Continuous Sedation Until Death as Physician-Assisted Suicide/Euthanasia: A Conceptual Analysis

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A distinction is commonly drawn between continuous sedation until death and physician-assisted suicide/euthanasia. Only the latter is found to involve killing, whereas the former eludes such characterization. I argue that continuous sedation until death is equivalent to physician-assisted suicide/euthanasia in that both involve killing. This is established by first defining and clarifying palliative sedation therapies in general and continuous sedation until death in particular. A case study analysis and a look at current practices are provided. This is followed by a defense of arguments in favor of definitions of death centering on higher brain (neocortical) functioning rather than on whole brain or cardiopulmonary functioning. It is then shown that continuous sedation until death simulates higher brain definitions of death by eliminating consciousness. Appeals to reversibility and double effect fail to establish any distinguishing characteristics between the simulation of death that occurs in continuous sedation until death and the death that occurs as a result of physician-assisted suicide/euthanasia. Concluding remarks clarify the moral ramifications of these findings.

Keywords: Continuous sedation until death, higher brain death, palliative care, palliative sedation therapy

I. INTRODUCTION

Many health care professionals and bioethicists draw a distinction between continuous sedation until death (CSD) and physician-assisted suicide/euthanasia (PAS/E), claiming that only the latter involves killing or hastening of
I argue that CSD is equivalent to PAS/E on the basis of higher brain definitions of death rather than whole brain or cardiopulmonary definitions. I begin by clarifying the concept of continuous sedation until death with respect to palliative sedation therapies in general. A case study is provided, involving a dying patient with intractable symptoms. I argue that requests by the patient in the case for either CSD or PAS/E would ultimately be identical. This is established through an analysis of the way CSD is practiced and the terminology used in palliative care settings. From here, a defense of higher brain definitions of death over whole brain and cardiopulmonary definitions is provided, along with an association between CSD and higher brain definitions of death. I then show that appeals to reversibility and double effect fail to reveal any significant differences between the two procedures. Finally, some concluding remarks regarding the moral implications of these findings are offered.

II. PALLIATIVE CARE AND CONTINUOUS DEEP SEDATION

Palliative care has its roots in the hospice movement begun in England by Cicely Saunders in the early 1960s (DuBoulay, 1984). Saunders inspired the American hospice movement while lecturing at Yale in 1963 (National Hospice and Palliative Care Organization, 2012). Further inspiration came from Dr. Elisabeth Kübler-Ross’s (1969) landmark book On Death and Dying. Hospice care eventually developed into the medical subspecialty we now refer to as “palliative care medicine.” John Peppin (2003, 343) defines palliative care in general as “...the relief of suffering through the treating of symptoms endured by incurable patients.” There are a number of ways to provide palliative care. One of the most common methods is through the use of drugs. Two different types of drugs often used in combination are analgesics and barbiturates. The former drugs reduce pain without the loss of consciousness, whereas the latter reduce pain by reducing or eliminating consciousness. Use of the term “palliative sedation therapy” more specifically refers to the achievement of palliative goals primarily through the use of barbiturates, with analgesics playing only a secondary role. In palliative sedation therapy, symptom relief is achieved by lessening or eliminating the consciousness of the patient.

Various types of palliative sedation therapies are typically distinguished by the impact they have on the patient’s state of consciousness. “Consciousness” is being used here in the broadest possible sense of the term, which includes not only self-consciousness, but all possible states of conscious awareness and experience. Morita et al. (2003, 358) define and classify these subgroups of sedation: “Sedation is . . . classified into several subgroups according to its level of duration: “mild sedation” (to maintain consciousness so that patients can communicate with caregivers), “deep sedation” (to achieve almost or
complete unconsciousness), “intermittent sedation” (to provide some periods where patients are alert), and “continuous sedation” (to eliminate the conscious life of patients until they die”).\textsuperscript{5} One of the most common terms used in the literature for what I am calling “CSD” is “terminal sedation.”\textsuperscript{6} There were objections to the use of this term because it could imply hastening death (Lo and Rubenfeld, 2005, 1812). Thus, instead of terminal sedation, other terms were used in its place, including “sedation for intractable distress in the imminently dying,” “end-of-life sedation,” . . . “palliative sedation,” “sedation in the final phase,” and “palliative sedation therapy” (Muller-Busch, Andres, and Jehser, 2003, 2). Recently, the term “continuous deep sedation” has emerged to more accurately reflect the meaning of the therapy while distancing itself from the idea that death is hastened (Hasselaar et al., 2008; Raus, Sterckx, and Mortier, 2011). I have opted for CSD as the most accurate characterization of what the therapy actually entails and implies (Rys et al., 2012).

