ETHICS & MEDICS
A Commentary of The National Catholic Bioethics Center on Health Care and the Life Sciences

THE RISE OF STEALTH EUTHANASIA

Medications used to manage pain and other symptoms—opiates, sedatives and barbiturates—can be misused to cause death. The *intention* to kill a patient, not just to treat pain and other symptoms, is becoming more common in palliative and end-of-life care settings. The purpose of this article is to expose disingenuous arguments used to hide *intentionality to kill* patients in end-of-life care settings.

A nurse informed one of the authors that a doctor admitted a patient with painful metastatic prostate cancer and then verbally directed the nurse to "warp him out of this world." She informed the doctor that she and the other nurses would provide the appropriate care for the patient, but the doctor insisted that the patient not be alive the next morning. However, the nurses were able to relieve the patient's symptoms without causing his death.

Kevin O'Reilly, writer for *American Medical News*, states that "treatments—when conducted with the consent of patients or surrogate decision-makers and implemented with the intent of alleviating pain or other symptoms in terminally ill patients—are broadly accepted as ethically and legally appropriate, even if they have the secondary effect of speeding the dying process." [1]

The principle of double effect is used to assess a good action that has both an intended good (primary) effect and an unintended bad (secondary) effect. Invoking the principle of double effect to justify speeding the dying process is disingenuous. In some palliative and end-of-life care settings, death from palliative sedation or use of opioids is not a secondary effect, but either the *intended* primary goal or the *unintended* result of failure to properly educate clinical staff. Becket Gremmels correctly reported that "the majority of studies have found that palliative sedation does not hasten death when used appropriately" and that there is "overwhelming evidence that the appropriate use of opioids at the end of life does not hasten death, and thus is not amenable to double-effect reasoning." [2] The key word is "appropriate."

Hospice and palliative care physicians and nurses must be well trained in the appropriate administration of medications and understand their potential to hasten death. Otherwise, unintentionally caused deaths are inevitable. When the staff is properly educated and the founding principles of hospice—to maintain dignity, to increase quality of life, and to provide comfort and pain control—are followed, hospice is a safe haven for patients in need of expert end-of-life care.

Double-effect reasoning should not be used to justify inappropriate use of opioids and sedation. At best, it is inaccurate to use the principle of double effect to justify an a priori intention to kill. At worst, it is a misleading attempt to justify an evil action.

Proper Titration of Opioid Analgesics

International standards of palliative medicine require careful dosage calculation and titration for administration of opioids to manage moderate to severe pain in patients. It is well established that clinically unnecessary doses of opioid medications or extreme increases in dosage are likely to cause adverse effects, such as respiratory suppression, loss of consciousness, coma, and even death.[3] Nazi doctors perfected euthanasia through morphine administration, so pretending that morphine use is always safe is a fantasy.[4]

When opioids are used to impose death, health care professionals usually cloak their actions by telling families that the signs of approaching death being observed are due to a terminal illness, not to the adverse effects of a clinical overdose, which conveniently mirror some of the signs of the end-stage active phase of dying.[5]

Misuse of Palliative Sedation

For decades, the praiseworthy goal of the hospice and palliative care mission has been to relieve patients' distressing symptoms, but *never to hasten death*. Even when a patient asked to be killed, it was always understood to be a cry for relief from suffering—physical, emotional, or spiritual—and not as permission to take a life.

Today, permanent sedation and the withholding of nutrition and hydration are often done with the intention

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that the patient die. This practice is known by various terms: "terminal sedation," "palliative sedation," "total sedation," "permanent sedation," "comfort sedation," and "deep continuous sedation." Authentic terminal sedation is used to relieve "terminal agitation" or restlessness at the end of life. It is never appropriately used as a first line of therapy. Permanent sedation is properly used when pain is so extreme that absolutely no other means have been effective.

Sedation has a legitimate place in end-of-life care but must be used only when absolutely necessary. When palliative sedation is misused to cause death, the patient is placed in a medically induced coma and nutrition and hydration is withheld. When this happens, circulatory collapse occurs from fluid volume deficit within a few days to a few weeks, depending on the patient's condition. This is an excruciating process for the patient and for those who must keep watch at the bedside.

Dr. William Burke, a St. Louis neurologist, describes what happens to patients as they undergo death from dehydration: "They will go into seizures. Their skin cracks, their tongue cracks, their lips crack. They may have nosebleeds because of the drying of the mucus membranes, and heaving and vomiting might ensue because of the drying out of the stomach lining. . . . It is an extremely agonizing death." [6] Even if patients are sedated, how could we be certain that they would feel no pain, thirst, or hunger?

Many in the field of hospice and palliative care—medical and nursing directors, nurses, social workers, and chaplains—as well as physicians across the country, confirm that there is a clear trend toward hastening deaths of patients. Oncologists and primary care practitioners are shocked when their patients, who have chronic or terminal illnesses but are not in the active phase of dying and are not expected to die suddenly, die within days or weeks of entering hospice. Internationally known hospice and palliative care leaders confirm these reports.[7] These professionals cannot *all* be wrong or ignorant.

Confirmation

Fifteen years ago, Dr. Joanne Lynn, a foremost authority in modern palliative care, was quoted in the *New York Times*: "When a patient is ready to die, I can stop nutrition and hydration, I can stop insulin and ventilation. I can sedate them." [8] This is intended death, not death from any terminal illness. Dr. Timothy E. Quill, palliative care specialist and physician-assisted suicide advocate, and Dr. Ira R. Byock, prominent hospice and palliative care physician, suggest that when patients request that death be hastened, terminal sedation and voluntary refusal of hydration and nutrition can "substantially increase patients' choices at this inherently challenging time." [9]

Thus, many hospice and palliative care physicians are urging, and actually performing, euthanasia by stealth. They administer sedatives that in themselves do not cause immediate death, but knowingly cause the conditions that result in death. This misuse of terminal sedation with intent to end life is properly termed "stealth euthanasia"—it is not active euthanasia or passive euthanasia, but a combination of both.[10]

It strikes people as wrong to withdraw food and fluids from patients who are not in the end-stage active phase of dying. O'Reilly, perhaps unintentionally, exposes this fact: "New developments in end-of-life care—aggressive pain and symptom management (even to the point of unconsciousness), along with *a greater willingness to withdraw* advanced, life-sustaining treatments such as mechanical ventilation, dialysis, and *artificial hydration and nutrition—still strike many people as wrong*." [11] It is horrifying that health care professionals—those to whom we entrust our lives—intentionally hasten death while pretending to be providing appropriate end-of-life care. That this *is a pretense* is becoming more and more evident to patients and families.

Although Medicare guidelines require patients to have a terminal diagnosis in order to be enrolled in hospice, patients who are not terminal are fraudulently admitted.[12] Sometimes patients with chronic conditions such as Alzheimer's disease or brain damage were admitted to hospice, and then they died from dehydration.[13]

The *Catechism of the Catholic Church* states that "an act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder." [14] Therefore, omission of nutrition and hydration that causes or hastens a patient's death must be rejected. Physicians who seek to continue providing food and fluids are often pressured not to do so. This results in patient deaths and terrible anguish for physicians.

Secular bioethical arguments are used to "justify" stealth euthanasia: for example, "poor quality of life," suggesting that the patient is "better off dead," or "respect for patient autonomy," even though many of these patients are not requesting death.

Expectations versus Reality

Traumatized families are reporting the hastened deaths of loved ones, and hospice and palliative care providers are warning that euthanasia and stealth euthanasia are sometimes being performed in end-of-life care settings. This is not surprising considering who leads the hospice and palliative care industry today. The National Hospice and Palliative Care Organization (NHPCO), the leading trade organization for this industry, is the actual legal and corporate successor to the Euthanasia Society of America.[15] The Euthanasia Society of America was successively known as the Society for the Right to Die, Choice in Dying, Partnership for Caring, and Last Acts Partnership before finally being absorbed into the NHPCO. This explains the contradiction between the publicly stated hospice mission and the reality in too many

clinical settings. It appears that the NHPCO is intent on quietly subverting that *life-affirming mission*.

The September 2000 declaration of the World Federation of Right-to-Die Societies, states in part,

> We wish to draw public attention to the practice of "terminal sedation" or "slow euthanasia" which is performed extensively today throughout the world in hospitals, nursing homes, hospices, and in private homes. . . . A physician may lawfully administer increasing dosages of regular analgesic and sedative drugs that can hasten someone's death as long as the declared intention is to ease pain and suffering. . . . Compassionate physicians, without publicly declaring the true intention of their actions, often speed up the dying process in this way.[16]

Indeed, the culture of death has deeply infiltrated the hospice and palliative care industry! Despite this, some health care professionals courageously remain faithful to the original mission of providing care until the natural end of life of a patient. Faithful professionals, who have a reverence for life, need support and encouragement as they serve extremely vulnerable patients.

The difficulty facing patients and their families is that they do not know how to discern which health care providers can be trusted to care and to never kill. The first question to ask when looking for a pro-life hospice or a palliative care program is does every physician and nurse reject all justifications for intentionally causing the deaths of patients? Authentic hospice involves *adding* resources to uphold the dignity of the patient and the sanctity of life. Yet because the average person is uneducated about their rights at the end of life, they often do not question the advice, orders, or actions of their health care professionals.

Discerning True Values

Patients who are in pain *need* pain relief that is safely administered and poses little or no risk of hastening death. They *do not need* (nor do most want) death. The culture of life promotes ethical principles that guide the appropriate and judicious use of sedatives and opioids. Practice has shown such use prolongs overall patient survival in end-of-life care settings.

