The distinction between euthanasia and palliative sedation is clear-cut

Lars Johan Materstvedt[1],[2]

Correspondence to Professor Lars Johan Materstvedt, Department of Philosophy and Religious Studies, Norwegian University of Science and Technology (NTNU), NO-7491 Trondheim, Norway; lars.johan.materstvedt@ntnu.no

ABSTRACT

This article is a response to Thomas David Riisfeldt's paper entitled 'Weakening the ethical distinction between euthanasia, palliative opioid use and palliative sedation'. It is shown that as far as euthanasia and palliative sedation are concerned, Riisfeldt has not established that a common ground, or a similarity, between the two is the relief of suffering. Quite the contrary, this is not characteristic of euthanasia, neither by definition nor from a clinical point of view. Hence, the argument hinges on a conceptually and empirically erroneous premise and is accordingly a non-starter.

WHAT IS EUTHANASIA?

Riisfeldt refrains from defining the term euthanasia, 'since there is considerable disagreement among interlocutors as to what the correct definition of the term actually is' (1). Still, he refers to a patient who 'voluntarily requests to be killed by his/her doctor', and remarks that this involves the injection of 'a lethal combination of drugs' (1). This concept is congruent with Dutch euthanasia, which is 'reserved for killing on request' by a doctor 'administering a lethal injection' (2).

The Netherlands has a euthanasia practice that dates back to the ruling in the Postma case in 1973 (2). In a joint document, the Royal Dutch Medical Association (KNMG) and the Royal Dutch Pharmacists Association (KNMP) state that 'euthanasia means that the physician administers a lethal substance to the patient' at his or her 'express request' (3). In line with this definition, The European Association for Palliative Care (EAPC) notices that euthanasia entails 'a doctor intentionally killing a person by the administration of drugs, at that person's voluntary and competent request' (4).

It may be added that according to international convention, euthanasia falls under the umbrella assisted dying, together with physician-assisted suicide and assisted suicide (5). However, elsewhere I and co-author Morten Magelssen have suggested that we stop using the word euthanasia because it can be positively leading due to its Greek origin 'good death'; it may be replaced with the precise technical (nonmoral) term 'killing on request' only, where it is

[1] Department of Philosophy and Religious Studies, Faculty of Humanities, Norwegian University of Science and Technology (NTNU), Trondheim, Norway.

[2] End of Life Studies Group, School of Interdisciplinary Studies, University of Glasgow, Dumfries Campus, Scotland, UK.

presumed that the request is a voluntary one (6). That would seem to satisfy Riisfeldt's concept as well.

WHAT IS PALLIATIVE SEDATION?

In a very recent long article on palliative sedation, Robert Twycross, Emeritus Clinical Reader in Palliative Medicine, Oxford University, writes that palliative sedation 'is a widely used term to describe the intentional administration of sedatives to reduce a dying person's consciousness to relieve intolerable suffering from refractory symptoms' (7). Twycross was a pioneer of the hospice movement – which was founded by the late Dame Cicely Saunders (8, 9) – during the 1970s, when he was instrumental in the establishment of palliative medicine as a specialty in the UK.

As early as 2001, guidelines for palliative sedation were worked out in Norway (10). Thirteen years later, the Norwegian Medical Association published the revised document Guidelines for Palliative Sedation at the End of Life. Its definition is as follows: 'By palliative sedation is meant pharmacological depression of the level of consciousness in order to alleviate suffering that cannot be relieved in any other way' (11). Put otherwise: to handle refractory symptoms.

In its most radical form deep and continuous palliative sedation (DCPS) the patient dies in a state of unconsciousness such that he or she becomes socially dead before becoming biologically so, making it a challenging treatment (12).

Of particular interest when discussing the ethical distinction between euthanasia and palliative sedation, is the view of the KNMG. In this Dutch medical association's 2009 guideline it is emphasized that 'continuous, deep sedation differs from euthanasia in that its aim is not to shorten life' and that 'consequently, a clear distinction should be drawn between the two' (13). Throughout the comprehensive document it is frequently repeated – indeed, insisted upon – that palliative sedation bears no resemblance to euthanasia. Since 1984, the KNMG has worked actively for the legalisation of euthanasia (2).