My thesis here only applies to the practice of CSD where the patient is rendered permanently unconscious until complete biological death. Continuous deep sedation may be an equally appropriate term so long as it is clear that the intent is the same as CSD. Typically, this means that nutrition and hydration are no longer provided once sedation begins. Any form of sedation in which the intention is to render a patient unconscious temporarily is not considered here.

Because CSD involves the permanent loss of consciousness for patients, it may seem similar to PAS/E. One common way to distinguish CSD from PAS/E has to do with intention. In CSD, the exclusive intent is thought to be pain management rather than hastening the death of the patient, which is what clearly occurs in PAS/E. It is also claimed that CSD is reversible, whereas PAS/E is not. A case study involving a comparison of CSD to PAS/E begins my attempt, continued throughout the paper, to show that these distinguishing marks can be questioned.

The case of Mrs. B. is from an article dealing with palliative sedation as a last resort.\textsuperscript{7} It epitomizes difficulties with management of pain that can develop at the end of life. In our case, Mrs. B. is dying of “widely metastatic breast cancer.” Although every effort is made to control her pain, which is described as “excruciating,” her pain remains unmanageable despite increases in her pain medications. The situation worsens when the medications result in Mrs. B. suffering myoclonic jerks throughout her whole body, from which she remains “awake and in severe distress.” At this point, the decision was made to turn to palliative (terminal) sedation. A few hours after Mrs. B. was sedated, “. . . her myoclonos subsided . . . [and she] died peacefully with her family near, approximately 4 hours later” (Lo and Rubenfeld, 2008, 1810).\textsuperscript{8}

This case involving myoclonus reflects one of the most common reasons health care practitioners turn to palliative sedation therapies. Other reasons
with respect to refractory symptoms include “pain, nausea, delirium, . . . restlessness, [and] respiratory distress . . .” (Cowan and Walsh, 2001, 404).

The barbiturate drugs used in CSD produce nonconscious states that can be distinguished from other noncommunicative states such as sleeping and locked-in syndrome where some form of consciousness is maintained. The loss of consciousness that results is permanent if the intention of CSD is realized.

Let us briefly compare a request for CSD versus a request for PAS/E on the part of Mrs. B. In both scenarios, this is a decision of last resort because both her pain and her symptoms have remained refractory. In both, Mrs. B. permanently loses consciousness. In both, it is necessary to call Mrs. B’s loved ones to the bedside before the procedure takes place so that they can say their proper goodbyes. In both, the outcome at the end of each procedure is that Mrs. B. dies a complete biological death. Both procedures are only successfully completed upon Mrs. B’s complete biological death.

A request for CSD, then, is a request to be relieved of intractable symptoms by first dying an experiential death—that is, chemically and purposefully simulating the condition of one who is dead based on higher brain functioning. The sedation blocks all conscious thought and any other possible kind of awareness. This is then followed by the process right up to complete biological death, without the patient ever returning to a conscious state. The sequence of events, then, for both CSD and PAS/E is practically identical.

III. CURRENT PRACTICES IN PALLIATIVE SEDATION THERAPIES

That sedation as used in the clinical setting for palliative purposes will end up being permanent is not always clearly revealed. In a recent New York Times front page story on CSD (Hartocollis, 2009), the author uses the case of a patient named Mr. Leo Oltzik as an example of how a health care team eventually turns to palliative sedation therapies because Mr. Oltzik’s symptoms could not be controlled. That the type of palliative sedation therapy used was meant to be permanent was never discussed directly with the family.

After three days of efforts to calm Mr. Oltzik failed, Dr. Halbridge told the family that he was going to try an intravenous (IV) drip . . . . “Our biggest challenge was to try to get him not to be so agitated,” Dr. Halbridge began . . . . “[W]e put him on an IV medication, which is dripping at a continuous rate,” he said (to the family) (Hartocollis, 2009, A1).

