

Death

# Forms of Cognitive Disability

**Locked-In Syndrome:** the level and content of consciousness may be normal, but the patient is so severely paralyzed that the patient may appear to have diminished or no consciousness.

**Dementia:** involves a progressive loss of cerebral functions. The most common form of dementia is Alzheimer's.

**Persistent Vegetative State:** generally involves no brainstem damage, allowing the eyes to open and close in apparent sleep cycles. Because the patient's gag and cough reflexes are intact, long-term survival is common.

**Comatose:** involves some brainstem damage resulting in permanently closed eyes and no or little gag and cough reflex; the latter makes long-term survival unlikely as it makes the patient highly susceptible to respiratory infections.

Permanently  
Unconscious

**Whole Brain Death:** The patient's brainstem (necessary for basic physiologic activities like respiration) is destroyed, as well as the cerebellum (necessary for thinking and conscious experience), and the patient will die unless kept on a respirator.

# When Are We Dead? (1/4)

**Pulmonary death:** Cessation of breath (as seen in movies: the inability to fog a mirror).

**Cardiac death:** used in the **Pittsburgh Protocol**

**Whole brain death:** as defined by the **Harvard Criteria**

**Higher brain death:** brainstem intact, but conscious thought no longer possible.

Death of what or whom?

- an organism?
- a person?

# When Are We Dead? (2/4)

A set of criteria for determining whether a person is dead was developed in 1968 by the *Harvard Ad Hoc Committee on Brain Death*.

**Brain death** requires an irreversible cessation of the functions of the entire brain (or “whole brain death”), including the brain stem, as indicated by a number of tests that show:

- Unreceptivity and unresponsiveness
- No movement or breathing
- No reflexes
- Flat electroencephalogram

In addition, the body temperature must be  $\leq 32^{\circ}$  C and there cannot be a presence of any central nervous system depressants. If there is no change after 24 hours, the person can be declared dead.

# When Are We Dead? (3/4)

A set of criteria for determining whether a person is dead was developed in 1990 at the University of Pittsburgh to facilitate organ donation (the so-called **Pittsburgh Protocol**), as noted below:

In the Pittsburgh program, a respirator-dependent patient who has previously agreed to forgo life supports and donate vital organs is taken to an operating room and disconnected from the respirator, leading predictably to cardiac arrest. Two minutes after cardiac arrest, the patient is declared dead on the basis of the cardiopulmonary standard: “irreversible cessation of circulatory and respiratory functions.” This procedure allows organ procurement to commence very shortly after cardiac arrest, providing relatively fresh organs for transplant. [DeGrazia, “Definition of Death” (SEP)]

# When Are We Dead? (4/4)

**The Uniform Declaration of Death Act (1981)** was approved by the American Medical Association and the American Bar Association (and since been adopted by all fifty states). It offers two criteria for legally declaring a person dead:

- (1) Irreversible cessation of circulatory and respiratory functions; or
- (2) Irreversible cessation of all functions of the entire brain, including the brain stem.

# Euthanasia and Assisted Suicide

# Euthanasia

- From the Greek *eu-* (good) and *thanatos* (death).
- The deliberate hastening of a person's death, normally done because the person is suffering from an illness that is both (1) incurable and (2) overly burdensome (either present and anticipated pain/suffering or anticipated mental debility).
- Active vs Passive (= commission vs omission)
- Voluntary vs Nonvoluntary vs Involuntary
- Assisted Suicide vs Euthanasia
- Withholding vs Withdrawing Treatment: Quinlan
- Principle of Double Effect: Conjoined Twins Gracie and Rosie [Intended vs Permitted (= direct vs indirect)]
- Proportionality (extraordinary treatment): Conroy, Schiavo



# Death and Moral Distinctions

## Commission vs Omission

(Active) Killing vs Letting Die (The Baby in the Lake; Trolley)

Withdrawing vs Withholding Treatment (Karen Quinlan)

... Ordinary vs Extraordinary Treatment (Claire Conroy)

... Futile Treatment: when it brings no clinical benefit.

