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ORIGINAL PAPER

Theravada Buddhism and Roman Catholicism on the Moral Permissibility of Palliative Sedation: A Blurred Demarcation Line

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Abstract
Although Theravada Buddhism and Roman Catholicism agree on the moral justification for palliative sedation, they differ on the premises underlying the justification. While Catholicism justifies palliative sedation on the ground of the Principle of Double Effect, Buddhism does so on the basis of the Third Noble Truth. Despite their theological differences, Buddhism and Catholicism both value the moral significance of the physician's intent to reduce suffering and both respect the sanctity of life. This blurs the demarcation line between Buddhism and Catholicism regarding the moral justification of palliative sedation.

Keywords Palliative sedation · Catholic bioethics · Buddhist bioethics · Principle of double effect · *Ahiṃsā*

Introduction

Addressing end-of-life issues in a contemporary, interreligious context is one of the most significant challenges in healthcare. It is especially problematic since some religions, such as Catholicism and Islam, offer strict guidelines about medical care. However, such directives are absent in other religions, such as Buddhism or Hinduism. Nonetheless, the absence of such directives does not ease the problem. Buddhism, for instance, is practiced in diverse cultures and appeals to different ideologies, so these features present more difficulties in applying religious, doctrinal perspectives to contemporary bioethics. However, Damien Keown (2001a) has argued that there are no "methodological obstacles" to applying the Buddha's

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teachings to current bioethical dilemmas because Buddhism does not tend to differentiate between ancient and modern problems. All problems, Keown argues, can be resolved by applying the eternal moral law (*dharma*), even those in cross-cultural settings.

I argue that, although Buddhism and Roman Catholicism often agree on the same conclusion for justifying palliative sedation, their premises and arguments differ. That is to say, both approaches agree that applying palliative sedation is morally permissible, but they differ on what considerations justify this end-of-life procedure. Moreover, both traditions value the moral obligations that physicians reduce pain and suffering and that they protect the sanctity of life. Thus, we might ask: to what extent does the approach of palliative sedation in Buddhism differ from or agree with the Roman Catholic approach? This paper uses Sanskrit words in an effort to capture the precise meaning of the Buddhist terms; "Catholicism" and "Roman Catholicism" are used interchangeably.

Although the recent literature explores the application of palliative sedation in each tradition, there is little discussion about interreligious comparisons. Comparing the perspectives of Buddhism and Catholicism on such end-of-life, bioethical issues is significant. So, this paper is significant not only because it engages in comparative religious bioethics but also because it considers treating patients in cross-cultural settings, which is relevant to global bioethics. The practitioners of the world's religions are becoming increasingly aware that the ethics that unite them are more significant than the theology that divides them (Keown & Keown, 1995).

This paper will focus on the ethics of palliative sedation and the interreligious problems concerning this end-of-life procedure. In what follows I will first consider the common aim between palliative sedation and *nirvāṇa* from the *nirodha* view, then scrutinise the value of the sanctity of life in both Buddhism and Catholicism. A final look will be given to the crucial role that intentions play in the principle of double effect (PDE), *ahiṃsā* (non-harming) and palliative sedation.

Background

This section discusses the moral issues around palliative sedation and the reasoning involved in determining the moral permissibility of palliative sedation within Roman Catholic and Buddhist ethics. I explore the relevance and significance of proportionalism in palliative sedation before explaining the goal of this end-of-life procedure.

The Goal of Palliative Sedation

Many researchers point out that the definition of palliative sedation is highly contested because the intentions of physicians cannot be determined precisely (Baumann et al., 2011). To avoid such complications, I restrict my discussion to the following definition of palliative sedation. Palliative sedation is "the intentional administration of sedative drugs in dosages and combinations required to reduce the consciousness of a terminal patient as much as necessary to adequately relieve

one or more refractory symptoms" (Broeckaert & Flemish Palliative Care Foundation, 2009). Broeckaert's definition of palliative sedation is also synonymous with "death without suffering", "good death", and "death with dignity" (Barilan, 2009). Importantly, palliative sedation indicates a particular type of symptom control, which is the primary intention of the physician administering the procedure, and so the features of adequacy and proportionality are especially important. According to Broeckaert (2011), physicians do not intend to reach a certain point of consciousness; instead, they intend to lower consciousness only as much as needed to alleviate patients' refractory symptoms. This may be called "proportionalism".