The journalist sums up the interaction between the health care team and the family as follows:

Much of the conversation had proceeded not in black and white, like a legal document, but in shades of gray. By the end, they all seemed to understand one another, though ultimately, Mrs. Oltzik would express some sadness at being unable to interact with her husband (Hartocollis, 2009, A1).
It is clear enough from the context that the intent of Dr. Halbridge is to use the palliative sedation therapy protocol that is permanent and not temporary. This could be stated more directly as follows: “We have failed to adequately manage Mr. Oltzik’s symptoms while he remains conscious, and he is very near death as it is. So we are going to sedate him permanently through to his complete biological death which will allow him to die a more peaceful biological death.”

Some physicians may believe that use of CSD avoids what some commentators have referred to as the devil’s choice (Magnusson, 2006). To make the devil’s choice is to be forced to choose between two actions, both of which are viewed with equal moral abhorrence. Here, the choices are to allow intractable suffering or to assist in suicide. Because neither is an acceptable alternative, CSD seems a way out. It eliminates suffering and avoids killing. That it does indeed avoid killing is what is being questioned here.

Many similarities between CSD and PAS/E have already been presented. That it is difficult clearly to distinguish CSD from PAS/E is further emphasized in the attitudes of some nurses. Consider these responses of nurses working within the field of palliative sedation therapy in an article by Judith A.C. Rietjens et al. (2007):

Obviously, once someone is sedated, they are not able to eat or drink anymore. So it seemed to me as assisted suicide, because you are sedating someone to the point that they are not able to do anything for themselves. You are doing that intervention and that is therefore going to contribute to their death. (Rietjens et al., 2007, 646)

I remember having questions about . . . what was appropriate intervention? Was this euthanasia? Was this PAS? Was I actually being asked to kill a human being? And so I remember having to do a lot of reflection upon that to explore those notions. (Rietjens et al., 2007, 647)

If the line were clear and distinct between CSD and PAS/E, these attitudes would tend not to emerge.

Two other points of significance are raised by the Rietjens article. The first is that a general consensus was reached among the nurses surveyed regarding the benefit of CSD.

All of the nurses consistently thought that the use of palliative sedation had positively contributed to the patient’s quality of dying . . . . I thought it improved the quality of dying. Because he was able to die without pain and it just appeared to be very peaceful. And that is a feeling I have in general regarding palliative sedation: that it makes the transition peaceful. (Rietjens et al., 2007, 647)

The same sentiment could be expressed about a death that resulted from PAS/E.

The second point is that palliative sedation is defined as “. . . using medications to induce unconsciousness until (the patient’s) death” (Rietjens et al., 2007, 643). However, this may be confusing because not all palliative sedation therapies are meant to be continually used until death. The terms used
to describe palliative therapies in which the sedation is meant to be permanent should not be used interchangeably with those that are not meant to be permanent. Because the implications of sedation that is meant to be permanent are profound, a categorization that clearly reflects the permanence is in order.

IV. CSD AS PAS/E

The thesis being defended here is not just that there are many similarities between CSD and PAS/E but rather that CSD is equivalent to PAS/E. CSD, as it has been defined and clarified here, is the permanent elimination of consciousness from a patient. To have one’s consciousness permanently eliminated is to die. It is a death of higher brain functioning. Those disagreeing with this thesis can make what seem to be on the surface three objections. The first is that death should not be defined in terms of higher brain functioning. The second is that even if the intent of CSD is permanent, it could still be reversed. The third is that by double effect, the intention of CSD is pain management, not killing. All three are unsound.

A Defense of Higher Brain Death

Until the 1960s, death was defined by and associated with the cessation of cardiopulmonary functioning. This was, by and large, a completely sufficient standard. However, the scenery changed dramatically in the 1960s, primarily from the successful development of mechanical ventilation and organ transplantation (Miller and Truog, 2009). During this decade, it became increasingly easier for physicians to sustain cardiopulmonary functioning, regardless of how little patients’ brains were functioning. This problem led to the establishment of the Harvard criteria of death in 1968. The definition of death that emerged from the Harvard criteria, “... irreversible functions of the entire brain, including the brain stem” (Youngner and Bartlett, 1983, 252), came to be characterized as whole brain death. Further defense and justification of this definition came from the President’s Commission’s 1981 report. Although a general acceptance emerged, it is quite clear from the literature that a complete consensus on how to properly and accurately define a human being as dead has not been achieved. The inability to reach a consensus since the President’s Commission of 1981 resulted in a white paper by the President’s Council on Bioethics in December 2008 (President’s Council on Bioethics, 2008).

