value to many others including teachers, professors, campus ministers, Christian pastors, parents, and married people. This book contains not only good theory

and well-argued moral conclusions but also much practical advice and wisdom.

Sedation at the End of Life: An Interdisciplinary Approach. Edited by Pauline Taboada. Philosophy and Medicine 116. Dordrecht, the Netherlands: Springer, 2015. xviii + 175 pp. ISBN 978-94-017-9105-2.

Reviewed by: Thomas M. Pitre, MD, *Portland, OR, USA*

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Sedation at the end of life has become an increasingly common practice over the past two decades. Its use as a therapeutic tool at the end of life should be considered something to use only as a last resort to control intractable symptoms refractory to all other available means of management. For some, the term “palliative sedation” (PS) has become synonymous with “terminal sedation” (and considered a disguised form of euthanasia), which highlights the essence of the ethical and moral controversies that surround its use. Pauline Taboada as editor of *Sedation at the End of Life: An Interdisciplinary Approach* does a thorough and scholarly job of bringing together internationally renowned palliative care specialists, bioethicists, philosophers, lawyers, and theologians to address this controversial paradigm of end-of-life care from a Catholic perspective. Each chapter is authored independently yet interwoven by the editors overarching goal to create a comprehensive whole dealing with sedation at the end of life.

Taboada’s preface and epilogue form the book-ends for this work comprised of ten chapters that deal with the essential facets and controversies that need to be considered in the use of sedation at the end of life. Catholic teaching on the inviolability and dignity of every human life combined with the vulnerability of the dying patient is the basic starting point of all the contributors. She stated *leitmotiv* in her preface and challenge to all the contributors is embodied in the following “seven relevant ethical questions”:

1. “Whether there is an ethically sound difference between Palliative Sedation (PS) and euthanasia and physician-assisted suicide.
2. Whether the principle of double effect can be appropriately applied to justify the use of sedation in some cases at the end-of-life.

3. Whether PS might be ethically acceptable in the case of patients that are not imminently dying (agony).
4. Whether decisions to limit medically assisted nutrition and hydration are essentially linked to PS or whether they should be regarded as independent issues.
5. Whether sedation is an adequate response to “existential suffering.”
6. Whether sedation could ever be used in the case of patients who are not able to give their informed consent (e.g., patients with cognitive impairment of diverse origins, etc.).
7. Whether clinical guidelines for the use of PS are desirable to orient health care professionals, patients, and relatives in the adequate use of sedation at the end-of-life.” (vi–vii)

Following her introduction in the preface, Taboada authors the first chapter (“Sedation at the End-of-life, Clinical Realities, Trends and Current Debate”) wherein she presents two clinical cases that set the stage for all that follows. Both are real cases and draw the reader to the bedside, which is where one needs to begin to have the proper context for the use of PS in caring for patients at the end of life. These two cases—one an appropriate use of PS and the other clearly euthanasia under the guise of relieving “existential suffering”—provide a backdrop to the debates that follow in subsequent chapters. She then systematically defines terms, concepts, and definitions with extensive references to the pertinent literature.

The expanding use of PS for psychospiritual or existential suffering led to the euthanizing of the patient in Taboada’s second clinical case. In a secular culture which places autonomy ahead of all else euthanasia or physician-assisted suicide is not considered wrong, and the principle of double effect has no application or meaning. A major theme addressed by the contributing authors elucidates how our Catholic moral tradition can be integrated with integrity to avoid imprudent use and abuses of PS.

While there is unavoidable overlap in the extensive discussion of the principle of double effect as it applies to PS, each author brings a unique and worthy perspective. Taboada has carefully selected

authors who use clinical, philosophical, and theological arguments in the application of the principle of double effect to expound on existential suffering.

The issue of the good of consciousness is also debated in the context of psychosocial suffering. In chapter 2, W. F. Sullivan cites Daniel Sulmasy's position that PS "is *not* justified ethically for the sole goal of alleviating the distress that might arise from a patient's *awareness* of those symptoms, such as in the experience of terminal dread" (19). But then Sullivan goes on to argue "although the capacity for consciousness is a human good, the *content* of consciousness, e.g., the distress that the patient is aware of, might not be." Sullivan feels that by aligning the "goals of care" with the understanding that one should never intentionally hasten death, it is possible to preserve the distinction between palliative care and euthanasia. The clear line in the sand drawn by Sulmasy, however, is thus blurred by this consideration.

Jansen and Sulmasy (2002) have published apart from references in this book a distinction of human suffering at the end of life between "neurocognitive suffering" (objective—arising from the underlying condition of the patient) and "agent-narrative suffering" (subjective—suffering as a result of reflection on the significance that their medical condition has or will have on their ability to be an agent in the world or to sustain valuable social relationships). Limiting PS to neurocognitive suffering avoids the slippery slope of abuses that PS has been on for some time now.

Chapter 3 ("Clinical Aspects of Palliative sedation for Refractory Symptoms") by Paul W. Walker from MD Anderson is an excellent clinical resource for the practical application of PS. In section 3.2 (28), he references Braun and colleagues four requirements for the use of PS which must be met *before* (my emphasis) it is discussed with the patient and/or family. These are as follows: (1) A terminal illness must be present. (2) The patient must be suffering from refractory symptoms. (3) Death must be imminent (within days). (4) A do-not-resuscitate order must be in effect. He goes on in section 3.5 (31) to delineate specific symptoms where PS may be needed including agitated delirium, dyspnea, pain, and the pros and cons of its use in existential distress. The remaining sections outline the drugs used and algorithms for their implementation and monitoring—all excellent clinical guidelines for the use of PS.

