is then removed from sedation and is often in a better state of being than before the period of respite sedation. Conversely, continuous sedation is regularly defined as the continued sedation of a patient until death unless other methods of symptom control arise.⁵⁴

The second distinction that secular ethics has made in palliative sedation is that of the depth of sedation. These depths of sedation are usually distinguished into three levels: mild, moderate, and deep.⁵⁵ Mild sedation usually consists of a light sedation where the patient's consciousness is lessened but regularly still maintains a significant level of awareness and rationality. Moderate sedation usually consists of a patient's consciousness becoming more significantly lessened where the patient begins to experience a loss in the duration and quality of interactions. Deep sedation is where the patient is brought to total unconsciousness and is no longer able to have meaningful interactions. Secular ethics has expressed few hesitations about the many types of sedation with one particular form sticking out as particularly ethically complex – continuous deep sedation.⁵⁶ Also known as continuous sedation to unconsciousness (CSU), there are a few ethically challenging aspects that are associated with this form of sedation.

4b. Forgoing Life-Sustaining Medical Interventions in CSU

One particular ethical challenge that is posed with CSU is the question surrounding whether or not a patient under CSU should forgo life-sustaining medical interventions. These life-sustaining medical interventions can consist of any intervention that can feasibly sustain human life if it is done. More specifically, these interventions are usually narrowed to medically assisted nutrition and hydration (MANH).⁵⁷ Broadly defined, MANH consists of providing artificial means of nutrition and hydration to a patient who can no longer receive them by mouth.⁵⁸ In the case of CSU, a patient is entirely incapable of oral intake and needs some form of MANH to sustain life.⁵⁹ However, there are some who express concerns that forgoing MANH will cause a patient's death.⁶⁰ Therefore, CSU is argued to be akin to euthanasia.

This, however, is an improper equivocation of two separate decisions. MANH is a unique ethical discussion since a patient can feasibly continue receiving it indefinitely and potentially

sustain biological life.⁶¹ Furthermore, the right to refuse life-sustaining medical interventions has been well established within secular ethics.⁶² Therefore, MANH exists as its own discussion and decision independent of CSU.⁶³ Therefore, it is dishonest to argue that CSU causes the hastening of death since data suggest that palliative sedation practices do not hasten death. This is furthered by data which suggests many patients who undergo CSU are already close to death.⁶⁴ As such, CSU and forgoing MANH (or any other life-sustaining medical treatment) are two separate discussions that must be had with a patient during informed consent.

4c. Depriving Consciousness

A second ethical dilemma that is often discussed in conjunction with CSU is the fact that it deprives a patient of consciousness. This poses a significant challenge since the patient is no longer capable of making independent decisions nor capable of meaningful interactions.⁶⁵ These are particularly troublesome within secular ethics since there exists a high value placed on respecting patient autonomy and providing the patient with maximal benefits and minimizing patient harms.⁶⁶ Since CSU entirely deprives a patient of consciousness, there exists a valid concern that a patient can no longer express his or her own wishes on the interventions done unto oneself. This poses a great challenge for patients since they will have to trust that their indicated surrogates make proper decisions about their care since they can no longer express these wishes.⁶⁷ Furthermore, with a patient being entirely deprived of consciousness, there is concern that this is doing more harm than good for the patient since the patient will no longer be able to vocalize pain and suffering.⁶⁸ This argument continues that if a patient is no longer conscious, then this prevents the patient from having a meaningful life or making meaningful interactions with loved ones. These are certainly valid concerns to hold. Healthcare providers ought to always have what is best for the patient in mind.

This then leads to the counterargument that is posed rooted within the notion of the burden/benefit analysis. The general concept of a burden/benefit analysis is that when posed with any medical intervention, there ought to be a weighing of the potential burdens that will come with this intervention against the potential benefits this intervention will have.⁶⁹ If the burdens are deemed too great for the patient, then the patient has the right to refuse this intervention. If the benefits are deemed significant enough for the patient, then it becomes ethical for the patient to receive this intervention. For some, CSU poses itself as too burdensome since the loss of consciousness might be deemed too significant of a burden.⁷⁰ For others, CSU can be considered beneficial since the potential for pain and suffering to be relieved at the cost of a loss of consciousness.⁷¹ Therefore, CSU's ethical complications become clearer and a deeper understanding of the ethical challenges that Catholic healthcare must answer are also elucidated.

5. A Framework for Palliative Sedation in Catholic Healthcare Organization

Having discussed the ethical complexities secular ethics has with palliative sedation, this essay can now discuss how the Catholic moral tradition and Catholic ethics can adapt the present practices of palliative sedation into Catholic healthcare organizations. A mention must be made that this essay does not wish to present specific methodology for palliative sedation. This framework exists solely as an ethical framework that Catholic healthcare organizations should consider when developing protocols for an ethical delivery of palliative sedation in line with Catholic teaching. These aspects of the framework are also not in any particular order. These aspects must all be considered equally, and one should not be prioritized at the expense of others.

5a. Proportionality of Sedation

The first aspect of this framework to consider is the proportionality of sedation. As discussed above, there is concern within secular ethics about the usage of palliative sedation since

improper use of the medications can result in the hastening of death. This concern is shared by Catholic ethics. More specifically, this concern is addressed in both the ERD and *Evangelium Vitae* where both mention that the treatment of pain and suffering is allowable so long as healthcare providers respond with proportional treatment.⁷² This is consistent with the practice of palliative sedation as it currently exists in healthcare.⁷³ Many argue that palliative sedation is only palliative sedation when the amount of medication and the levels of sedation provided are aligned with the needs and levels of pain and suffering expressed by the patient.