In addition, the ethics of palliative sedation are based on the moral obligation to relieve the pain and suffering of patients. Terminally ill patients might experience physical, psychological, social, or spiritual suffering (Randall & Downie, 1996). Saunders (1984) calls this combination of suffering "total pain". According to Cassell (2010), "most generally, suffering can be defined as the state of severe distress associated with events that threaten the intactness of the person" (p. 640). Moreover, for Cassell, suffering is not restricted to physical pain and, if physicians fail to understand the total nature of suffering, then that too becomes a cause of suffering.

Hence, the ultimate goal of palliative sedation, Barilan (2009) argues, is not only to alleviate physical suffering but also to ensure a decent death for patients, so that patients may die with their dignity and autonomy. One may ask about the underlying moral plausibility of palliative sedation. Interestingly, secular ethics, as does Catholicism, justifies palliative sedation through PDE (Baumann et al., 2011). Catholic authorities offer explicit guidelines for end-of-life issues (Catholic Church, 2018, p. 20–22).

Issues in Interreligious Bioethics

Roman Catholicism defends palliative sedation on the grounds of PDE because this principle was a crucial principle in pre-Vatican II Catholic medical ethics (Kelly et al., 2013). This principle aims to answer whether an agent's right intention can morally justify an action that involves both good and bad effects (Kelly, 2007). The PDE states that action with both good and bad consequences may be morally permissible if and only if the following four conditions are met: (1) the action itself should not be ethically wrong; (2) a negative consequence must cause a positive outcome; (3) the agent does not to intend the negative consequence; and (4) the negative consequence must not be more significant than the positive consequence (Kelly, 2007). One may wonder why PDE is significant in Catholicism. Interestingly, it may be applied to many ethical issues, especially ones concerned with the rightness or wrongness of voluntary human actions. Thus, PDE is used to determine the right actions that uphold a Catholic ethical perspective. According to the Catholic Church's (2018), *Ethical and Religious Directives for Catholic Health Care Services*,

> Patients should be kept as free of pain as possible so that they may die comfortably and with dignity, and in the place where they wish to die. Since a person has the right to prepare for their death while fully conscious, they should not

> be deprived of consciousness without a compelling reason. Medicines capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death. Patients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering (p. 28).

For instance, following PDE, if a physician's intention is to alleviate pain and not to cause the patients' death, then palliative sedation may be permissible. However, when a physician provides morphine to a patient with their or their surrogates' consent, the effects of that action may involve both good (e.g. reducing the patient's pain) and bad effects (e.g. lead to the patient's death). According to Roman Catholicism, this action is morally justified because it satisfies the four conditions, of which the physician's intention is primarily important.

Because the physicians intend to reduce the pain of their patients, the beneficial result of alleviating pain must be included when one evaluates the relevant action morally (Mackler, 2003). Hence, for Roman Catholicism, the physician's intention is essential and is important for determining the moral permissibility of any instance of palliative sedation (Kelly et al., 2013).

On the other hand, physicians, healthcare providers, and social workers often face obstacles. The case of a cross-cultural society for Buddhist migrants is an example of this (McCormick, 2013). According to Keown (2001a), Buddhists recognise four authorities: scriptures, authorities in conformity with scriptures, the commentarial tradition, and individual opinion. This is profoundly problematic because Buddhism has no central authority concerning how to interpret its doctrines or ethical theories (Ashcroft et al., 2007, p. 27).