## Intending vs Permitting

Direct vs Indirect Killing: The Principle of Double Effect

An action with a foreseeable and evil consequence is still **permissible** if:

- (1) the act is good in itself or at least indifferent (nature of the act)
- (2) only the good consequences of the act are intended (intention)
- (3) the good consequences are not the result of the evil (means and effects)
- (4) the good consequences are commensurate with the evil (proportionality)

# Euthanasia: passive vs active

**Passive euthanasia:** brought about by withholding some life-saving treatment (e.g., withholding a life-saving transplant, or hemodialysis, or failing to intubate, or give antibiotics, or administer CPR, or give food or water — the range here is quite wide, from the extraordinary to the ordinary).

**Active euthanasia:** brought about by actively killing the patient, most commonly by giving an overdose of a sedative or painkiller.

Callahan argues that these are **not** morally equivalent, and that to claim they are is to confuse causality (the direct physical cause of death) and culpability (moral responsibility). What does he mean by this? Do you agree?

# Ways to Hasten Another's Death

	The death is...	Voluntary	Non-Voluntary	Involuntary
Active ("killing")	Intended	Debbie Dr. Quill	Dr. Kadijk and Baby Doe	(homicide)
	Unintended (foreseen?)	(e.g., pain management with opiates)		(involuntary manslaughter)
Passive ("letting die")	Intended	Perlmutter Bouvia	Quinlan Cruzan	(criminal negligence)
	Unintended (foreseen?)	(e.g., not intervening medically on grounds of proportionality)	Saikewicz Conjoined Twins	(routine avoidable deaths)

**Voluntary:** with consent

**Non-Voluntary:** with implicit consent

**Involuntary:** against consent (*not* euthanasia)

# Assisted Suicide vs Euthanasia

**Assisted Suicide:** one assists the patient in committing suicide.

**Active Euthanasia:** one acts in some way to hasten the death of the patient.

**Passive Euthanasia:** one allows the patient to die (rather than acting to save the patient).

Physician assisted suicide is **legal** in some states and countries (see next slide).

Euthanasia remains **illegal** in the US and in most other countries, although passive euthanasia is widely practiced (DNR orders, etc.) and active euthanasia (such as dosing pain killers that inhibits respiration) is not uncommon.

# Physician Assisted Suicide (PAS)

**AMA Code of Ethics:** “Physician-assisted suicide occurs when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).”

**PAS is legal** in **Oregon** (Nov. 8, 1994), **Washington** (Nov. 4, 2008), **Montana** (by court ruling, Dec. 31, 2009), **Vermont** (May 20, 2013), **California** (Oct. 5, 2015), and **Colorado** (Nov. 8, 2016), as well as in several other countries (**Belgium**, **Germany**, **Luxembourg**, **the Netherlands**, and **Switzerland**).

# Physician Assisted Suicide (PAS)

## Standard Legislation

The patient must:

- Be a legal resident of the state
- Be 18 years of age or older
- Be mentally competent
- Have six or fewer months to live
- Make two separate oral requests (at least 15 days apart)
- Make one written request
- Obtain confirmation from a second physician of the terminal diagnosis and mental
- Be informed of alternatives to suicide, such as palliative care (hospice, pain-management)

# Supporting Moral Principles

- (1) **Autonomy**: The principle of autonomy (that we should respect the capacity of individuals to choose their own vision of the good life) held very little sway until about 200 years ago, but now it counts as one of our central moral principles.
- (2) **Beneficence**: Minimize suffering of the patient (Quality of Life arguments).

## A few worries...

- (1) **Religious**: “One must not knock on God’s door unbidden.”
- (2) **Sanctity of Life**: PAS/euthanasia may coarsen our view of life.
- (3) **Professional prohibitions** against ending life.
- (4) **Coercion** of vulnerable populations.
- (5) **Failure to “make life worth living”** for the sick and disabled.



# Principle of Double Effect

A doctrine in the **natural law** tradition that places the following restrictions on the permissibility of an action when some of the foreseeable consequences of the action are evil:

- (1) the act is good in itself or at least indifferent;
- (2) only the good consequences of the act are intended;
- (3) the good consequences are not the effect of the evil; and
- (4) the good consequences are commensurate with the evil consequences.

# Respect for Persons

**Respect for Persons** is commonly understood as the basis of four other principles:

- Autonomy
- Veracity
- Fidelity
- Avoidance of Killing