The Last Sweet Murmurs of the Dead:
Should a physician aim at relieving suffering by rendering a patient unconscious until death?

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Problematics

- The shades of sedation
  - The classical practice of double effect palliation
  - The introduction of "terminal sedation"
  - Replaced by "palliative sedation"
  - Sedation in the imminently dying
  - "Proportionate palliative sedation"
  - "Sedation to unconsciousness"

- "Existential suffering" as an indication

Necessary preliminary discussion

- Suffering
- Meaning and value of human consciousness
- Philosophy of medicine
  - The norms of therapeutics
- Different kinds of intentions
- Rule of double effect

Suffering

"The suffering intrinsic in animal existence is…not primarily that of pain (which is occasional and a concomitant) but of want and fear—i.e.—an aspect of appetitive nature as such."

-- Hans Jonas

The Phenomenon of Life

Two Types of Suffering

Neuro-cognitive

Agent-narrative

Jansen & Sulmasy, *Theor Med Bioeth* 2002; 23:321-337

Neuro-cognitive suffering

- occasioned by physiological disturbances or disruptions in physical integrity
- e.g. – pain, depression, delirium, nausea, seizures, etc.

Agent-narrative suffering

- occasioned by disturbances in one's sense of agency, narrative history, or relationships with other persons
- e.g. – loneliness, alienation, rejection, guilt, despair, doubt, self-hatred.

CONSCIOUSNESS

Human Consciousness is a Higher Order Human Good

- Not a transcendental good, like life itself, but:
- Consciousness is integral to the flourishing of human beings as the kinds of things that they are:
  - rational, affective, social, aesthetic, worshipping, free, etc.
- Consciousness is necessary for human beings to do good to others:
  - Spouses, parents, teachers, health professionals, etc.

Natural diminutions in consciousness

- Sleep – a temporary restorative diminution in consciousness
  - