What Do We Mean?

Dying, Euphemisms, and Deception

David E. Smith, MD, MA
Director, Supportive Medicine
Baptist Health – Little Rock

Misguided Intent

- **39% of physicians had ordered drugs to hasten death** (1990)
- **16% of critical nurses engage in assisted suicide or euthanasia.** (1992)
- **Reasons --probably a mix of**
  - **Lack of ethical teaching**
  - **Malformed intentions.**

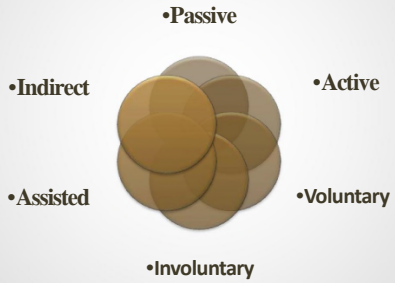
EUTHANASIA

- **From the Greek words: Eu (good) and Thanatosis (death) and it means "Good Death, "Gentle and Easy Death."**
- **"Mercy killing."**
- **Ending a life of a person either by a lethal injection or ending medical treatment.**

Goals for discussion

1. **Common practice and understanding**
   - It is the practice of intentionally ending a life in order to relieve pain and suffering.
   - Other debatable subcategories
2. **Postmodern definitions and worldview**
3. **Common misunderstanding and misapplications of sedation and good palliative care**

Types of euthanasia:



Voluntary euthanasia is committed with the willing or autonomous cooperation of the subject. This means that the subject is free from direct or indirect pressure from others.

Non voluntary euthanasia occurs when the patient is unconscious or unable to make a meaningful choice between living and dying, and an appropriate person takes that decision for him/her.

→This is usually called **murder**

Active euthanasia:

– It is when death is brought by an act for example taking a high dose of drugs

– Intentionally to end a person's life by the use of drugs, either by oneself or by the aid of a physician.

Assisted suicide:

–This usually refers to cases where the persons who are going to die need help to kill themselves and ask for it.

--It may be something as simple as getting drugs for the person, and putting those drugs within their reach.

Debatable/Deceptive Use of term "Euthanasia"

*Indirect "euthanasia": (*Double Effect Doctrine)

–This means providing treatments -mainly to reduce pain- that has a side effect of shortening the patient's life.

–Since the primary intent wasn't to kill,

– It is morally accepted by most people.

– Potential for abuse (see case)

Passive euthanasia:

When death is brought by an omission eg:

–When someone lets the person die, this can be done by withdrawing or withholding treatment.

*Withdrawing treatment: For example switching off a machine that keeps the person alive.

*Withholding treatment: For example not carrying out a surgery that will extend life of the patient for a short time.

MORAL DECISION-MAKING

FACTS	WORLDVIEW
LOYALTIES	REASONING

EUPHEMISMS

Right to Die and Words & Changing Meanings

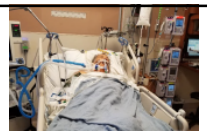
- Word use usually reflects their values, loyalties and world view.
- Word use and euphemisms may reflect their underlying agendas.
- Classic example of postmodern definition - "It depends on how you define the word is."

EUPHEMISMS

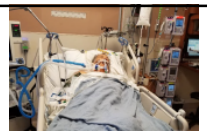
Right to Die and Words -Changing Meanings

- **Words that are familiar may now have far different meaning that they did only a few years ago**
  - Compassion
  - Comfort care
  - Terminal vs imminent
- **Right to die proponents have created fuzzy euphemisms and have redefined well-understood concepts and ethical principles**
  - Compassion in choices *(formerly Hemlock Society 1991-2004)*
  - Physician "Aid in dying"
  - "Death with dignity"
  - "Gentle landing"
  - "Deliverance"
  - "Chosen death"
  - "Lethal overdose of medication"

Compassionate Ventilator Withdrawal: Use and Misuse of "Double Effect"



31 y/o chronically ill female c cerebral palsy multiple medical problem – admitted with probable aspiration pneumonia. Later required breathing machine which was continued for 6 days. No previous history of narcotics. Decision to stop ventilator.



31 y/o chronically ill female c cerebral palsy multiple medical problem – admitted with probable aspiration pneumonia. Later required breathing machine which was continued for 6 days. No previous history of narcotics. Decision to stop ventilator.

Medications over 41minutes (death 36 minutes after tube removed)

Huge narcotic given -- Dilaudid- 34 mg (680 mg MME)

Huge sedative given -- Versed – 60 mg (last 10 mg dose – apneic and 6 min before expiration)

(0859 non breathing patient given more drugs (Dilaudid 4 mg, Versed 10mg) **Patient dead 6 minutes later** (@ 0905).