Furthermore, it is noteworthy that the Government of the Netherlands is clear that palliative sedation is 'a normal medical procedure' (14).

A FUNDAMENTALLY FLAWED EMPIRICAL PREMISE

Despite Riisfeldt's appropriate emphasis of key elements like 'kill' and 'lethal drugs' in connection with euthanasia, he nonetheless believes there to be a parallell task for both euthanasia and palliative sedation: like the latter, euthanasia is performed 'as a means to relieve' the patient's 'suffering' (1).

But that observation is fundamentally flawed. Euthanasia is *not treatment*, hence it cannot possibly relieve symptoms. Instead, one *ends* suffering by ending the sufferer's life (15).

The EAPC puts the point succinctly: '"Terminal" or "palliative" sedation in those imminently dying must be distinguished from euthanasia. In terminal sedation the *intention* is to relieve intolerable suffering, the *procedure* is to use a sedating drug for symptom control and the successful *outcome* is the alleviation of distress. In euthanasia the *intention* is to kill the patient, the *procedure* is to administer a lethal drug and the successful *outcome* is immediate death' (4).

Accordingly, Riisfeldt's line of reasoning entails that he commits a *category mistake* at the very outset of the article; the categories euthanasia and palliative sedation simply do not belong in the same basket. Other medicial ethicists have done the same, claiming that 'euthanasia is to knowingly kill a person by the administration of drugs, at that person's voluntary and competent request *for the sake of relieving symptoms and primarily intolerable suffering of different kinds*' (16). Bobbie Farsides speaks about 'offering assisted dying as a therapeutic option' (17). On the contrary, therapy is exactly what assisted dying is not about (18). Daniel Sokol writes: 'The doctor who administers a fatal injection to a patient with end stage motor neurone disease, who has asked clearly and repeatedly for an earlier death, is relieving human suffering' (19). No, killing is not relieving.

Quite recently, a palliative care physician who is president-elect of the Canandian Medical Association has explained in a BMJ paper why he chose to start performing euthanasia after it became legal in Canada in 2016 (20). He depicts his performing of euthanasia in the following fashion: 'I alleviated his suffering in a way that wasn't possible through any other means. This experience exemplified for me the reason I went into medicine: to alleviate suffering. I know that's what I did for' the patient (20). He did not.

Compare with what some Dutch primary care physicians (PCPs) say, in qualitative research, of their experience of performing euthanasia. A collection of the rather straightforward utterances: 'I still always have a sense of guilt. I feel as if I'm an executioner'; 'In the USA, there are people who execute the death penalty on authority of the judge. In Holland, we [as PCPs] are appointed as such, to take someone's life'; 'With euthanasia, I always feel: "was that necessary"? I hate it'; 'Euthanasia was put on my plate. It's a rotten job' (21).

By pointing this out I am by no means saying anything on the morality of euthanasia, the possible participation of physicians or, for that matter, whether or not euthanasia should be legalised. For example, applying various theories of normative philosophical ethics will yield very different views of those issues indeed (5). My observation is empirical, not ethical: euthanasia is *not* about alleviating suffering.

Still, it can be said that euthanasia is performed in order to *prevent* further suffering. Empirically speaking, that is true. But preventing is not relieving and so this rejoinder is inadequate (15).

CONCLUSION: NO WEAKENING OF THE DISTINCTION

By way of conclusion, one of the key elements in Riisfeldt's attempt at weakening the ethical distinction between euthanasia and palliative sedation – I refrain from addressing his separate discussion of the Doctrine of Double Effect – is the introduction of an erroneous conceptual and empirical-clinical premise. Consequently, his claim that there is the basic, aforementioned similarity between euthanasia and palliative sedation cannot be substantiated. Whichever similarties there might be between euthanasia and palliative sedation, the relief of suffering isn't one of these.