This is where the first major ethical challenge is posed by palliative sedation, in particular with CSU. As mentioned previously, CSU is ethically complex given the fact that the consciousness of the patient is entirely deprived. Catholic moral teaching makes clear mention that consciousness of a patient ought not be deprived without a “compelling reason.”⁷⁴ John Paul II expands this by stating the loss of consciousness is unfavorable because a dying patient should tend to his or her moral and familial duties at the end-of-life.⁷⁵ Furthermore, the dying patient ought to be able to prepare himself or herself to meet God after death. Therefore, it is argued that total unconsciousness at the end-of-life is unfavorable and ought to be avoided if possible.

However, the same documents include the provision that while loss of consciousness is unfavorable, it is permissible. This is due to the rationale that if all plausible methods of pain relief have been feasibly exhausted and the lessening of consciousness is the remaining option, this is a less favorable but morally permissible pain relief intervention.⁷⁶ The question then becomes how much sedation ought to be administered to the patient. This then becomes something of a secondary ethical dilemma but is more easily solved. Secular ethics provides a response consistent with Catholic ethics in that the levels of sedation ought to be titrated till the patient’s pain and suffering are controlled, up to and including CSU.⁷⁷

As such, Catholic healthcare organizations ought to respond in kind by providing proportional levels of sedation for patients who have feasibly exhausted all plausible methods of pain relief and are still experiencing intractable pain and suffering. This proportionality extends up to and including continuous sedation to unconsciousness (CSU). This is consistent with the Catholic moral tradition in that those who are suffering ought to be comforted by the medical profession.⁷⁸ Proper ethical consideration must be had when judging if all plausible pain relief measures have been exhausted since there could be other plausible pain relief measures that have yet to be attempted. This is to safeguard against the potential for abuse that could result from the care team prematurely determining the patient's pain and suffering indicate an immediate deep sedation incurring the aforementioned unfavorable burdens.⁷⁹ This improper usage of palliative sedation is not ethical since it prioritizes the sedation of the patient over ensuring proper care for the patient.⁸⁰ This improper usage is also not in line with Catholic teaching since it immediately assumes the best course of action is to deprive the patient of consciousness which was previously established to be unfavorable due to the denying of the dying's duties to prepare for death. Total unconsciousness must be avoided at all costs unless the levels of pain and suffering expressed by the patient indicate this is necessary. Lesser levels of sedation ought to be attempted first before CSU is performed all the while palliative sedation being reserved as a last-resort option.⁸¹

5b. Intentions of Sedation

The second aspect of this framework to consider is that of the intentionality of palliative sedation. This is particularly relevant as there are significant challenges that are presented when a patient intends for palliative sedation to be similar to assisted death. This type of patient presents an ethical challenge since the Catholic moral tradition is unilaterally against assisted death.⁸² Therefore, if intentions for palliative sedation are not thoroughly noted and explicated,

there exists a risk of scandal on the part of the Catholic healthcare organization since there is improper intentionality behind the intervention and it could begin to creep closer to assisted death.⁸³ As such, one method of ensuring this intentionality is upheld is to give proper informed consent regarding the depth and duration of sedation to be performed.⁸⁴

This should consist of the care team providing information (including types of sedatives and levels of sedation) to the patient or appropriate surrogate regarding palliative sedation that is in line with current evidence-based practices.⁸⁵ Furthermore, the care team should thoroughly discuss the possibility for deeper sedation to bring the patient sufficient relief, up to and including CSU. The patient should also be given the opportunity to discuss advanced care planning regarding life-sustaining medical treatment while the patient is still lucid (if possible). This allows for the continued respect of patient autonomy once the patient becomes sedated. This is also in line with Catholic teaching that an informed patient can make advanced care planning that forgoes life-sustaining medical treatment so long it is deemed extraordinary.⁸⁶ This discussion also should consist of potential complications that might arise while the patient is under sedation with subsequent advanced care planning. It is highly recommended that a patient also identifies a surrogate decision-maker before the patient is put under any form of sedation.⁸⁷ This is to help serve the patient's best interests in making decisions that are beyond the discussions had during informed consent.

One potential ethical challenge that is posed to both secular and Catholic ethics regarding this aspect of intentionality is the problem often referred to as "redescription." In short, this argument puts forward that it is impossible to truly know what anyone has at heart when a person says one thing but could truly feel something entirely different.⁸⁸ This problem is very much present with palliative sedation. There is recorded misuse of palliative sedation where patients or physicians

truly intend to hasten death by utilizing sedative medications beyond the indicated amounts and thereby are now hastening death.⁸⁹ As such, those who assert the “redescription” counterargument against palliative sedation argue that this misuse of palliative sedation indicates that healthcare organizations who utilize palliative sedation could covertly be performing euthanasia. While this is a true statement and is impossible to prevent in its entirety, there do exist methods that can limit this possibility.

The commonly proposed solution to this “redescription” issue is to rely on a properly implemented protocol of proportionality.⁹⁰ If the proportion of sedation is properly managed to only be what is required to bring about the intended relief of pain and suffering, then there is little worry that physicians or those in the care team will be providing improper and immoral doses of sedative medication. Furthermore, it must be noted that this notion of proportionality highlights the nature of intentionality within palliative sedation. Palliative sedation intends to only provide symptom control, specifically the relief of pain and suffering.⁹¹ The intention of palliative sedation should never be the reduction of consciousness. If this were to become the case, this practice would fall outside of the bounds of palliative sedation.

It is this understanding of palliative sedation that allows its practice to be acceptable within the Catholic moral tradition. As discussed above, the Catholic tradition has taught that patients are allowed to receive intensive methods of pain relief since all humans have a duty to take care of themselves.⁹² Therefore, so long the intentions of palliative sedation are upheld as a form of intensive pain management, it is permissible in Catholic healthcare organizations.

5c. Moral Distress at the End of Life

One aspect of this framework that this essay wishes to discuss are the experiences of moral distress within healthcare that have begun to push on Catholic healthcare. One broad definition

of moral distress is the experience of tension that is present when a healthcare professional has both professional duties to uphold against the needs of patients.⁹³ This can be experienced in many ways among the various settings of healthcare. However, what is most relevant to this discussion is the experience of the acute care setting. Evidence has shown that many healthcare professionals in the acute care setting experience moral distress regarding non-beneficial/excessive treatment of patients who are suffering.⁹⁴ As a result, a sort of damage to the healthcare professional's moral life and the professional begins to experience tangible pains not dissimilar from post-traumatic stress disorder.⁹⁵ This then leads to less beneficial care for patients and deteriorates the professional's interpersonal interactions at-large.⁹⁶

One specific instance of this moral distress is regarding the end-of-life phase of acute care. Many patients in this phase of care are often receiving non-beneficial forms of curative treatment. Simply put, the patient is still being treated for a disease that the patient is likely not going to recover from and is regularly in a great deal of pain and suffering.⁹⁷ It is here that many healthcare professionals begin to experience moral distress in continuing non-beneficial treatment that is prolonging this patient's pain and suffering when there are interventions that can be done that will provide potential relief from this pain and suffering.

It is here that this framework wishes to pose the notion that palliative sedation can exist as a potential intervention to help alleviate these experiences of moral distress. While there exist many palliative interventions that can help alleviate some of these experiences of pain and suffering, there exist patients who will not respond well to these interventions.⁹⁸ As such, there exists a valid reason for palliative sedation to be present in Catholic healthcare organizations not only to provide care for the patients who need it but also to help healthcare professionals who wish to provide good and appropriate care for the dying.

This notion of palliative sedation being provided as not only a form of care for the dying but also a way to mitigate moral distress is in line with Catholic moral tradition with the statements of ERD 7 that generally states that healthcare employees must be treated respectfully and justly.⁹⁹ Within this understanding, it logically follows that part of this respect and just treatment of healthcare professionals is the acknowledgement that there is potential for true harm in the experiences of moral distress. As such, it is this framework's recommendation that palliative sedation can exist as a last-resort option to continue providing care for the dying while also minimizing the potential moral distress as a result of continuing futile treatment or the non-treatment of pain and suffering despite best palliative care efforts.

5d. Catholic "Assistance in Dying"

The next aspect this framework wishes to discuss is that of the present challenges of assisted death against Catholic healthcare. As mentioned in the introduction, there are a number of advocates for assisted death interventions that are gaining growing support across the United States. One can argue this began in 1997 with the Oregon "Death with Dignity Act."¹⁰⁰ At time of writing, there are eight states (and Washington, D.C.) in the US that have legalized assisted death.¹⁰¹ As such, there is a tangible challenge being posed against Catholic healthcare. Since no form of assisted death is permissible in the Catholic tradition, Catholic healthcare is faced with the challenge of accepting assisted death to accommodate for patient's requests or not providing assisted death and potentially providing suboptimal care (if assisted death is understood as beneficial as assisted death advocates assert).

Advocates will often argue that patients without access to assisted death can suffer needless pain and suffering.¹⁰² Some will go so far to argue that forcing a patient to experience needless pain and suffering is akin to tyranny and deeply violates patient autonomy and the healthcare

professional's obligations to do no harm.¹⁰³ Further still, some advocates will argue that assisted death is within the bounds of medicine since the actions of providing the means of death to a patient is promoting a patient's right to self-determination and acting in the best interests of the patient.¹⁰⁴ Furthermore, if the patient truly wishes to have a "death with dignity" some advocates will argue that to deny a patient this wish is detrimental to the nature of a healthcare professional since this is sometimes viewed as a form of abandonment by the professional.¹⁰⁵ In other words, there is a deeply held view that to deny a patient the assurance of a "dignified death" through assisted death is to deny a healthcare professional's duty toward a patient. The Catholic moral tradition takes issue with the totality of these arguments given its understanding of the immutable dignity of the human person.¹⁰⁶ However, there exists a potential middle ground in this debate that has not been sufficiently explored, palliative sedation.

As this essay has discussed, Catholic healthcare has a deeply established argument about why it cannot practice assisted death. Briefly restated, there exists a deep understanding on the permissibility of intensive pain management as a permissible intervention if it becomes necessary since these interventions are aimed at relief of pain and suffering. As such, there exists a strong moral foundation to build off of for palliative sedation to be adapted into Catholic healthcare organizations. As previously stated, palliative sedation is an intervention that is solely aimed at the relief of pain and suffering by both the healthcare professional and patient.¹⁰⁷ This is enforced by the methods of informed consent and strict protocols in a specific organization to prevent abuse. Therefore, palliative sedation can exist as a sort of pseudo- "assisted death" for those Catholic healthcare organizations to provide comfort and peace of mind to those who are still strongly desiring a last-resort intervention for pain and suffering that is not manageable by standard palliative care measures.