It is possible to provide justifications for all three standards, depending on what conditions one wants to establish as being necessary and sufficient for human life. Miller and Truog (2009) opt for a more biologically oriented definition of death. They claim that the bodies of patients meeting the standards of the President’s Commission of 1981 still possess many
functions associated with life. “These patients maintain hormonal balance, control of temperature, the ability to fight infection, and wound healing . . . [and] have [even] been able to gestate a fetus for up to a few months” (Miller and Truog, 2009, 186). The authors go on to claim that the only valid way to define death is to base it on biology because “life and death are biological concepts” (Miller and Truog, 2009, 190). They also claim that defining death based on higher brain functioning and consciousness is to confuse “the absence of personhood and death” (Miller and Truog, 2009, 186).

An interesting counterexample to Miller and Truog’s definition was raised by John Lizza, who points out that if we accept the definition of Miller and Truog, we would have to say that a decapitated person with a sustained body must be considered alive (Lizza, 2010, 393). Miller and Truog reply that this case of a living decapitated person is merely “. . . repugnant but by no means absurd” (Miller and Truog, 2010, 398). However, this response can be questioned. Any definition of death that cannot rule out a decapitated person is flawed in some significant way.

A further consideration against biologically based definitions of death has to do with the extremely swift consensus that emerged from the original Harvard criteria of 1968. This is rather remarkable, considering the profundity and potential complexity of the issue. We can understand the relative speed with which consensus was reached as a reflection of the fact that most people realized the need to invoke a definition of death based on consciousness and all other human awareness that went beyond our mere biological functioning. If that were not the case, there would have been a veritable uproar over the declaration of a patient as dead that still maintained significant biological functioning. The insight of the whole brain definition is that it allowed us to move beyond biology. The problem is that it did not go far enough.

W. Chong’s (2005) thesis serves as a good example of the inherent difficulties in attempting to justify whole brain death. Chong outlines three general definitions of death: whole brain death, as discussed above; higher brain death, based on the neocortical functioning; and the traditional cardiopulmonary criteria.

Chong finds fault with both traditional cardiopulmonary definitions of death and higher brain–based definitions of death, opting instead to defend whole brain death. He offers two different scenarios that serve as counterexamples to both cardiopulmonary and higher brain–based definitions. The first involves a person who suffers a sudden and irreversible cardiac arrest along with a sudden and irreversible injury prohibiting respiration. Such an individual would be dead by cardiopulmonary standards, but the individual may remain conscious for a few seconds and could even speak or utter sounds. We would not say the individual is dead, yet he would have to be considered dead by the cardiopulmonary definition (Chong, 2005, 22).
This situation might seem problematic for those defending the cardiopulmonary definition of death, but a more thorough analysis reveals that it not really problematic at all. In some dramatic instances, states of consciousness survive our biological functioning. Chong refers to this possibility as an “animated corpse” (Chong, 2005, 22). This is not a disproof of the cardiopulmonary definition of death. This state can only last for “several seconds” (Chong, 2005, 22) and, as such, is merely an artifact of the dying process. As such, it is not sufficient to serve as a counterexample. If the state could persist for several hours or days, the challenge would be formidable. But, as it currently stands, the problem with defining death is not consciousness persisting without bodies, but the reverse, bodies persisting long after consciousness has died.

To counter the higher brain definitions of death, Chong sites cases of persistent vegetative-state patients who will “. . . often show other classic signs of biological life . . . and in virtue of brain stem reflexes may cough . . . blink . . . and swallow food that is placed in their mouths” (Chong, 2005, 23). Chong goes on to argue that the preferred solution is to refine whole brain death so as to better meet difficult and exceptional cases rather than to throw the baby out with the bath water, so to speak.