On the other hand, in the culture of death, unethical practices—overdosing with opioids and "permanent sedation" with dehydration—are surreptitiously employed to deliberately end lives prematurely. Those involved maintain that their only intent is to do good (i.e., "relieve pain"). At best, they are deceiving themselves; at worst, they are lying to others. They may say, "We're letting him go," "His quality of life is very poor," or "It's her time."

Pope John Paul II stated that "there is need to develop a deep critical sense capable of discerning true values and authentic needs."[17] What is at stake in the struggle between the culture of life and the culture of death is our very ability to discern true values. The needs of the most vulnerable among us cannot be truly understood or met without first recognizing the sanctity of human life. What is at stake affects not only patients but also the medical profession and the whole of society. Whether practices that are knowingly used to impose death are "justified" by principles of secular bioethics or the *misuse* of the principle of double effect, they are always unethical.[18]

The American Medical Association's position is that "the societal risks of involving physicians in medical interventions to cause patients' deaths are too great in this culture to condone euthanasia or physician-assisted suicide at this time."[19] The British Medical Association is also *officially* opposed to euthanasia. However, the influential *BMJ*—a journal that is supposedly independent of the British Medical Association yet is often cited as its official voice—has taken a position in favor of euthanasia.[20] An editorial and two articles were published in *BMJ* supporting the purportedly "neutral" stance of health care professionals not to oppose any efforts to legalize euthanasia. However, one of the two articles, by Dr. Raymond Tallis, an emeritus professor of geriatrics, was titled "Our Professional Bodies Should Stop Opposing Assisted Dying."[21] This makes the American Medical Association's qualification "at this time" profoundly troubling.

Stealth euthanasia methods avoid the readily identifiable labels "euthanasia" and "assisted suicide." Nevertheless, physicians who use their medical skills to impose death by stealth defy the American Medical Association's official policy and are dishonest with their patients and the public.

They have been edging closer and closer to open euthanasia, but they are not there yet. In a few years, not too many, we will hear, "Everybody knows that we've been hastening death. Since we're doing it anyway, let's make it more 'humane'—let's legalize direct euthanasia through lethal injection." Unless there is a major change in the health care system and in society, this is guaranteed.

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[2] Beckett Gremmels, "Double Effect and Pain Medication: A Separation Devoutly to Be Wished," *Ethics & Medics* 38.1 (January 2013): 2.

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[5] For a detailed outline of signs of the stages of dying, see Hospice Patients Alliance, "Signs and Symptoms of Approaching Death," http://www.hospicepatients.org/hospic60.html.

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[7] Ron Panzer discusses these claims in depth in his book *Stealth Euthanasia: Healthcare Tyranny in America* (Rockford, MI: Hospice Patients Alliance, 2011).

[8] Gina Kolata, "'Passive Euthanasia' in Hospitals Is the Norm, Doctors Say," *New York Times*, June 28, 1997, 10.

[9] Timothy E. Quill and Ira R. Byock, "Responding to Intractable Terminal Suffering: The Role of Terminal Sedation and Voluntary Refusal of Food and Fluids," *Annals of Internal Medicine* 132.5 (March 7, 2000): 408–414.

[10] Panzer, *Stealth Euthanasia*.

[11] O'Reilly, "End-of-Life Care," emphasis added.

[12] US Department of Justice, "Arizona Hospice to Pay $3.7 Million to Resolve False Claims Allegations," press release, May 31, 2012, http://www.justice.gov/usao/az/press_releases/2012/APR/PR_05312012_Hospice_Family_Care.html.

[13] See Hospice Patients Alliance, "Actual Reports of Involuntary Euthanasia Cases in Hospital Settings: Eleven Letters," 2002, http://www.hospicepatients.org/actual-hosp-euth-cases.html; and Terri Schiavo Life and Hope Network, "Terri's Story: Timeline," http://www.terrisfight.org/timeline/.

[14] *Catechism of the Catholic Church*, n. 2277. See also n. 2279: "Even if death is thought imminent, the ordinary care owed to a sick person cannot be legitimately interrupted. The use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable. Palliative care is a special form of disinterested charity. As such it should be encouraged."

[15] Hospice Patients Alliance, "From Euthanasia Society of America to National Hospice & Palliative Care Organization (1938–Present)," http://www.hospicepatients.org/euthanasia-soc-of-america-to-natl-hosp-and-palliative-care-org.pdf.

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[20] Hilary White, "*British Medical Journal* Campaigns for Legalized Euthanasia," *LifesiteNews.com*, June 13, 2012.

[21] Raymond Tallis, "Our Professional Bodies Should Stop Opposing Assisted Dying," *BMJ* 344.4115 (June 13, 2012).

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