Moreover, different schools of Buddhism in different parts of the world have diverse interpretations of what the Buddha taught. Keown (2001b) points out, the Buddha did not assign any successors and, thus, the community of monks (*sangha*) interprets the Buddhist doctrine in various ways. When disagreements arise, Buddhists work through dilemmas by consulting the four authorities (Keown, 2001b). The most prominent traditions of Buddhism are *Theravada* (Southern Asia) and *Mahayana* (Northern Asia). Theravada is somewhat conservative, and Mahayana is liberal or innovative (Kasulis, 2005, p. 304–306). According to McCormick (2013), because of the diverse traditions and native practices, Buddhists differ on the articulation of their doctrines, especially that of *karma*. Consequently, this creates disagreements regarding end-of-life issues. For instance, the Theravada tradition often follows the Five Precepts directly, whereas Mahayana does not. Instead, the Mahayana tradition emphasises compassion (McCormick, 2013). This paper primarily focuses on Theravada tradition and uses "Buddhism" to refer Theravada Buddhism.

Some may argue that my approach involves a stereotypical, unbalanced, and oversimplified distinction about dealing with contemporary end-of-life issues. This paper does not focus on such distinction given space constraints. Although different schools interpret doctrines and ethical aspects differently, there are no controversies about what count as the basic Buddhist teachings, such as the Four Noble Truths, the Eightfold Path, *nirvāṇa*, *dharma*, *karma,* and so on. Keown (2001b) has remarked that "the goal of diminishing *dukkha* is common to all forms of Buddhism,

the Buddha himself made suffering and the end of suffering the primary focus of his teaching". The next section argues that the Third Noble Truth (the *nirodha* view) is one of the most relevant aspects in Buddhist normative bioethics to justify the application of palliative sedation.

Common Aim Between *Nirvāṇa* and Palliative Sedation

Despite the diversity within Buddhism, all schools agree on the importance of the Four Noble Truths: (1) there is suffering, (2) there are causes of suffering, (3) it is possible to cease suffering, and (4) the Noble Eightfold Path is the way to end suffering (Brannigan & Boss, 2001). The First Noble Truth proclaims the existence of suffering (*dukkha*) and the Fourth identifies ways to diminish suffering. Interestingly, Western philosophers often argue that Buddhist philosophy is pessimistic by focusing on the First and the Second Noble Truths (Chatterjee & Datta, 1984). In response to this, Indian philosophers argue that Buddhism begins with a pessimistic observation but is wholly optimistic to the extent that it declares that suffering can have an end in the Third Noble Truth (the *nirodha* view). This paper emphasises the optimism of Buddhism and the possibility to end suffering (*dukkha*) in conjunction with the relevant basic teachings (e.g. *dharma*, the Five Precepts, etc.) of Buddhism.

I explore Buddhist bioethics through the lens of the Third Noble Truth (i.e. sufferings can have an end) and other related ideas, such as *dharma* (universal moral law), *śila* (moral conduct), the Eightfold Path (suffering could be ended through practising this path), *karma* (moral deed), and the Five Precepts. All of these teachings have enormously influenced the development of Buddhist normative bioethics. The most significant notion that is related to cessation of suffering is *nirvāṇa* (the ultimate enlightenment or liberation through the cessation of *dukkha),* the ultimate goal of Buddhism (Keown, 2001b).

The *nirodha* view emphasises the fulfilment of life through the realisation of *nirvāṇa*, the state of enlightenment. Buddhists believe that *nirvāṇa* is intrinsically valuable, and *nirvanic* values are eternal, absolute, and transcendent (King, 1964). On the other hand, the karmic values are synonymous with worldly values. Attaining *nirvāṇa* is the ultimate goal of human life and the state through which human beings are liberated from the cycles of birth and rebirth (Keown, 2005, p. 288–289). According to the *Pāli Dhammapada*, "The Buddha declares *nirvāṇa* to be the highest of all things [*nibbanam paramam vadanti Buddha*]" (Saddhatissa, 1970, p. 166).

To understand *nirvāṇa* requires also understanding several relevant concepts. For instance, the concept of *dharma* (universal moral law) is related to the law of *karma* which controls the moral actions of past and future lives. According to the law of *karma*, antecedent moral actions affect any individual existence thBuddhist ethics is moreough the cycles of birth and rebirth (Keown & Keown, 1995). One attains *nirvāṇa* through following the structure of the Noble Eightfold Path (right views, right resolve, right speech, right action, right livelihood, right effort, right mindfulness, and right meditation; Harvey, 2000). Among these, the paths of right speech, right action, and right livelihood are *śila* (moral conduct). Keown (2001b) states that there are two types of relationship between *nirvāṇa* and *śila*: oblique relationships

(passive or static) and direct (dynamic) relationships. In the oblique relationship, *śila* is the basis for the development of knowledge; and in the direct relationship, *śila* itself is a part of *nirvāṇa*. By following the paths of *śila* one can produce right actions or develop virtues (*punna*), such as generosity and morality. As such, *śila* is how the practical is emphasised in Buddhist ethics.

