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Palliative Sedation for Existential Suffering: The Enduring Wisdom of the Hippocratic Oath

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Palliative sedation, also known as terminal sedation or continuous palliative sedation, is the practice of sedating a patient to treat refractory symptoms at the end of life. Refractory symptoms are those that "cannot be adequately controlled" without inducing unconsciousness.[1] In response to refractory symptoms, palliative sedation administers "sedative medications to reduce patient consciousness to the minimum extent necessary to render intolerable and refractory suffering tolerable."[2] This sedation can vary in its intensity and it can be either intermittent or continuous, in which case it typically persists until death.[3] There is a consensus among ethicists and within the medical profession that palliative sedation is an acceptable treatment for refractory physical symptoms, but there is significant debate about palliative sedation as a treatment for existential suffering. In this paper, I will briefly introduce the practice of palliative sedation for existential suffering and look at arguments for and against. Then, I will assert that it is inappropriate to use palliative sedation to treat existential suffering and that palliative sedation for existential suffering fails to take existential suffering seriously. Finally, I will consider guidance that modern medicine should heed on this issue from the Christian Hippocratic tradition.

Introduction to Palliative Sedation for Existential Suffering

When it comes to palliative sedation, some have asserted that it is comparable to physician-assisted suicide (PAS) or voluntary active euthanasia (VAE), and this can be especially true from the perspective of the patient. As a Canadian physician explained: "With some patients, it's really, 'Well, so let me get this straight. As far as I'm concerned, both of them (palliative sedation and PAS) are the same. I go to sleep and I die in my sleep. Sedation, you could do it this afternoon, right? I want that one.'"[4] Despite the popular level conflation, and even some scholarly arguments for an equivalence,[5] there is nonetheless a consensus within the medical community in support of palliative sedation, even while physician-assisted suicide and voluntary active euthanasia remain controversial.[6] In fact, the Supreme Court acknowledged the distinction between physician-assisted suicide and palliative sedation in their decision in *Vacco v. Quill*. They reference Leon Kass before the subcommittee on the Constitution of the House Committee on the Judiciary and write, "in some cases, painkilling drugs may hasten a patient's

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death, but the physician's purpose and intent is, or may be, only to ease his patient's pain. A doctor who assists a suicide, however, 'must, necessarily and indubitably, intend primarily that the patient be made dead.'"[7] Belief in the ethical permissibility of palliative sedation is the consensus view of physicians[8] and major medical organizations today.[9]

Despite the developed consensus around the permissibility of palliative sedation, debate lingers around the conditions for which palliative sedation is an appropriate treatment. This debate centers around the question of palliative sedation in response to existential suffering, a practice that medical organizations have not found consensus on. There are diverse definitions of existential suffering, especially about its overlap with other categories like spiritual or psychological suffering.[10] Generally speaking, existential suffering is suffering that occurs not directly because of physical causes but "from a loss or interruption of meaning, purpose, or hope in life."[11] Palliative sedation for existential suffering remains condemned by the American Medical Association (AMA), which embraces palliative sedation solely for the relief of "refractory clinical symptoms, not to respond to existential suffering arising from such issues as death anxiety, isolation, or loss of control."[12] Instead, "existential suffering should be addressed through appropriate social, psychological or spiritual support."[13] In contrast, the National Hospice and Palliative Care Organization remains "unable to reach consensus on a recommendation regarding the use of palliative sedation for suffering that is primarily nonphysical in origin."[14] They follow up this acknowledgment with a series of statements urging caution and consultation before administering palliative sedation for the relief of existential suffering. Physician sentiment seems to reflect a similar unease, with a 2010 survey finding that only 31 percent of physicians supported palliative sedation for the relief of "psychological and spiritual suffering" despite widespread agreement on the permissibility of palliative sedation for physically rooted symptoms.[15]