5e. Obligations to Ordinary Treatment of Illness

This then leads into the final aspect this framework wishes to propose, the foundational understanding of Catholic healthcare in the treatment of illness. As previously discussed, Catholic healthcare has a foundational obligation to provide care for the sick and dying. The Catholic moral tradition has come to understand these forms of care that are morally obligatory as “ordinary” with its antithesis being “extraordinary.”¹⁰⁸ This general delineation exists to indicate that there are some forms of care that are deserved of all human beings since they are essential to sustaining life.¹⁰⁹ Clear examples of these can include food and water. Extraordinary care usually indicates treatment that is providing some form of benefit to the patient but is deemed too burdensome to provide a true benefit to the patient. Furthermore, this attachment can become a disproportionate understanding of the value of biological life.¹¹⁰ Given these delineations, the Catholic moral tradition has determined that pain relieving medication falls under ordinary forms of care so long as these interventions do not propose a disproportionate burden onto the patient. Furthermore, the Catholic moral tradition has also stated that intensive pain management interventions do also fall under the category of ordinary care since they regularly bring the patient to a level of peace and comfort to better prepare oneself for death.¹¹¹

One potential ethical complication that arises from this assessment is the notion that palliative sedation can deprive a patient of some level of consciousness at the time of death. As discussed, this can be the form of a light deprivation of consciousness in mild sedation to a total loss of consciousness in deep sedation. Needless to say, this is not favorable since it will deny the right one has to prepare for death as expressed by the Catholic moral tradition.¹¹² However, there is explicit mention that while depriving a patient of consciousness is not favorable, there is also direct statement that says a patient can have a reduced level of consciousness if there is a

“sufficient reason.” This statement opens the door for interpretation on what constitutes a “sufficient reason” in the case of a dying patient.

One could make the argument that palliative sedation is never truly permissible since there are limitless interventions one could attempt to relieve pain. This is an inherently flawed argument since, while it is true that there are innumerable potential methods of pain relief, this does not mean that all of these methods are equally accessible or viable.¹¹³ This argument can be taken to the extreme that heavy doses of morphine are a form of intensive pain relief and therefore ought to be attempted in lieu of palliative sedation. However, this is known to be an improper response since opiates used improperly can cause the hastening of death through respiratory depression.¹¹⁴ Furthermore, consider an opiate-resistant patient. This patient might already be on the maximum safe dosages. Therefore, situations like these illustrate there can come a time when a patient has reasonably exhausted all feasible methods of pain relief. This then leaves the care team with the remaining option of palliative sedation as the last-resort option to bring about the relief of pain and suffering (aside from assisted death).

As expressed throughout this essay, this usage of palliative sedation ought not be the first choice when considering intensive pain relief due to the loss of consciousness. This sentiment is shared by secular ethics.¹¹⁵ These ethicists reason that palliative sedation should not be used frivolously and must be properly reserved as a last-resort option given the many burdens and sacrifices that accompany it. The Catholic moral tradition echoes this rationale albeit with an underscoring of an obligation to care. As expressed throughout this essay, the terminally ill and dying are in deep need of intense levels of care. The Catholic tradition asserts that assisted death is antithetical to these obligations of care and cannot be viewed as such.¹¹⁶ This framework then recommends that Catholic healthcare organizations provide palliative sedation as a source of

healing in the face of unmanageable pain and suffering in an effort to sustain the obligations to care Catholic healthcare without resorting to the immoral practices of assisted death.

6. Conclusion

This essay has set out to provide a new framework for Catholic healthcare organizations to implement palliative sedation as part of these organizations' standards of care. This essay first discussed the surface level documentation regarding Catholic healthcare's rejection of assisted death (physician assisted suicide and active voluntary euthanasia), namely the moral impermissibility of ending human life and the intrinsic value that each human has. This essay then discussed Catholic moral teaching as it pertains to the obligations to care that exist within the foundational understandings of Catholic healthcare. These obligations arise from the same understandings of why Catholic healthcare cannot perform assisted death; human life is of absolute value. As such, Catholic healthcare is called to care for and help heal human life, not destroy it. This essay then assessed the present state of palliative sedation within secular healthcare and the challenges it has faced. In particular, this essay discussed some ethical challenges that arise in secular palliative sedation to illustrate the notions of intentionality and proportionality. These issues of secular ethics then provide the backdrop for this essay's framework for Catholic palliative sedation. This framework is presented in five key aspects to consider when designing palliative sedation protocols within a Catholic healthcare organization: I.) Proportionality of Sedation, II.) Intentions of Sedation, III.) Moral Distress at the End of Life, IV.) Catholic "Assistance in Dying," and V.) Obligations to Ordinary Treatment of Illness. These aspects of the framework provide a foundational understanding of palliative sedation within the Catholic moral tradition and are recommended as guidance for Catholic healthcare organizations to provide the best possible care for terminally patients at the end-of-life.

It must be acknowledged that this framework is not exhaustive. There are many deeper discussions that can be had about ethical dilemmas present in the practices of palliative sedation and assisted death. There are certainly many more aspects of the Catholic moral tradition that can be discussed to provide a deeper understanding of the permissibility of palliative sedation in Catholic healthcare. However, this framework serves as a foundational touchstone for Catholic healthcare organizations and Catholic healthcare ethicists to begin the discussion about how palliative sedation can be implemented as a standard practice within Catholic healthcare. It must be stated that this framework is not intended to be exhaustive of all ethical aspects of palliative sedation. Nor is this framework intended to be authoritative in regard to specific practices of palliative sedation. This essay and framework exist to support the foundational mission of Catholic healthcare, the healing ministry of Jesus Christ, in an increasingly pluralistic society while maintaining alignment to the Roman Catholic understandings of human dignity.