Initial and Total Dose Typical Opioid Naïve vs This Case

Typical TOTALS (opioid naïve)

- **Dilaudid – 2 - 6 mg**
- **Versed – 3-16**
- **Typical time to death – 1-18 hrs**

> 30 % leave ICU

Initial and Total Dose Typical Opioid Naïve vs This Case

Typical TOTALS (opioid naïve)

- Dilaudid – 2 - 6 mg
- Versed – 3-16
- Typical time to death – 1-18 hrs

> 30 % leave ICU

This CASE

- **Dilaudid – 34 mg (6-17 x's usual)**
- **Versed – 60 mg (4-20 x's usual)**
- **Time to Death -- 0.7 hrs**

Medical staff and reviewers uncomfortable

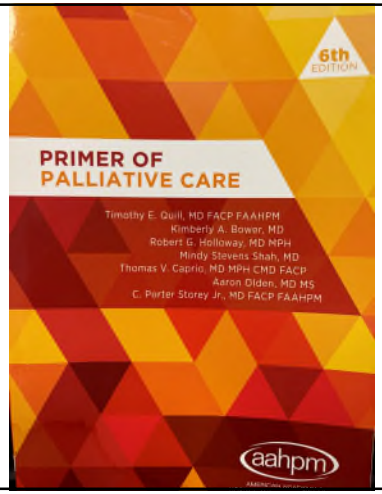
- MD had privileges taken away because of 7 cases that used narcotics and sedatives in doses "exceeding the standard of care"
- Outside reviewers agreed
- MD sued out of state reviewers for compensation due to loss of privileges and subsequent financial impact of loss of hospital access
- Case tried in Federal Court in Little Rock
- One reviewer called his actions "euthanasia"

DEFENSE OF WHY EXTRAORDINARILY LARGE DOSES

1. In palliative medicine no ceiling doses to the amount of medications needed for relief.
2. Suffering patients at end of life should be given the benefit of the doubt regarding dosage to ensure no smothering or discomfort.
3. "Terminal" extubation patients should be given more latitude regarding the amounts of medicine given according to the doctrine of double effect.

QUESTIONS RAISED IN THIS CASE

- Was this euthanasia?
- Was this acceptable treatment allowed by "Double Effect" (what is that?)
- What is the role of intent?
- Who can judge intent?
- Was this treatment or killing?



TIMOTY QUILL, MD
Expert Witness

- Nationally acclaimed palliative care MD @ University of Rochester
- Board member Death with Dignity Center (Portland, Oregon)
- 1991 -published case NEJM of physician assisted suicide

TIMOTY QUILL, MD
Expert Witness

- Nationally acclaimed palliative care MD @ University of Rochester
- Board member Death with Dignity Center (Portland, Oregon)
- 1991 -published case NEJM of physician assisted suicide (referred to Hemlock Society)

- **1996 Landmark Supreme Court case - Vacco vs Quill -** (cases dealt with the constitutionality of laws prohibiting physician-assisted suicide in the states of Washington and New York) SCOTUS - "Everyone, regardless of physical condition, is entitled, if competent, to refuse lifesaving medical treatment; no one is permitted to assist a suicide . . . When a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication."
- **Helped pass 2016 Canadian law allowing physician assisted suicide and ? euthanasia**
- **Lobbying for PAS legalization in Massachusetts (evasive when answering euthanasia question)**

TIMOTY QUILL, MD
Expert Witness

- **1996 Landmark Supreme Court case - Vacco vs Quill -** (cases dealt with the constitutionality of laws prohibiting physician-assisted suicide in the states of Washington and New York) SCOTUS - *"Everyone, regardless of physical condition, is entitled, if competent, to refuse lifesaving medical treatment; no one is permitted to assist a suicide . . . When a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication."*
- **Helped pass 2016 Canadian law** allowing physician assisted suicide and ? euthanasia
- **Lobbying for PAS legalization in** Massachusetts (evasive when answering euthanasia question)

TIMOTHY QUILL'S RESPONSES

- **Active euthanasia -- when the doctor actually delivers a lethal medication, "which is not legal in US"** *(but not necessarily unethical)*
- **Terms** *(euphemisms)* **used for MD who helps end of life care**
  - **Physician aid in dying**
  - **Physician assisted death**
  - Physician- assisted suicide *("if you were opposed to this practice, call it PAS - because you want to equate it with mental illness and that that go with words like suicide; don't use it if you think it should be an option for people.")*

TIMOTHY QUILL'S RESPONSES

- Active euthanasia -- when the doctor actually delivers a lethal medication, "which is not legal in US" *(but not necessarily unethical)*
- Terms *(euphemisms)* used for MD who helps end of life care
  - Physician aid in dying
  - Physician assisted death
  - Physician- assisted suicide *("if you were opposed to this practice, call it PAS - because you want to equate it with mental illness and that that go with words like suicide; don't use it if you think it should be an option for people.")*
- **Quill - this was "not euthanasia like Netherlands -** would have required dose of medicine 10-20 times as much and large dose of medicine after that to stop the heart."
- **"Ventilator withdrawals are palliative emergencies."** The dose of medicine("palliative sedation") given to patient was appropriate. (but later under cross examination said that patients should receive the lowest amount necessary to control symptoms).