Arguments Supporting and Opposing Palliative Sedation for Existential Suffering

There are a variety of arguments used to support palliative sedation for existential suffering.[16] Cassell and Rich argue against the AMA statement, believing that it is not possible to truly separate existential suffering from physically rooted suffering.[17] For Cassell and Rich, attempts to distinguish these types of suffering are not only incorrect but are grounded in a discredited body-mind dualism. Instead, they argue that the person is an integrated whole, and suffering "variously destroys the coherence, cohesiveness, and consistency of the whole."[18] Accordingly, "suffering is an affliction of persons, not bodies," and it is not possible to say palliative sedation is justified for one kind of suffering and not another.[19] A feeling of loss of meaning can afflict a person just like physically rooted refractory symptoms. Banja writes positively about Cassell and Rich's position while adding that the AMA is likely concerned that embracing palliative sedation for existential suffering would change "who will control the physician's most powerful asset—the prescription pad" by moving decisional authority on this question firmly to the patient and away from the physician.[20] For Banja, there is no "ultimate, fundamental, essential, moral truth about the nature of [end-of-life] suffering," so the answer to questions around palliative sedation and existential suffering will necessarily be a compromise of interests, but palliative sedation for existential suffering is certainly morally permissible.[21]

Proponents of palliative sedation for existential suffering often object that disallowing the practice denies the legitimacy of existential suffering, improperly putting it to a lower tier, one that physicians are not allowed to treat. These advocates see palliative sedation for existential suffering as the only response that takes this suffering seriously. As an example, consider the question of a Canadian physician, "Can you really say that physical suffering should take greater priority over psychosocial or existential?"[22]

On the other hand, opponents of palliative sedation for existential suffering assert that existential suffering is distinguishable from suffering that is physically rooted, and this distinction is significant for clinical practice. Jansen and Sulmasy make this argument, distinguishing what they call agent-narrative and neurocognitive suffering.[23] Agent-narrative suffering corresponds to existential suffering and "has an *indirect* causal relationship to the patient's underlying medical condition.[24] This is opposed to neurocognitive suffering, which "has a *direct* causal relationship to the patient's underlying medical condition.[25] Agent-narrative suffering includes feelings like fear, loneliness, angst, sadness, and worthlessness, while neuro-cognitive suffering includes anxiety disorder, chest pain, phantom limb pain, insomnia, and bone pain. The distinction between these two is "clinically and ethically significant," and it is observed in a variety of clinical settings, not just those involved in terminal sedation.[26] In addition to the AMA statement that acknowledges this distinction, many physicians believe that there is a distinction between existential suffering and suffering that is appropriately treated with palliative sedation.[27]

Palliative Sedation Is an Inappropriate Solution to Existential Suffering

I agree with the argument that palliative sedation is an inappropriate treatment for existential suffering, because existential suffering is distinguishable from physically rooted suffering in an ethically significant way. Suffering is complex, and in any instance it may be challenging to delineate between kinds of suffering. Certainly, this is an area with need for clinical judgment. Yet, it remains important to acknowledge the distinction between the kinds of suffering a patient may experience, because that determines what interventions are appropriate.[28] Because existential suffering is not exclusively or even primarily a physical phenomenon, it should not be treated with a physical intervention.

What is more, the practice of palliative sedation for existential suffering undermines the validity of existential suffering. While it is a common refrain to hear proponents assert that they are taking existential suffering seriously by being willing to administer sedation in response, the act of sedating existential suffering diminishes its significance. In fact, palliative sedation only appears to be an appropriate response to existential suffering if you accept that there is no objective meaning to life or to death. However, if there is a spiritual reality, then palliative sedation becomes inappropriate and a means of masking concerns about things that really matter. As Curlin and Tollefsen write, "these are real problems and real forms of suffering. As such,

they require choices, attempts to maintain or restore what harmony is possible at the end of life: acceptance with death, repentance of sin, reconciliation with loved ones, and peace with God."[29] The arguments that justify palliative sedation for existential suffering rest on disputable assumptions about reality and meaning that a significant number of both patients and physicians reject.

Instead, a much better solution is to pursue interventions that are aimed at the psychosocial restoration that Jansen and Sulmasy argue for.[30] If it is possible to discover meaning or to find spiritual truth, even at the end of life, then palliative sedation is not an acceptable treatment for existential suffering, and doctors must encourage patients to pursue appropriate interventions, aimed at resolving underlying issues, rather than resorting to a medicated coma. It is only an approach like the one advocated by the AMA that truly takes existential suffering seriously, while palliative sedation denies the possibility of any objective basis behind the suffering and thus denies the reality of the suffering.