Chong’s findings are questionable. It is unclear that a patient reacting biologically to stimuli with no awareness whatsoever needs to be considered alive merely because of biological functioning.13 If biological reactions to stimuli were crucial for determining death, we never would have accepted brain-dead definitions of death in the first place. Furthermore, several biological functions, such as the division of skin cells, can continue after death for a number of hours and have no bearing whatsoever on determining death (Vasiliev et al., 2002).14 Chong ultimately relies on intuition in support of this point.

I think it intuitively clear that an organism that breathes spontaneously, has circadian rhythms, and exhibits these complex (though non-conscious) responses to stimuli is not dead on any ordinary understanding of life and death—strongly suggesting that the irreversible loss of consciousness also does not amount to death. (Chong, 2005, 23, emphasis added)

Nevertheless, intuitions cut both ways. The tombstone of Nancy Cruzan reads:

Nancy Beth Cruzan
Most Loved
Daughter-Sister-Aunt
Born July 20, 1957
Departed Jan 11, 1983
At Peace Dec 26, 1990

This family states that Nancy suffered a death of her personhood when she “departed” after her automobile accident in 1983 based on her irreversible
loss of consciousness. It makes perfect sense to include that as her date of departure on her tombstone. This intuition is consistent with definitions of death based on higher brain functioning.

Consciousness also played an important role in the Terri Schiavo case. The parents of Terri Schiavo argued on Terri’s behalf because they thought she was aware, not because they wanted to merely sustain her biological body (Campo-Flores, 2005). Had they thought she lacked all capacity for consciousness, they may have not been as vehement in their desire to sustain her biological body.

If we take Chong’s position against higher brain death to its logical conclusion, he faces a challenge similar to that which Lizza leveled against Miller and Truog. Although Miller and Truog had to grant that a completely headless person is still alive, Chong avoids that, but then he must admit that a person with only a brain stem is still alive. That still leads to absurdities because we can imagine patients with all of their heads and brains removed other than their brain stems. This person is still alive under Chong’s definition of whole brain death, yet clearly the person is not alive in any way that resembles what is meaningful to human life.

Further difficulties with the whole brain definition defended by Chong have been effectively articulated by Robert Veatch (1993). Whole brain definitions constantly grant exceptions to the standard definition, which demands “... irreversible cessation of all functions of the entire brain, including the brain stem” (President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 1981, 2). Several of these exceptions are outlined by Veatch. When supposed irreversibility is declared, there could still be living brain cells that can produce electroencephalography activity and “functioning isolated nests of neurons ...” (Veatch, 1993, 18). Realizing full irreversible cessation rarely occurs. This means what should be the exception in whole brain death is the rule. Thus, the definition is inherently flawed.

Considering, then, the three options for defining death as outlined here, the higher brain (neocortical) definition of death is the most appropriate. It allows us to invoke the most meaningful aspect of being human as the determining characteristic of death, which is the capacity for some kind of minimal conscious awareness on the part of the individual. Batavia states it this way: “The essence of being human is consciousness” (Batavia, 2002, 229). If a person suffers what is in everybody’s best judgment a permanent loss of consciousness, it is reasonable to consider the human being dead. It is important to clarify here that I do not make judgments regarding the level or quality of these conscious states. I only propose here that that some minimum level of consciousness, or the potential for future conscious states, be maintained in order for a human being, qua human being, to be considered alive. A person under general anesthesia is still very much alive because of the potential for future conscious states. A person undergoing CSD never
returns to a conscious state. Batavia goes on to define death as “... when a person is permanently unconscious... as human beings, such individuals are dead” (Batavia, 2002, 229). Youngner and Bartlett (1983) express it this way: “We suggest that the loss of consciousness and cognition constitutes the death of the human” (256). The authors go on to state that a person who only has a functioning brain stem due to a stroke and has lost all conscious capacity does have a living body but is no longer a living person—“Only a mindless organism survives; a human has died” (Batavia, 2002, 257).

Acceptance of whole brain–based or biology-based definitions of life forces us to include almost completely decapitated bodies and mindless organisms as “alive.” Such individuals may indeed be alive as an organism is alive, but that is not a meaningful way for a human being to exist or to be considered alive. It is only through a standard based on consciousness and all other human awareness that we avoid such problems and most appropriately determine a human being qua human being as living or dead.

Higher brain definitions of death are based on consciousness. Those supporting higher brain death correctly prioritize conscious experience over biological functioning. The reasons offered to show that higher brain death is the most appropriate definition of death also support the view that CSD is equivalent to higher brain death. CSD permanently eliminates consciousness. In so doing, it also eliminates human life.