Endnotes:

-
- ¹ R. Collier, "Assisted death gaining acceptance in US," *CMAJ* 189, no. 3 (Jan 23 2017); "Government: scope for assisted suicide for people who regard their life as completed," 2016, accessed Mar. 27, 2021, <https://www.government.nl/topics/euthanasia/news/2016/10/21/government-scope-for-assisted-suicide-for-people-who-regard-their-life-as-completed>; Sigrid Dierickx et al., "Euthanasia in Belgium: Trends in reported cases between 2003 and 2013," *CMAJ* 188, no. 16 (2016): E407.
- ² Dierickx et al., "Euthanasia in Belgium: Trends in reported cases between 2003 and 2013."; Government of the Netherlands, "Termination of Life on Request and Assisted Suicide (Review Procedures) Act," (2002); "Medical Assistance in Dying," accessed Mar. 28, 2021, <https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html>.
- ³ "Death with Dignity Acts," 2020, accessed Feb. 16, 2021, <https://www.deathwithdignity.org/learn/death-with-dignity-acts/>.
- ⁴ Wendy K. Mariner, "Physician Assisted Suicide and the Supreme Court: Putting the Constitutional Claim to Rest.," *Am J Public Health* 87, no. 12 (Dec 1997): 2058; Timothy E. Quill, Bernard Lo, and Dan W. Brock, "Palliative options of last resort: a comparison of voluntarily stopping eating and drinking, terminal sedation, physician-assisted suicide, and voluntary active euthanasia," *JAMA* 278, no. 23 (Dec 17 1997): 2099. A mention must be made that the Supreme Court of the US has limited jurisprudence on the topic of assisted death. As of recent there have only been two cases before the Court that have provided any federal jurisprudence on assisted death, *Washington v Glucksberg* and *Vacco v Quill*. However, these decisions were only regarding the question of a constitutional right to assisted death, not on the laws themselves. The Court left this decision open and still allows states to make laws individually regarding the legalities and procedures of procuring assisted death.
- ⁵ Ana S. Iltis, "On the impermissibility of euthanasia in Catholic healthcare organizations," *Christian bioethics* 12, no. 3 (2006): 282.
- ⁶ T. W. Kirk et al., "National Hospice and Palliative Care Organization (NHPCO) position statement and commentary on the use of palliative sedation in imminently dying terminally ill patients," *J Pain Symptom Manage* 39, no. 5 (May 2010): 915, 17.
- ⁷ B. Broeckaert and Federation Flemish Palliative Care, "Treatment decisions in advanced disease: a conceptual framework," *Indian J Palliat Care* 15, no. 1 (Jan 2009): 7.
- ⁸ "Oregon's Death with Dignity Act," 2021, accessed Mar. 25, 2021, <https://www.oregon.gov/oha/PH/ProviderPartnerResources/Evaluationresearch/deathwithdignityact/Pages/index.aspx>; Collier, "Assisted death gaining acceptance in US."
- ⁹ Liberia Editrice Vaticana, *Catechism of the Catholic Church*, Second ed. (Città del Vaticano, 1997), 2258.
- ¹⁰ Vaticana, *Catechism of the Catholic Church*, 2280.
- ¹¹ Vaticana, *Catechism of the Catholic Church*, 2281.
- ¹² Vaticana, *Catechism of the Catholic Church*, 2288.
- ¹³ Vaticana, *Catechism of the Catholic Church*, 2258.
- ¹⁴ Vaticana, *Catechism of the Catholic Church*, 2282.
- ¹⁵ United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Sixth Edit ed. (Washington, DC, 2018), 60.

-
- ¹⁶ Broeckaert and Flemish Palliative Care, "Treatment decisions in advanced disease: a conceptual framework," 7.
- ¹⁷ David F. Kelly, Gerard Magill, and Henk Ten Have, *Contemporary Catholic Health Care Ethics* (Washington, D.C.: Georgetown University Press, 2013), 212-13; Broeckaert and Flemish Palliative Care, "Treatment decisions in advanced disease: a conceptual framework," 7.
- ¹⁸ Vaticana, *Catechism of the Catholic Church*, 2261.
- ¹⁹ Vaticana, *Catechism of the Catholic Church*, 2268.
- ²⁰ Vaticana, *Catechism of the Catholic Church*, 2261.
- ²¹ Authority, "Oregon's Death with Dignity Act.," *House of Commons of Canada Bill C-14*; Dierickx et al., "Euthanasia in Belgium: Trends in reported cases between 2003 and 2013.," Netherlands, "Termination of Life on Request and Assisted Suicide (Review Procedures) Act."
- ²² Vaticana, *Catechism of the Catholic Church*, 2276-77.
- ²³ Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 60.
- ²⁴ John 4:50; Mark 1:31, 41-42, 2:11-12, 7:33-35; Matt. 9:29-30
- ²⁵ Matt. 25:32, 34, 36 (RSV-2CE)
- ²⁶ "The Corporal Works of Mercy," 2021, accessed Mar. 31, 2021, <https://www.usccb.org/beliefs-and-teachings/how-we-teach/new-evangelization/jubilee-of-mercy/the-corporal-works-of-mercy>.
- ²⁷ "Mission Overview," 2021, accessed Mar. 31, 2021, <https://www.chausa.org/mission/overview>.
- ²⁸ Bishops, "The Corporal Works of Mercy."
- ²⁹ "Life and Dignity of the Human Person," 2021, accessed Mar. 31, 2021, <https://www.usccb.org/beliefs-and-teachings/what-we-believe/catholic-social-teaching/life-and-dignity-of-the-human-person>; "Evangelium Vitae," The Holy See, 1995, accessed Mar. 10, 2021, http://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html.
- ³⁰ "Palliative Care," 2020, accessed Mar. 31, 2021, <https://www.who.int/news-room/fact-sheets/detail/palliative-care>; Farr A. Curlin, "Hospice and Palliative Medicine's Attempt at an Art of Dying," in *Dying in the twenty-first century: toward a new ethical framework for the art of dying well*, ed. Lydia S. Dugdale (Cambridge: The MIT Press, 2015), 47.
- ³¹ C. Saunders, "The evolution of palliative care," *J R Soc Med* 94, no. 9 (Sep 2001): 431; A. Bradshaw, "The spiritual dimension of hospice: the secularization of an ideal," *Soc Sci Med* 43, no. 3 (Aug 1996): 411.
- ³² "About USCCB," 2021, accessed Mar. 31, 2021, <https://www.usccb.org/about>.
- ³³ Bishops, *Ethical and Religious Directives for Catholic Health Care Services*.
- ³⁴ Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 60.
- ³⁵ Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 61.
- ³⁶ John Paul II, "Evangelium Vitae," 3.
- ³⁷ John Paul II, "Evangelium Vitae," 4.
- ³⁸ John Paul II, "Evangelium Vitae," 54.
- ³⁹ John Paul II, "Evangelium Vitae," 65.
- ⁴⁰ John Paul II, "Evangelium Vitae," 65.
- ⁴¹ John Paul II, "Evangelium Vitae," 65.
- ⁴² Gina M. Noia, "The Principle of Double Effect within Catholic Moral Theology: A Response to Two Criticisms of the Principle in Relation to Palliative Sedation," *Journal of Moral Theology*