The Christian Hippocratic Tradition

At this point, it is helpful to introduce the tradition of Christian Hippocratism, which bears a notable relevance on this discussion. Christian Hippocratism is an intellectual tradition that springs from the intersection between Christian medical ethics and the Hippocratic Oath. These two traditions have an ancient relationship, since it was the Christian acceptance of the Hippocratic Oath that was key to the Oath's transition from a minority document to a dominant viewpoint.[31] Verhey writes about the Christian perspective on the Hippocratic Oath and remarks how Christians adopted the Oath for use, and surprisingly little content of the Oath was changed between the original and the Christian adaptation of it.[32] The Oath is a pagan document, so certainly there were some needed revisions to align with the precepts of Christianity, but even with these changes, there is a clear continuity. Christian Hippocratism recognizes the wisdom of the Oath and seeks to apply its principles to medical ethics today in a way consistent with biblical principles.

While Christian Hippocratism has much to say to today's medical ethics controversies, there are two contributions from Christian Hippocratism that are especially relevant for the current discussion: the significance of spiritual reality and the prohibition on acting outside of your area of expertise.

The Hippocratic Oath acknowledges the importance of spiritual reality because it is an oath sworn before numerous pagan gods.[33] The original authors of the oath seem to have understood that swearing before gods was the highest authority that they could swear by, and so swearing to the gods is central to the enforcement of the ethic expressed in the oath. This is a key factor of the Oath that modern versions miss—they are not truly oaths because they rarely call the participants to swear, and especially not to swear by a deity.[34] While the Hippocratic Oath clearly understood spiritual reality to be important, this was understood in a distinctly pagan environment. The main content that Christians changed in the Hippocratic Oath was to remove the reference to pagan deities and to replace it with an oath sworn to the Christian God. It is at this point, the content of spiritual truth, that Christianity and the Hippocratic Oath most clearly depart. The God of the Bible cannot be confused with or replaced by an assortment of pagan gods. Only Christianity knows that the true means of reconciliation with God is through his Son Jesus Christ. Yet, both Christianity and the Hippocratic Oath agree that the spiritual world truly exists and that man's relationship with the divine is of crucial importance.

This understanding of spiritual reality has relevance for the discussion about palliative sedation in cases of existential suffering. As has been mentioned, the practice of palliative sedation for suffering with spiritual dimensions denies the legitimacy of spiritual reality. It is no accident that proponents of this practice operate from a view that denies the existence of spiritual truth. On the other hand, ethicists and physicians informed by Christian Hippocratism know that there is spiritual reality. Many of the key questions that underlie existential suffering—like the meaning of life and death, life after death, and right relationship to God—are of grave, eternal significance for the patient. If medical professionals will not help their patients answer these questions, the very least they can do is not put them into a coma while they are wrestling with them.

The other insight that Christian Hippocratism brings to this conversation comes from a portion of the Oath that is rarely considered relevant: "I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work."[35] Critics of the Hippocratic Oath have suggested that this provision represents a ban on surgery perhaps coming from some moral aversion on the part of the authors.[36] But this view is not the most reasonable understanding of the Oath, since it explicitly refers this practice to those who are qualified for this work.[37] Instead, this prohibition on surgery should be understood to reflect the belief that surgery was outside the scope of practice of the physician, and the physician is obligated only to administer remedies for which he is qualified.[38] When understood in this light, it is easy to disagree with the particular application by concluding that surgery may belong to the physician trained in surgery while upholding the principle that physicians must serve patients only when they are trained and serving in their area of practice.

Such a principle is widely recognized in medical ethics even today, and it has special relevance for the discussion of palliative sedation to relieve existential suffering. The modern physician is under pressure to provide an ever-expanding range of services to his or her patients. Consider the World Health Organization definition of health: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[39] If a doctor is tasked with promoting health, he is now responsible for much more than he learned at medical school. In the case of existential suffering, the physician may be able to address some underlying issues through compassionate listening, encouragement, and appropriate spiritual interventions. However, he must recognize that his profession may not specialize in the tools necessary to resolve each instance of existential suffering. Against such a backdrop, it is critical that a physician acknowledge his own limits and be prepared to serve his patients with qualified referrals.