The Reversibility Criterion

One may argue that even though a patient who undergoes CSD is dead by higher brain standards, this can, in principle, still be reversed, which is not the case once the decision to undergo PAS/E has been undertaken. Therefore, because one case is reversible whereas the other is not, there is a significant conceptual difference between the two cases (Muller-Busch, Andres, and Jehser, 2003, 5).

Although it is true that a patient undergoing PAS/E is typically entering a situation that will become irreversible in a far quicker manner than one undergoing CSD, this difference in time ultimately has no bearing on the conceptual identification of these two acts. What matters is that in a case of successful CSD, the ultimate end is identical with that in PAS/E. If a patient requests CSD and someone interrupted the process, it would no longer be CSD in the same way that a failed suicide is no longer a suicide but merely an attempted suicide.

Perhaps an analogy will make the case clearer. Suppose that I have a degenerative condition that will make me a complete paraplegic in one year. Further suppose that because I want to practice this lifestyle that I will have to endure, I chemically induce the paralysis six months before its physiological onset from the disease. This chemically induced state can be distinguished from the disease-based paralysis I will eventually realize, because
only the former state can be reversed. But if my intent is never to reverse the induced state, and it does persist through to the onset of the diseased state, no meaningful difference could then be drawn between the two states. I became paralyzed at the onset of the chemically induced state, even though it was, in principle, reversible. The reversibility is only relevant if the situation is indeed reversed. Likewise, in successful CSD, a person is unconscious from the onset of barbiturates until biological death.

I conclude that reversibility has no relevance as a distinguishing mark between successful CSD and successful PAS/E. What would be relevant as distinguishing marks are the intentions at the start of the act, the most likely end results of the act, and the actual end result of the act. When comparing acts of CSD and PAS/E on these grounds, all are identical. The reason intention is identical is that the intention in CSD is to permanently eliminate a patient’s consciousness. In other words, the intention is to simulate neocortical death through to actual neocortical and biological death. If the original intention is carried through, the patient, for all intents and purposes, dies at the onset of the sedation.

It should also be noted that both CSD and PAS/E are reversible in principle. It is just that the time frame in which PAS/E remains reversible will be relatively short, compared to that in CSD. For instance, in a case of PAS/E, a sudden decision could be made to pump a patient’s stomach soon after the patient has ingested lethal drugs. This might be effective in counteracting the poison if one wanted to reverse the original intention of the act. And if such action did successfully prevent the death of the patient from taking place, we would no longer consider the role the physician played in this act as one of assisted suicide because the act was not carried through to its intended end. In the same way, if the decision to undergo CSD was interrupted and the patient was returned to a conscious state, we would no longer consider the case as one of CSD. Thus, reversibility plays no role in an actual case where sedation is terminal. Reversibility is simply a red herring.15

Double Effect

Appeals to double effect in issues of bioethics are numerous, including “maternal–fetal conflict, organ donation and transplant, euthanasia, and resource allocation . . .” (Aulisio, 1997, 142). The argument as it relates to CSD and PAS/E can be formulated as follows: in PAS/E, the actual intent is to cause the death of the patient. In CSD, there is no such intention. The intention is only to manage the patient’s pain. The patient then dies of natural causes, not by the hand of the health care practitioner (Cowan and Walsh, 2001; Muller-Busch, Andres and Jehser, 2003; Peppin, 2003). Therefore, it is only PAS/E that involves killing. CSD does not involve killing and as such is essentially a different type of act. This principle can be invoked even if it is found that the drugs used in palliative care hasten the death of the patient. Joseph Boyle
states it this way: “the intent of the physician prescribing the life-shortening analgesics is to control suffering, not to shorten life . . . . Consequently, this action (CSD) is not euthanasia, but palliative care” (Boyle, 2004, 51).