REFERENCES

1. Riisfeldt TD. Weakening the ethical distinction between euthanasia, palliative opioid use and palliative sedation. *J Med Ethics* 2019;45:125–130. https://jme.bmj.com/content/45/2/125
2. Griffiths J, Bood A, Weyers H. *Euthanasia and law in the Netherlands*. Amsterdam: Amsterdam University Press, 1998.
3. KNMG/KNMP. Guidelines for the Practice of Euthanasia and Physician-Assisted Suicide. Utrecht: The Netherlands, August 2012. www.knmg.nl/adviesrichtlijnen/dossiers/euthanasie/viewpoints-and-guidelines-euthanasia.htm
4. Materstvedt LJ, Clark D, Ellershaw J, *et al*. Euthanasia and physician-assisted suicide: a view from an EAPC Ethics Task Force. *Palliat Med* 2003;17:97–101. https://journals.sagepub.com/doi/10.1191/0269216303pm673oa
5. Materstvedt LJ. Ethical issues in physician aid-in-dying. In: Cherny N, Fallon M, Kaasa S, Portenoy R, Currow D, eds. *Oxford Textbook of Palliative Medicine*, 6th edn. Oxford: Oxford University Press, 2020.
6. Materstvedt LJ, Magelssen M. Medical murder in Belgium and the Netherlands. *J Med Ethics* 2016;42:621–4. https://jme.bmj.com/content/42/9/621.full
7. Twycross R. Reflections on palliative sedation. *Palliative Care: Research and Treatment* 2019;1–16. https://journals.sagepub.com/doi/10.1177/1178224218823511
8. Clark D. *Cicely Saunders: Founder of the Hospice Movement: Selected Letters 1959–1999*. Oxford: Clarendon Press, 2002.
9. Clark D. *Cicely Saunders: A Life and Legacy*. Oxford: Oxford University Press, 2018.
10. Førde R, Materstvedt LJ, Markestad T, *et al*. Palliative sedation at the end of life – revised guidelines. *Journ Norw Med Assoc* 2014;135:220–221. https://tidsskriftet.no/en/2015/02/palliative-sedation-end-life-revised-guidelines
11. Den norske legeforening [The Norwegain Medical Association]. Guidelines for palliative sedation at the end of life, 2014. http://legeforeningen.no/Emner/Andre-emner/Publikasjoner/Retningslinjer/
12. Materstvedt LJ, Bosshard G. Deep and continuous palliative sedation (terminal sedation): clinical-ethical and philosophical aspects. *Lancet Oncol* 2009;10:622–627. www.thelancet.com/journals/lanonc/article/PIIS1470-2045(09)70032-4/fulltext
13. Royal Dutch Medical Association (KNMG). Guideline for Palliative Sedation, 2009. www.knmg.nl/advies-richtlijnen/dossiers/palliatieve-sedatie.htm
14. Government of the Netherlands. Palliative Sedation: A Normal Medical Procedure, 2018. www.government.nl/topics/euthanasia/palliative-sedation-a-normal-medical-procedure
15. Materstvedt LJ. Intention, procedure, outcome and personhood in palliative sedation and euthanasia. *BMJ Support Palliat Care* 2012;2:9–11. https://spcare.bmj.com/content/2/1/9
16. Juth N, Lindblad A, Lynöe N, *et al*. European Association for Palliative Care (EAPC) framework for palliative sedation: an ethical discussion. *BMC Palliat Care* 2010;9:20. https://bmcpalliatcare.biomedcentral.com/articles/10.1186/1472-684X-9-20

17. Farsides B. Commentary: Palliative care and assisted dying are not mutually exclusive. *BMJ* 2018;360:k544. www.bmj.com/content/360/bmj.k544

18. Finlay IG. Assisting suicide is no therapy. *Omsorg. Nordisk tidsskrift for palliativ medisin* [*Care. Nordic Journal of Palliative Medicine*] 2008;4:7–11. www.livinganddyingwell.org.uk/sites/default/files/LDW%20-%20Medicine%20-%20Nordic%20Journal%20of%20Palliative%20Care.pdf

19. Sokol D. Assisted dying is compatible with the Hippocratic Oath. *thebmjopinion* 2019. https://blogs.bmj.com/bmj/2019/02/14/daniel-sokol-assisted-dying-is-compatible-with-the-hippocratic-oath/

20. Buchman S. Why I decided to provide assisted dying: it is truly patient centred care. *BMJ* 2019;364:l412. https://www.bmj.com/content/364/bmj.l412

21. van Marwijk H, Haverkate I, van Royen P, *et al*. Impact of euthanasia on primary care physicians in the Netherlands. *Palliat Med* 2007;21:609–14. https://journals.sagepub.com/doi/abs/10.1177/0269216307082475