While he may have the capacity to alleviate some related suffering, suffering that is rooted outside of physical causes demands spiritual and psychological interventions. Heeding the ancient wisdom of the Christian Hippocratic tradition, a physician would not view sedating

patients into a state of unconsciousness as an appropriate intervention for existential suffering. Rather, he would recognize that he must practice within his competence, and when problems are outside his competence, he must make the appropriate referral to those whose methods are properly suited to the nature of the malady. As Kass so eloquently put it, "Acting incompetently from good intentions is often worse than doing nothing, especially in the increasing number of instances in which the offer of pills and other forms of medical assistance for what are fundamentally problems of living fosters the false and enfeebling expectation that life itself has a technical solution."[40]

Conclusion

The question of palliative sedation for existential suffering is a significant question, specifically because existential suffering is such a serious thing. The Christian Hippocratic tradition recognizes that existential suffering is so serious largely because of the objective nature of spiritual reality and the true need to be reconciled to God through Jesus Christ. This understanding, coupled with a firm commitment for physicians to serve only within the area of their competence and the appropriate domain of their profession, will lead physicians to reject the practice of palliative sedation for existential suffering. Instead, they will make appropriate interventions and referrals to those who are qualified to ameliorate such serious suffering. It is this approach that truly takes existential suffering seriously, and it is this approach that best cares for the needs of patients.