Rule of Double Effect
(RDE)

1. **The primary act must be inherently good, or at least morally neutral.**
2. **The good effect must not be obtained by means of the bad effect.**
3. **The bad effect must not be intended, only permitted. There must be no other means to obtain the good effect.**
4. **There must be a proportionately grave reason for permitting the bad effect.**

Christian Medical and Dental Society

Rule of Double Effect Simplified
(Farr Curlin MD)

- Willing (intend) only the good effects
- **Proportionality principle**
  - Use a dose that fits not only the symptoms being treated but also all of the relevant contextual features of the situation

Proportionate Palliative Sedation
vs
Palliative Sedation to Unconsciousness

- **Proportionate - use just enough and no more**
  - reduce signs of pain and distress (suppress consciousness only insofar as necessary to relieve distressing symptoms).

vs

- **Use of sedative intentionally to suppress consciousness without limit**

Distinguishing Sedation Terminology

- **Double-effect sedation**
- **Therapeutic (parsimonious) direct sedation**
- **Sedation to unconsciousness and death**

Distinguishing Terminology

Double-effect sedation

("ordinary sedation")

- **The intention -** is to treat a symptom,
- **Sedation** is a not unexpected but not intended *(but tolerated)* side effect. .

Sulmasy

Distinguishing Terminology

Therapeutic parsimonious direct sedation

- **Intend to sedate but only enough sedation to relieve suffering.**
- **Do not intend unconsciousness and death."**
  - Quill-"proportionate palliative sedation".
  - Sulmasy - ". . . is ethically justifiable." *(But not technically justified under RDE)*

Sedation to unconsciousness and death

- **Action -- neither good nor neutral (issue of intention)**
- **Violates the proportionality requirement of rule of double effect**

Sulmasy

Case – intractable pain

2017 51 y/o tongue & head and neck
- Multiple bone & skin metastasis;

2020
- Sept - **intractable pain - to hospice;**
  - fentanyl 200 + oxycodone 20 q 4 hr
- Oct - **on Dilaudid PCA IV infusion** 1 mg/hr (480 MME/24hr)
- **Dec 10 -restless, agitation, delirium,** constantly up and down at home, no sleep
- **Dec 26 -admission for uncontrolled pain and delirium on VERY large amout of sedative and narcotic**
  - Ativan 8 mg/hr IV (direct effect = sedation)
  - Dilaudid 10 mg/hr IV PCA (4100 MME/24 hrs).IV PCA.

Case – intractable pain

- **Dec 28 Low dose ketamine added** (anesthesia agent in usual doses)
- **Dec 30 Low dose Methadone added** *Hydromorphone continued*
- **Jan 9 Big dose Methadone 135 mg** *(1620 MME/d)* (because of furrowed brow & arms flailing indicating pain and distress)
- **Jan 11 Mild agitation/restless.** Hydromorphone stopped. **Fentanyl** 250 µg/hour started *(1800 MME/d)*
- **Jan 13 day 18 – death** *(still on Lorazepam 8 mg/hr; Ketamine, fentanyl, and methadone)* (***3420 total MME***)

What's the difference between PALLIATIVE & TERMINAL SEDATION

PALLIATIVE SEDATION	TERMINAL SEDATION
Only applied if necessary to alleviate suffering, which is rare.	Applied even if unconsciousness is not needed to alleviate suffering.
Purpose: To relieve suffering	Purpose: To end life.
Death is caused by the disease or injury.	Death is usually caused by dehydration or starvation.
The level of consciousness may vary, with focus on allowing as much awareness as possible.	The patient is rendered unconscious.

Sedation to unconsciousness and death

- **Being conscious is desirable**
- **Violates the 3rd condition of double effect (don't do evil that good may result)**
- **Violates basic goals of medicine – restore patient health and use as little of medicine as poison (otherwise likely poison).**

CONCLUSIONS

1. Euthanasia and PAS are moral equivalents with different agents and names.
2. Therapeutic, parsimonious sedation is clinically beneficial and ethical
3. Inappropriate sedation (to death) is a form of euthanasia
4. Palliative medicine (with a goal of restoration of health) uses appropriate pain control and sedation.
5. Withholding and withdrawing from patients whose health cannot be restored is done (appropriately) only when burdens are greater than benefit.