-
- 6, no. No. 2 (2017): 133; Iltis, "On the impermissibility of euthanasia in Catholic healthcare organizations," 284-85; Vaticana, *Catechism of the Catholic Church*, 2279.
- ⁴³ H. ten Have and J. V. Welie, "Palliative sedation versus euthanasia: an ethical assessment," *J Pain Symptom Manage* 47, no. 1 (Jan 2014): 131.
- ⁴⁴ Robert C. Macauley, *Ethics in Palliative Care* (New York: Oxford University Press, 2018), 167.
- ⁴⁵ Broeckaert and Flemish Palliative Care, "Treatment decisions in advanced disease: a conceptual framework," 4.
- ⁴⁶ John Paul II, "Evangelium Vitae," 65.
- ⁴⁷ Broeckaert and Flemish Palliative Care, "Treatment decisions in advanced disease: a conceptual framework," 5.
- ⁴⁸ Iltis, "On the impermissibility of euthanasia in Catholic healthcare organizations," 287.
- ⁴⁹ ten Have and Welie, "Palliative sedation versus euthanasia: an ethical assessment," 129; Broeckaert and Flemish Palliative Care, "Treatment decisions in advanced disease: a conceptual framework," 5; M. Maltoni et al., "Palliative sedation therapy does not hasten death: results from a prospective multicenter study," *Ann Oncol* 20, no. 7 (Jul 2009): 1164.
- ⁵⁰ Broeckaert and Flemish Palliative Care, "Treatment decisions in advanced disease: a conceptual framework," 5-6; John Paul II, "Evangelium Vitae," 65.
- ⁵¹ Maltoni et al., "Palliative sedation therapy does not hasten death: results from a prospective multicenter study," 167-68.
- ⁵² Broeckaert and Flemish Palliative Care, "Treatment decisions in advanced disease: a conceptual framework," 6.
- ⁵³ Macauley, *Ethics in Palliative Care*, 254; Maltoni et al., "Palliative sedation therapy does not hasten death: results from a prospective multicenter study," 1163.
- ⁵⁴ Macauley, *Ethics in Palliative Care*, 255.
- ⁵⁵ Macauley, *Ethics in Palliative Care*, 254; Maltoni et al., "Palliative sedation therapy does not hasten death: results from a prospective multicenter study," 1163.
- ⁵⁶ Macauley, *Ethics in Palliative Care*, 258.
- ⁵⁷ ten Have and Welie, "Palliative sedation versus euthanasia: an ethical assessment," 131.
- ⁵⁸ Macauley, *Ethics in Palliative Care*, 184.
- ⁵⁹ Macauley, *Ethics in Palliative Care*, 261.
- ⁶⁰ ten Have and Welie, "Palliative sedation versus euthanasia: an ethical assessment," 131.
- ⁶¹ Macauley, *Ethics in Palliative Care*, 264.
- ⁶² Macauley, *Ethics in Palliative Care*, 265.
- ⁶³ ten Have and Welie, "Palliative sedation versus euthanasia: an ethical assessment," 132; Maltoni et al., "Palliative sedation therapy does not hasten death: results from a prospective multicenter study," 1168.
- ⁶⁴ P. Claessens et al., "Palliative sedation: a review of the research literature," *J Pain Symptom Manage* 36, no. 3 (Sep 2008): 329.
- ⁶⁵ Macauley, *Ethics in Palliative Care*, 258-59.
- ⁶⁶ Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (Oxford: Oxford University Press, 2019), 103, 217.
- ⁶⁷ Macauley, *Ethics in Palliative Care*, 259.
- ⁶⁸ Macauley, *Ethics in Palliative Care*, 270.
- ⁶⁹ Beauchamp and Childress, *Principles of Biomedical Ethics*, 20-21.
- ⁷⁰ Macauley, *Ethics in Palliative Care*, 259.