Buddhist ethics is more concerned with its application to daily life than with pondering theoretical issues, and so has a different focus than does Western ethics. Buddha taught that it is possible to stop suffering through three stages. Those stages are moral conduct (*śila),* concentration (*samadhi*) and wisdom (*panna*; King, 1964). Keown (2001a) explains that, although the process of attaining *nirvāṇa* is mainly ethical, one achieves a certain kind of "detachment". Achieving detachment indicates the end of suffering through craving—lust (*rāga*), hatred (*dosa*), delusion (*moha*), pride (*māna*), false views (*diṭṭhi*), grief (*soka*), and indecision (*kathaṃkathā*)—which causes the cycles of rebirth (Saddhatissa, 1987). Therefore, *nirvāṇa* is not a distinct phenomenon unconnected to many other significant aspects of Buddhism. The interrelationship between *nirvāṇa* and other relevant tenets makes it difficult to identify any single aspect that shapes Buddhist bioethics.

The most significant aspect of attaining *nirvāṇa* is that in attaining the state one has removed *tanha* (thirst, lust and desire or even the "production of consciousness"; Saddhatissa, 1970). The ultimate purpose of *nirvāṇa* is to diminish suffering in Buddhist philosophy (Keown, 2001b). Buddha says,

> Whatever the thing, whether conditioned (*sankhata*) or unconditioned (*asankhata*), that which is declared the highest is dispassionateness, absence of desire- which is to say: the subduing of pride, the removal of thirst, the uprooting of desire or attachment, the breaking of the cycle of rebirth, the destruction of craving, dispassionateness, cessation, *Nirvāṇa* (Saddhatissa, 1970, p. 167–168).

Interestingly, Buddhism and palliative sedation are both concerned with a kind of "*telos"* (purpose) to fulfil (Keown, 2001b). For instance, it is possible to reduce the pain people with cancer experience through palliative sedation, regardless of the physical, psychological, and spiritual dimensions of the pain (Randall & Downie, 1996). In this treatment, physicians follow a middle way ("no more, no less"; Broeckaert & Flemish Palliative Care Foundation, 2009, p. 5). Likewise, the ultimate purpose of *nirvāṇa* is to diminish suffering. However, the nature of pain in Buddhism and palliative sedation is different. The nature of suffering is discussed in background. Briefly, pain indicates a particular type of physical or psychological suffering in palliative sedation, whereas suffering implies the end of birth and rebirth cycles in Buddhism.

Common Ground between Buddhism and Catholicism: Sanctity of life

The moral significance of the "sanctity of life" in Catholicism is based on the idea that human life is a gift from God, which means that it is sacred (Keown & Keown, 1995). Moreover, Catholic moral teachings weigh the quality of life in determining the end-of-life decisions. Roman Catholicism does not defend the prolongation of

life that is deficient in quality because Catholic theology rests on the idea that God bestows dignity, destiny, and integrity to human life (Kelly et al., 2013). To be more specific, the *Ethical and Religious Directives for Catholic Health Care Services* maintains that

> The truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owner of life, so we do not have absolute power over life. We must preserve our life and use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome. (Catholic Church, 2018, p. 25–26)

The dignity of human beings is very significant insofar as Catholics believe people to be created in the image of God (Kelly et al., 2013; Mackler, 2003). Hence, life is a precious gift from a loving and kind God and should be preserved by human beings. In the words of James McCartney,

> we are guided by the principle that life is precious, that we are bidden to preserve and guard our health, that we are bidden to intervene in nature to raise the human estate, and that our lives are not our own, but are part of the legacy bequeathed to us by the Creator (as cited in Mackler, 2003, p. 14–15).