Notes

1. Timothy W. Kirk and Margaret M. Mahon, "National Hospice and Palliative Care Organization (NHPCO) Position Statement and Commentary on the Use of Palliative Sedation in Imminently Dying Terminally Ill Patients," *Journal of Pain and Symptom Management* 39, no. 5 (2010): 917, https://doi.org/10.1016/j.jpainsymman.2010.01.009.
2. Kirk and Mahon, "NHPCO Position Statement," 917.
3. This paper will not analyze all the ethical dimensions of palliative sedation, but it is worth acknowledging here the practice of what Farr and Tollefsen call "proportionate palliative sedation." In proportionate palliative sedation, the goal is not unconsciousness but the minimal level of sedation needed to relieve refractory symptoms, with unconsciousness as a foreseen but unintended consequence. This distinction is often viewed as key to separating palliative sedation and physician-assisted suicide or voluntary active euthanasia. Throughout this paper, it is assumed that palliative sedation is not aimed at unconsciousness but is practiced proportionately, in accordance with both Curlin and Tollefsen's definition and the definition given in the NHPCO position statement. Farr A. Curlin and Christopher Tollefsen, *The Way of Medicine: Ethics and the Healing Profession* (University of Notre Dame Press, 2021), 166–69. Kirk and Mahon, "NHPCO Statement," 917.
4. Alexandra Guité-Verret, Jessica Boivin, Andrew M. R. Hanna, James Downar, Shirley H. Bush, Isabelle Marcoux et al., "Continuous Palliative Sedation Until Death: A Qualitative Study of Palliative Care Clinicians' Experiences," *BMC Palliative Care* 23, no. 1 (2024): 8, https://doi.org/10.1186/s12904-024-01426-2.
5. Samuel H. LiPuma, "Continuous Sedation Until Death as Physician-Assisted Suicide/Euthanasia: A Conceptual Analysis," *Journal of Medicine and Philosophy* 38, no. 2 (2013): 190–204, https://doi.org/10.1093/jmp/jht005.
6. Patrick Smith agrees with the distinction between palliative sedation and physician-assisted suicide, asserting that, to be morally justified under the principle of double effect, palliative sedation must aim at pain relief and foresee unconsciousness, when necessary, rather than aimed at unconsciousness. Patrick T. Smith, "Distinguishing Terminal Sedation from Euthanasia," *The National Catholic Bioethics Quarterly* 15, no. 2 (2015): 287–301, https://doi.org/10.5840/ncbq201515231.
7. *Vacco v. Quill*, 521 U.S. 802 (1997). It is worth nothing that the Supreme Court also believed its logic supports a physician who withdraws or withholds life-sustaining treatment in accordance with the wishes of the patient.
8. Michael S. Putman, John D. Yoon, Kenneth A. Rasinski, and Farr A. Curlin, "Intentional Sedation to Unconsciousness at the End of Life: Findings from a National Physician Survey," *Journal of Pain and Symptom Management* 46, no. 3 (2013): 326–34, https://doi.org/10.1016/j.jpainsymman.2012.09.007.
9. "Sedation to Unconsciousness in End-of-Life Care," AMA Code of Medical Ethics, accessed December 16, 2024, https://code-medical-ethics.ama-assn.org/ethics-opinions/sedation-unconsciousness-end-life-care#:~:text=Sedation%20to%20unconsciousness%20must%20never,final%20stages%20of%20terminal%20illness; Kirk and Mahon, "NHPCO Position Statement."
10. 10. For an introduction to the lack of definition around existential suffering and the need for further research on the topic, see Patricia Boston, Anne Bruce, and Rita Schreiber, "Existential Suffering in the Palliative Care Setting: An Integrated Literature Review," *Journal of Pain and Symptom Management* 41, no. 3 (2011): 604–18, https://doi.org/10.1016/j.jpainsymman.2010.05.010.
11. Kirk and Mahon, "NHPCO Position Statement," 916.
12. "Sedation to Unconsciousness in End-of-Life Care."
13. "Sedation to Unconsciousness in End-of-Life Care."
14. Kirk and Mahon, "NHPCO Position Statement," 921.
15. Putman et al., "Intentional Sedation to Unconsciousness," 329.
16. For an introduction to argumentation on both sides of the question, see Paulo Rodrigues, Jasper Crokaert, and Chris Gastmans, "Palliative Sedation for Existential Suffering: A Systematic Review of Argument-Based Ethics Literature," *Journal of Pain and Symptom Management* 55, no. 6 (2018): 1577–90, https://doi.org/10.1016/j.jpainsymman.2018.01.013.
17. Eric J. Cassell and Ben A. Rich, "Intractable End-of-Life Suffering and the Ethics of Palliative Sedation," Pain Medicine 11, no. 3 (2010): 435–38, https://doi.org/10.1111/j.1526-4637.2009.00786.x.
18. Cassell and Rich, "Intractable End-of-Life Suffering," 436.
19. Cassell and Rich, "Intractable End-of-Life Suffering," 436.
20. John D. Banja, "When Moral Arguments Become Intractable," *Pain Medicine* 11, no. 3 (2010): 439, https://doi.org/10.1111/j.1526-4637.2010.00799.x.
21. Banja, "When Moral Arguments Become Intractable," 439.
22. Guité-Verret et al., "Continuous Palliative Sedation Until Death," 7.
23. Lynn A. Jansen and Daniel P. Sulmasy, "Proportionality, Terminal Suffering, and the Restorative Goals of Medicine," *Theoretical Medicine and Bioethics* 23, no. 4/5 (2002): 321–37, https://doi.org/10.1023/a:1021209706566.
24. Jansen and Sulmasy, "Proportionality," 325
25. Jansen and Sulmasy, "Proportionality," 324.
26. Jansen and Sulmasy, "Proportionality," 322.
27. Putman et al., "Intentional Sedation to Unconsciousness," 329.
28. Jansen and Sulmasy give the example of an amputee who experiences both agent-narrative and neuro-cognitive suffering as a result of his amputation. It is obvious in this instance that these kinds of sufferings, while resulting from the same event, are distinct and should not be treated by the same interventions. Jansen and Sulmasy, "Proportionality," 326.
29. Curlin and Tollefsen, *The Way of Medicine*, 168.
30. Jansen and Sulmasy, "Proportionality."
31. Allen Verhey "The Doctor's Oath—and a Christian Swearing It," *The Linacre Quarterly* 51, no. 2 (1984): 143.
32. Verhey, "The Doctor's Oath," 152.
33. "I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfil according to my ability and judgment this oath and this covenant." Quoted in Leon Kass, "Is There a Medical Ethic?" in *Toward a More Natural Science* (Free Press, 1985), 228.
34. Robert D. Orr, Norman Pang, Edmund D. Pellegrino, and Mark Siegler, "Use of the Hippocratic Oath: A Review of Twentieth Century Practice and a Content Analysis of Oaths Administered in Medical Schools in the U.S. and Canada in 1993," *The Journal of Clinical Ethics* 8, no. 4 (1997): 381–82, https://doi.org/10.1086/jce199708409.
35. As quoted in Leon Kass, "Is There a Medical Ethic?" 229.
36. Robert M. Veatch and Carol G. Mason, "Hippocratic vs. Judeo-Christian Medical Ethics: Principles in Conflict," *The Journal of Religious Ethics* 15, no. 1 (1987): 94–95.
37. Note that this clause referring to those who "are engaged in this work" is not repeated in the paragraphs forbidding deadly drugs and abortion, suggesting that the author of the Hippocratic Oath considered surgery in a morally different category than giving deadly drugs or abortion.
38. Kass "Is there a Medical Ethic?" 236.
39. "Frequently Asked Questions," World Health Organization, accessed December 16, 2024, https://www.who.int/about/frequently-asked-questions#:~:text=What%20is%20the%20WHO%20definition,absence%20of%20disease%20or%20infirmity.%E2%80%9D.
40. Kass, "Is there a Medical Ethic?" 236.