I found John Keown's chapter 7 ("Palliative Sedation', Ethics and the Law: An Overview of the 'Sanctity of Life', 'Best Interests' and 'Autonomy'") is particularly good. In section 7.3.5 (104) on autonomy he begins: "Autonomy is a valuable capacity,

and part of human dignity, but its contribution to dignity is conditional, not absolute. Exercising one's autonomy to destroy one's (or another's) life is always wrong because it is always disrespectful of human dignity." This distinction is important in maintaining a proper balance in end-of-life decision-making. The current cultural tendency to assist or hasten death whether it be in the use of PS for existential suffering or the voluntary stopping eating and drinking with the promised use of PS if needed to treat the delirium of dehydration or other distress is very real in Oregon. Keown's clear perspective on common law is insightful and I enjoyed his clarity in the whole chapter.

Chapter 9 ("Clinical Guidelines for the Use of Palliative Sedation: Moving from Contention to Consensus") and chapter 10 ("The Case against Clinical Guidelines for Palliative Sedation") embody a good exercise in contrasting where this train is headed and where it should not be going. Blair Henry in chapter 9 provides a very helpful historical perspective that anyone interested in the clinical use of PS should read (123). His three tables that follow (sections 9.1–3, pp. 125–27) are also very instructive tabulations of the key issues addressed throughout the book. He makes a good case for appropriate study of PS to gain consensus on appropriate use of PS to avoid its use "*inadvertently, as an appropriate shortcut to achieving a 'good death' for all involved in the end-of-life process.*" John Scott in his introduction to chapter 10 (143) provides a concise overview against the use of Clinical Practice Guidelines that could stand-alone as a convincing argument not to use them. He then methodically expands his thesis and in this final chapter hints at what Taboada herself might feel.

My personal perspective (Pitre 2009) clearly favors the return to the bedside to accompany the patient and family in each individual case using prudential clinical judgment. PS should not be brought into end-of-life care unless absolutely necessary "as a last resort."

This book is a very timely overview of PS that is increasingly being used in palliative care at the end of life. I would recommend it particularly to palliative care and hospice providers while all of us should become as familiar with this complex paradigm as possible. As Catholic leaders and professionals in health care, we need to be able to discuss sedation at the end of life as we will surely be called on either professionally or personally to confront this issue.

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Nurses and Midwives in Nazi Germany: The "Euthanasia Programs". By Susan Benedict, and Linda Shields. Routledge Studies in Modern European History. London: Routledge, 2014. 266 + xvi pp. ISBN: 978-0-415896-65-8.

Reviewed by: Nancy Valko, RN, *National Association of Prolife Nurses, Washington, DC, USA*
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In my nursing education during the 1960s, the Nazi euthanasia program was covered during a class but mainly as a ghastly aberration that was unthinkable today with our now strong ethical principles. As students, we were shocked and horrified by the revelation that nurses were integral to Nazi killing programs. We had little knowledge of the mechanisms that existed to encourage nurses to kill those patients whose lives were deemed "not worth living."

Unfortunately, it is difficult these days to find information about nurses during the Nazi regime, even on the American Nurses Association website. Thus, the editors of this book do nurses and the public a great service by examining the little-known but crucial role of nurses in the Nazi euthanasia programs. Knowing this history is more important than ever as efforts to legalize assisted suicide and euthanasia continue to grow.

The authors explain the history, education, propaganda, and pressures that led so many nurses to participate in the killing of hundreds of thousands of helpless men, women, and children in the 1930s and 1940s; they also propose a model for teaching nursing ethics using the Nazi euthanasia program to encourage nursing students to examine ethical principles and their own values as a nurse in today's healthcare system.

Each chapter of this small but densely packed book deals with a different aspect of nursing and midwifery involvement in the Nazi euthanasia regime, information often surprising as well as disturbing. The book brings into focus the similarities between the development of the Nazi euthanasia program and the changes in medical and legal ethics that have developed over the years to result in the current

withdrawal of feedings for patients with severe brain injuries or dementia, legalized abortion, the increasing acceptance of physician-assisted suicide, and other ethical problems arising from new technologies.

As the editors themselves state: "One important aim of this book is to prevent the Nazi crimes happening again. As with many studies of the Holocaust and the Nazi era, the keys remain education and exposure to the reality of what occurred. Lobbying for the return of history as a permanent component of all curricula should be high on the agenda" (246).

The Medicalization of Killing

The authors start with the rise of the influential eugenics movement in the early twentieth century in countries like the United States where the American Eugenics Society even held conferences on eugenics, such as the 1937 one which included the topic "The Relation of Eugenics to the Field of Nursing." Eventually, the US eugenics movement fell out of favor after the Nazi euthanasia programs were discovered in World War II.

Even prior to World War II, German professional nursing publications discussed eugenics as "providing a scientific basis for the positive eugenics promoting reproduction among the healthy (often of northern European descent) middle to upper classes and negative eugenics encouraging limited reproduction and forced sterilization of the 'unfit' (who were often poor, uneducated, and more recent immigrants) as reasonable" (51). Eugenic language was most prevalent in public health and psychiatric nursing texts and in discussions of poverty, immigrants, cleanliness, and social problems.

The editors also point to the influence on Adolf Hitler of the 1920 book titled *Approval of the Extirpation of Worthless Human Lives* by Germans Karl Binding, a jurist, and Alfred Hoche, a psychiatrist. Binding and Hoche noted that there were no legal arguments preventing legalizing the killing of those whose lives were considered not worth living.

There was extensive propaganda aimed at increasing the acceptance of euthanasia by the public