Hence, this feature of Roman Catholicism is significant for developing Catholic bioethics. Consequently, human beings are responsible for preserving life and health by pursuing effective medical treatment (Mackler, 2003).

While both Catholicism and Buddhism do not support killing human beings, their underlying justifications are different. Roman Catholicism does not support voluntary euthanasia. No one—physicians, healthcare providers or anyone else—may end the life that God has gifted someone without an appropriate assessment on the quality of life. Similarly, Buddhism also does not support euthanasia because the First Precept states living beings should not be injured or killed in virtue of bad karmic outcomes (Harvey, 2000). The idea of "sanctity of life" in Buddhism can be defended on the ground of the First Precept of non-harming (*ahiṃsā*). According to King (1964), *ahiṃsā* is the most significant feature of the Buddhist tradition: *ahiṃsā* not only protects human beings from negative emotions, such as resentment, aversion, and craving, but also encourages human beings to be more kind, compassionate, benevolent, and gracious (King, 1964). Moreover, *ahiṃsā* constrains one from deliberately destroying life and so is also substantially significant as the groundwork of attaining *nirvāṇa* (Keown & Keown, 1995).

Interestingly, Catholicism maintains that, rather than possess instrumental value, human life possesses a value which is itself precious and cannot be a means to an end (Keown & Keown, 1995). While an emphasis on the intrinsic value of life parallels a Kantian emphasis, Catholic ethics regarding end-of-life issues are not as rigorous as Kantian ethics. Whatever the context may be, a Kantian would not defend killing or lying because neither can be universalised. Kant's offers one formulation of the categorical imperatives as, "Act only on that maxim through which you can at the same time will that it should become a universal law" (Kant, 1785/1993, p.

30). However, Catholicism's flexibility on end-of-life issues and its endorsement of PDE permits palliative sedation in some instances, even if doing so may incidentally reduce the lifespan of a person (Keown & Keown, 1995). Having compared the concept of the sanctity of life in Buddhism and Catholicism, this paper attempts to argue that intention plays a significant role in the PDE and *ahiṃsā*.

Intention in the Principle of Double Effect, *Ahiṃsā*, and Palliative Sedation

This section analyses the significance of intention in Catholicism through PDE and in Buddhism through *ahiṃsā* and how intention affects each tradition's response to palliative sedation. While the nature of *nirvāṇa* and salvation are different, both concepts serve as a common ground between the traditions, especially given the underlying ethical implications are similar. While Catholicism values the sanctity of life, it permits palliative sedation in those cases that satisfy PDE.

A further question may arise at this point: why is it essential for a Catholic to perform morally right actions? Catholics believe that "God put us in the world to know, love, and serve him, to come to paradise" (Gracia, 2006, p. 181–182). Performing morally right actions leads to salvation. However, Catholics should not act with the intention of doing so to go to heaven. This, again, echoes the notion in Kantian ethics that we should perform our duty for duty's sake rather than aim for reward or praise (Kant, 1785/1993). Therefore, PDE is significant in Catholicism because Catholics use it to determine right actions that will lead them to their ultimate destination, the Kingdom of Heaven.

The function of intention is central to PDE and helps to clearly demarcate euthanasia from palliative sedation (Broeckaert & Flemish Palliative Care Foundation, 2009). Some may worry that PDE might justify euthanasia. Catholic ethicists would argue that this principle does not defend any straightforward killing. Instead, euthanasia or any deliberate hastening of death should be prohibited (Kelly et al., 2013). In euthanasia, physicians intend to terminate life; in palliative sedation, they intend to alleviate pain (Broeckaert & Flemish Palliative Care Foundation, 2009). Others might argue that some forms of palliative sedation (e.g. continuous sedation until death) is morally equivalent to physician-assisted death because such procedures have the same consequence—death. However, this objection cannot be sustained because the intentions of physicians are different. The PDE, which prioritises the intention to relieve pain instead of hastening death, is the deciding factor here (Benton, 2006).