It should be apparent from the section on reversibility that the traditional arguments in support of CSD based on double effect are not applicable here. The intention of CSD is to eliminate consciousness. In my view, eliminating consciousness is in effect the same as inducing a state that is functionally identical with neocortical death. Because CSD and neocortical death are functionally equivalent, there is no morally significant distinction between these states. Double effect can only be applied when an action is clearly distinguished from a separate (and possibly foreseeable) outcome. That is, in double effect, the two effects must be separable. But here, there is no such distinction. The intended effect—the permanent elimination of consciousness—is the same as human death. Thus, there is no double effect (good and bad effects) in successful cases of CSD. There is only one effect.16

V. CONCLUSION

The thesis being defended here does not involve moral evaluation. It claims that CSD is indistinguishable from PAS/E. To say that CSD occurred would be to say that killing occurred. That does not make it immoral because context determines when killing is or is not justifiable. Self-defense involves killing but is morally justifiable. CSD is also morally justifiable because it rests on the principles of respect for patient autonomy, mercy, compassion, and physician nonabandonment. Fully articulating that defense would require a separate article. The present concern is to demonstrate the claim that no significant differences can be made between acts of CSD and those of PAS/E. For those insisting that life and death should be understood biologically, the case could be made that CSD is not death. This can only be done at the expense of a definition of death based on consciousness and all other human awareness and instead forces us into a much less desirable “one size fits all” notion of death. This does not do justice to being human and the significance that consciousness and all other human awareness abilities have to human life. Identifying CSD with higher brain death is a more precise and accurate characterization of what occurs. Clarifying our actions to the greatest possible extent should help us improve the care of the immanently dying. That is the fundamental inspiration behind this analysis.

NOTES

1. This distinction is defended by the following authors: Muller-Busch, Andres, and Jehser (2003); Peppin (2003); Cowan and Walsh (2001); and Lo and Rubenfeld (2005).
2. Common analgesics range from aspirin, acetaminophen, and ibuprofen all the way through to more powerful opiates such as codeine and morphine (Brunton et al., 2005).

3. Common barbiturates include phenobarbital, midazolam, and sodium thiopental (Korsmeyer and Kranzler, 2008).

4. For further reading on distinguishing consciousness from self-consciousness and other possible states of awareness, see Arp (2007) and Gomes (2007).

5. Muller-Busch, Andres, and Jehser (2003) provide a similar breakdown as Morita et al. (2003).

6. For instance, see Cowan and Walsh (2001), Loewy (2001), Boyle (2004), and Battin (2008).

7. Referring to an action as a “last resort” needs further clarification. For patients in a setting that does not legally allow PAS/E, CSD can be seen as a “last-resort” option. For those choosing CSD in a setting that also allows for PAS/E, it may be that CSD is thought to be one step removed from the “last resort” of PAS/E. Insofar as it can be shown that there are no significant differences between CSD and PAS/E based on necortical death, as this article purports, both ultimately turn out to be last-resort options.

8. For the entire case, see Lo and Rubenfeld (2008, 1810).

9. The term “refractory” is used to describe a situation in which it is not possible to alleviate patients of their symptoms other than through heavy sedation (or death).

10. Sleeping produces dream states, and a locked-in patient is still conscious of his/her environment—neither occurs for patients put under benzodiazepine derivatives like midazolam.

11. Singer defines what I refer to here as experiential death as follows: “Since the unconscious patient has no experiences at all, and does not recover consciousness before dying, the hedonistic utilitarian will judge terminal sedation as identical, from the point of view of the patient, to euthanasia at the moment when the patient becomes unconscious. Nor will the preference utilitarian be able to find a difference between the two states . . . .” (Singer, 2003, 537).

12. The choice Meryl Streep’s character is forced to make by a Nazi guard in the film Sophie’s Choice between sending either one or both of her children to their death epitomizes the devil’s choice.

13. Patients who are temporarily unconscious are certainly alive, even though they may have no biological reaction to stimuli. The point here refers to patients who have permanently lost consciousness, although they still may be able to react to stimuli.

14. Studies regarding the viability of skin from cadavers used for burn victims indicate that skin can be taken up to as much as 17 hours after death (Vasiliev et al., 2002).

15. Several aspects of this argument against the relevance of reversibility were offered to me by Joseph P. DeMarco of Cleveland State University.

16. P. Lee and R. George argue that the moral worth of a human being rests on a personhood status that need not be tied to consciousness (Lee and George, 2008, 173–93). Double effect is relevant to CSD according to this argument. The thesis being defended in this section calls this line of reasoning into question, making double effect irrelevant.

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