-
- ⁷¹ Macauley, *Ethics in Palliative Care*, 260.
- ⁷² Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 61; John Paul II, "Evangelium Vitae," 65.
- ⁷³ Macauley, *Ethics in Palliative Care*, 270; ten Have and Welie, "Palliative sedation versus euthanasia: an ethical assessment," 131; Broeckaert and Flemish Palliative Care, "Treatment decisions in advanced disease: a conceptual framework," 6; Claessens et al., "Palliative sedation: a review of the research literature," 328.
- ⁷⁴ Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 61; ten Have and Welie, "Palliative sedation versus euthanasia: an ethical assessment," 130.
- ⁷⁵ John Paul II, "Evangelium Vitae," 65.
- ⁷⁶ John Paul II, "Evangelium Vitae," 65.
- ⁷⁷ Macauley, *Ethics in Palliative Care*, 270; Broeckaert and Flemish Palliative Care, "Treatment decisions in advanced disease: a conceptual framework," 6.
- ⁷⁸ Vaticana, *Catechism of the Catholic Church*, 2292-94.
- ⁷⁹ Claessens et al., "Palliative sedation: a review of the research literature," 330.
- ⁸⁰ Macauley, *Ethics in Palliative Care*, 270; ten Have and Welie, "Palliative sedation versus euthanasia: an ethical assessment," 133; Broeckaert and Flemish Palliative Care, "Treatment decisions in advanced disease: a conceptual framework," 6; Claessens et al., "Palliative sedation: a review of the research literature," 328.
- ⁸¹ Claessens et al., "Palliative sedation: a review of the research literature," 330.
- ⁸² Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 70; Vaticana, *Catechism of the Catholic Church*, 2282.
- ⁸³ Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 68, 71.
- ⁸⁴ Macauley, *Ethics in Palliative Care*, 257.
- ⁸⁵ Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 55; Claessens et al., "Palliative sedation: a review of the research literature," 329.
- ⁸⁶ Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 56-59.
- ⁸⁷ Macauley, *Ethics in Palliative Care*, 257.
- ⁸⁸ Noia, "The Principle of Double Effect within Catholic Moral Theology: A Response to Two Criticisms of the Principle in Relation to Palliative Sedation," 135.
- ⁸⁹ ten Have and Welie, "Palliative sedation versus euthanasia: an ethical assessment," 127.
- ⁹⁰ ten Have and Welie, "Palliative sedation versus euthanasia: an ethical assessment," 131; Claessens et al., "Palliative sedation: a review of the research literature," 330.
- ⁹¹ Broeckaert and Flemish Palliative Care, "Treatment decisions in advanced disease: a conceptual framework," 6.
- ⁹² Vaticana, *Catechism of the Catholic Church*, 2288.
- ⁹³ Kristen Jones-Bonofiglio, *Health Care Ethics Through the Lens of Moral Distress*, The International Library of Bioethics, (Cham: Springer, 2020), 3, 5.
- ⁹⁴ Jones-Bonofiglio, *Health Care Ethics Through the Lens of Moral Distress*, 5, 57, 91-92.
- ⁹⁵ Jones-Bonofiglio, *Health Care Ethics Through the Lens of Moral Distress*, 105.
- ⁹⁶ Jones-Bonofiglio, *Health Care Ethics Through the Lens of Moral Distress*, 54.
- ⁹⁷ Jones-Bonofiglio, *Health Care Ethics Through the Lens of Moral Distress*, 58.
- ⁹⁸ Claessens et al., "Palliative sedation: a review of the research literature," 310.
- ⁹⁹ Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 7.
- ¹⁰⁰ Authority, "Oregon's Death with Dignity Act."

-
- ¹⁰¹ "Death with Dignity Acts," 2021, accessed Apr. 2, 2021, <https://www.deathwithdignity.org/learn/death-with-dignity-acts/>.
- ¹⁰² Kelly, Magill, and Have, *Contemporary Catholic Health Care Ethics*, 213; Iltis, "On the impermissibility of euthanasia in Catholic healthcare organizations," 281-82.
- ¹⁰³ John Harris, "Euthanasia and the Value of Life," in *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, ed. John Keown (Cambridge: Cambridge University Press, 1995), 19-20.
- ¹⁰⁴ Macauley, *Ethics in Palliative Care*, 234-35.
- ¹⁰⁵ Macauley, *Ethics in Palliative Care*, 236.
- ¹⁰⁶ Vaticana, *Catechism of the Catholic Church*, 2258-88.
- ¹⁰⁷ Broeckaert and Flemish Palliative Care, "Treatment decisions in advanced disease: a conceptual framework," 6.
- ¹⁰⁸ Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 56-57.
- ¹⁰⁹ Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 58; Vaticana, *Catechism of the Catholic Church*, 2288.
- ¹¹⁰ Vaticana, *Catechism of the Catholic Church*, 2289.
- ¹¹¹ Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 61; John Paul II, "Evangelium Vitae," 65.
- ¹¹² John Paul II, "Evangelium Vitae," 65.
- ¹¹³ Kelly, Magill, and Have, *Contemporary Catholic Health Care Ethics*, 213, 18.
- ¹¹⁴ Macauley, *Ethics in Palliative Care*, 204.
- ¹¹⁵ Macauley, *Ethics in Palliative Care*, 259-60.
- ¹¹⁶ John Paul II, "Evangelium Vitae," 66.