However, if considered from a medical perspective, then some might argue that palliative sedation and euthanasia have the same goal (*telos*): to relieve patients' suffering (Cassell, 2010). Meilaender (2018) offers an important consideration about the moral plausibility of palliative sedation: Given that a terminal patient experiences extreme suffering and the ultimate purpose of medicine is to alleviate patients', it is justifiable to administer a considerable amount of sedative medication to control the patients' symptoms. In fact, it is also morally plausible to sedate patients to unconsciousness to prioritise the ultimate goal, alleviating patients' pain

(Meilaender, 2018).One might question the nature of such justifications. According to Patrick Daly (2015), the justification of palliative sedation involves the nature of virtue ethics: as Aquinas emphasised, “the goal of an action has a lot to do with what the person acting desires” (p. 203).

Moreover, critics could argue that the First Precept cannot be applied to palliative sedation because there is no intrinsic difference between palliative sedation and euthanasia (especially assisted suicide). For instance, some argue that palliative sedation is euthanasia in disguise (Tannsjo, 2004). However, as Buddhism proclaims in its First Precept, one ought not harm a living being and so the precept would not support euthanasia or any types of suicide (Keown, 2001a). It is therefore essential to analyse the underlying moral plausibility of palliative sedation and distinguish between palliative sedation and euthanasia through differences in intention. Hence, although the justification of euthanasia is controversial in Buddhist ethics, there is no conflict regarding palliative sedation to the extent that these cases involve physicians’ intentions to diminish pain.

According to Catholic ethicists, physicians’ intention is not “let’s give the patient enough morphine to prevent any attempt of breathing”. Instead, they intend to control refectory symptoms: “let him die a natural death” or “let him die with dignity” (Kelly, 2007). Nonetheless, there should be no conflict in cases of palliative sedation because the physicians’ intend to diminish pain.

On the contrary, the concept of the Law of *Karma* is also very significant in Buddhism because the Law of *Karma* assists Buddhists to maintain an ethically right life. This indicates that if any Buddhist performs a morally wrong action, they will experience adverse outcomes and be reborn as animal or nonhuman creature. Therefore, they will not be able to stop the bondage from the cycles of birth and rebirth that prevent the attainment of *nirvāṇa*.

Therefore, the role of intention in the Buddhist Law of *Karma* is significant. For instance, the First Precept (*ahiṃsā*) declares “*panatipata veramani sikkhapadam samadiyami*” (I undertake the precept to refrain from harming intentionally any living being; Saddhatissa, 1987, p. 73). That is, any “intentional” killing or harming others is forbidden. McCormick (2013) clarifies that “despite an apparently clear precept against killing, Buddhists have some flexibility in decision making if their intentions are pure and their heart is compassionate” (p. 223). Therefore, Buddhism may defend the application of palliative sedation, uphold the First Precept, and still attain the ultimate goal of *nirvāṇa.*

It is important to note that Catholicism and Buddhism do not necessarily consider suffering as a negative phenomenon. In fact, there is a close relationship between the very concept of suffering and the ultimate goals of Catholicism and Buddhism. For instance, Catholicism values suffering because it is an instrument used to grasp the exquisite design of God and to attain salvation. Suffering in life also deepens Catholics’ faith in God and provides intimacy with God. As Pope John Paul II maintained “Suffering is a necessary ingredient of sanctity… [for Christ’s] is a crucified love, a love that atones and saves through suffering” (as quoted Garcia, 2006, p. 184–185).

One might question how suffering is valued in Buddhism. Buddhist patients may not be prepared to utilise pain management processes because, as some think, such suffering is essential to prepare for attaining the ultimate goal (Veatch, 2000).

Dealing with such situations in a cross-cultural setting involves enormous difficulties for healthcare workers. From a Buddhist theoretical perspective, suffering involves being bound to the cycles of birth and rebirth. The Buddhist concept of suffering is a broader sense of suffering whereas a narrower sense of suffering would only include the physical pain that the patient experiences. Thus, healthcare providers or social workers should be aware of dealing with such issues.

Another way to resolve the complexity of suffering in Buddhism is to emphasise the more optimistic aspect of Buddhist philosophy, the Third Noble Truth, which upholds that suffering can be ended. Thus, if Buddhist patients reflect on the pessimistic aspect of Buddhism, they might not go through pain management, whereas shifting the focus to a more positive outlook may enable them to accept the available pain management practices. Hence, although Buddhism and Roman Catholicism both agree on the moral permissibility of palliative sedation, they differ on the reasons one should carrying out such procedures. Both approaches, however, agree that the intentions of physician matter.

Research Limitations

This section briefly reflects on some of the limitations of this study. First, some philosophers, such as Singer (2011), affirm that there is no intrinsic difference between killing and allowing to die. Singer's argument is that the wealthy people of the planet should donate money to the underprivileged who suffer or die from poverty-related causes. If the affluent do not donate, then, perhaps they do not kill the extremely poor, but they still allow the poor to die. In this case, Singer states that allowing the extreme poor to die is equivalent to killing them. His argument is analogous to discussions about the ethics of palliative sedation. That is, although physicians' intentions of physicians are used to justify palliative sedation, one might worry that physicians allow patients to die by administering a high dose of morphine, especially when physicians know the side effects of such drugs. Therefore, such philosophical distinctions, in this regard, require more clarification.

Second, given that Buddhism and Catholicism both agree that palliative sedation is the morally permissible in certain cases, one might wonder whether Buddhism would benefit from appealing to PDE in justifying palliative sedation. One might respond by claiming that this remains a challenge because Buddhism has no clear guidance about PDE. However, contemporary interreligious discussion reduces the gap or conflicts among different theological approaches.

Furthermore, one may argue that the lack of consensus among Buddhists creates too many problems when treating patients who have a Buddhist background. Physicians or social workers should be required to know the diverse attitudes of Buddhism. How are physicians to deal with this crisis in a cross-cultural setting? According to McCormick (2013), social workers, for instance, should investigate Buddhist beliefs regarding the law of *karma* and provisions about rebirth and the significance of dignified death in the Theravada or Mahayana traditions rather than ask Buddhist families about their beliefs.

Third, one might argue that the intentions of physicians could be abstruse and unclear. Jansen (2010) argues that there is no adequate evidence to support this claim. So, more empirical research should be conducted to learn about the psychological states of physicians.

Lastly, although there is empirical research on the attitudes of Catholic nurses, physicians, and healthcare providers regarding palliative sedation, such research on Buddhist nurses is still inadequate. Some empirical research indicates that mainstream, Flemish nurses prefer palliative sedation to euthanasia (Gielen et al., 2012). Thus, research on the attitudes of Buddhist nurses should be conducted to understand their attitudes towards palliative sedation. Such research would help scholars understand the larger picture and the relevant issues of applying to normative bioethical principles.

Conclusion

I argued that despite theological differences between Catholicism and Buddhism, both agree on the moral permissibility of palliative sedation. The Third Noble Truth (the *nirodha* view) is particularly significant for Buddhist bioethics and the justification of palliative sedation. Although there are diverse interpretations of Buddhism, all Buddhist schools agree on the significance of the Four Noble Truths. Palliative sedation is compatible with the goal of *nirvāṇa* (i.e. alleviating pain or suffering). However, the concept of *nirvāṇa* in the *nirodha* view is not inseparable from other vital features in Buddhism (i.e. Five Precepts, *dharma*, *śila,* etc.).

I also scrutinised the First Precept, or *ahiṃsā*. Following that discussion I compared the significance of sanctity of life in Catholicism and Buddhism. Catholicism values the sanctity of life because it is the gift from God, whereas Buddhism grounds it in the First Precept. Finally, I clarified the crucial role of intention in PDE and *ahiṃsā*, as well as its role in palliative sedation, to show how intention clearly demarcates between palliative sedation and euthanasia. Both Buddhism and Catholicism use intention to justify moral permissibility of palliative sedation.

However, some research limitations indicate that more philosophical, medical, and empirical research must occur to advance healthcare in cross-cultural setting. The findings of this paper are significant because they can be applied to treat patients in such settings. I recommend that more relevant empirical research should be conducted to deepen our understanding of the relevant dilemmas in healthcare.

Declaration

Conflict of interest

The author declares that she has no conflict of interest.

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