Bibliography

- "Oregon's Death with Dignity Act." 2021, accessed Mar. 25, 2021, <https://www.oregon.gov/oha/PH/ProviderPartnerResources/Evaluationresearch/deathwithdignityact/Pages/index.aspx>.
- Beauchamp, Tom L., and James F. Childress. *Principles of Biomedical Ethics*. Oxford: Oxford University Press, 2019.
- "About Usccb." 2021, accessed Mar. 31, 2021, <https://www.usccb.org/about>.
- "The Corporal Works of Mercy." 2021, accessed Mar. 31, 2021, <https://www.usccb.org/beliefs-and-teachings/how-we-teach/new-evangelization/jubilee-of-mercy/the-corporal-works-of-mercy>.
- Bishops, United States Conference of Catholic. *Ethical and Religious Directives for Catholic Health Care Services*. Sixth Edit ed. Washington, DC, 2018.
- "Life and Dignity of the Human Person." 2021, accessed Mar. 31, 2021, <https://www.usccb.org/beliefs-and-teachings/what-we-believe/catholic-social-teaching/life-and-dignity-of-the-human-person>.
- Bradshaw, A. "The Spiritual Dimension of Hospice: The Secularization of an Ideal." *Soc Sci Med* 43, no. 3 (Aug 1996): 409-19.
- Broeckaert, B., and Federation Flemish Palliative Care. "Treatment Decisions in Advanced Disease: A Conceptual Framework." *Indian J Palliat Care* 15, no. 1 (Jan 2009): 30-6.
- "Medical Assistance in Dying." accessed Mar. 28, 2021, <https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html>.
- "Death with Dignity Acts." 2020, accessed Feb. 16, 2021, <https://www.deathwithdignity.org/learn/death-with-dignity-acts/>.
- Claessens, P., J. Menten, P. Schotsmans, and B. Broeckaert. "Palliative Sedation: A Review of the Research Literature." *J Pain Symptom Manage* 36, no. 3 (Sep 2008): 310-33.
- Collier, R. "Assisted Death Gaining Acceptance in Us." *CMAJ* 189, no. 3 (Jan 23 2017): E123. *House of Commons of Canada Bill C-14*.
- Curlin, Farr A. "Hospice and Palliative Medicine's Attempt at an Art of Dying." In *Dying in the Twenty-First Century: Toward a New Ethical Framework for the Art of Dying Well*, edited by Lydia S. Dugdale, 47-63. Cambridge: The MIT Press, 2015.
- Dierickx, Sigrid, Luc Deliens, Joachim Cohen, and Kenneth Chambaere. "Euthanasia in Belgium: Trends in Reported Cases between 2003 and 2013." *CMAJ* 188, no. 16 (2016): E407-E14.
- "Death with Dignity Acts." 2021, accessed Apr. 2, 2021, <https://www.deathwithdignity.org/learn/death-with-dignity-acts/>.
- Harris, John. "Euthanasia and the Value of Life." In *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, edited by John Keown, 6-22. Cambridge: Cambridge University Press, 1995.
- Iltis, Ana S. "On the Impermissibility of Euthanasia in Catholic Healthcare Organizations." *Christian bioethics* 12, no. 3 (2006): 281-90.
- "Evangelium Vitae." The Holy See, 1995, accessed Mar. 10, 2021, http://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html.
- Jones-Bonofiglio, Kristen. *Health Care Ethics through the Lens of Moral Distress*. The International Library of Bioethics. Cham: Springer, 2020.

- Kelly, David F., Gerard Magill, and Henk Ten Have. *Contemporary Catholic Health Care Ethics*. Washington, D.C.: Georgetown University Press, 2013.
- Kirk, T. W., M. M. Mahon, Hospice Palliative Sedation Task Force of the National, and Committee Palliative Care Organization Ethics. "National Hospice and Palliative Care Organization (Nhpco) Position Statement and Commentary on the Use of Palliative Sedation in Imminently Dying Terminally Ill Patients." *J Pain Symptom Manage* 39, no. 5 (May 2010): 914-23.
- Macauley, Robert C. *Ethics in Palliative Care*. New York: Oxford University Press, 2018.
- Maltoni, M., C. Pittureri, E. Scarpi, L. Piccinini, F. Martini, P. Turci, L. Montanari, O. Nanni, and D. Amadori. "Palliative Sedation Therapy Does Not Hasten Death: Results from a Prospective Multicenter Study." *Ann Oncol* 20, no. 7 (Jul 2009): 1163-9.
- Mariner, Wendy K. "Physician Assisted Suicide and the Supreme Court: Putting the Constitutional Claim to Rest." *Am J Public Health* 87, no. 12 (Dec 1997): 2058-62.
- "Government: Scope for Assisted Suicide for People Who Regard Their Life as Completed." 2016, accessed Mar. 27, 2021, <https://www.government.nl/topics/euthanasia/news/2016/10/21/government-scope-for-assisted-suicide-for-people-who-regard-their-life-as-completed>.
- Netherlands, Government of the. "Termination of Life on Request and Assisted Suicide (Review Procedures) Act." 2002.
- Noia, Gina M. "The Principle of Double Effect within Catholic Moral Theology: A Response to Two Criticisms of the Principle in Relation to Palliative Sedation." *Journal of Moral Theology* 6, no. No. 2 (2017): 130-48.
- "Palliative Care." 2020, accessed Mar. 31, 2021, <https://www.who.int/news-room/fact-sheets/detail/palliative-care>.
- Quill, Timothy E., Bernard Lo, and Dan W. Brock. "Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia." *JAMA* 278, no. 23 (Dec 17 1997): 2099-104.
- Saunders, C. "The Evolution of Palliative Care." *J R Soc Med* 94, no. 9 (Sep 2001): 430-2.
- "Mission Overview." 2021, accessed Mar. 31, 2021, <https://www.chausa.org/mission/overview>.
- ten Have, H., and J. V. Welie. "Palliative Sedation Versus Euthanasia: An Ethical Assessment." *J Pain Symptom Manage* 47, no. 1 (Jan 2014): 123-36.
- Vaticana, Liberia Editrice. *Catechism of the Catholic Church*. Second ed. Città del Vaticano, 1997.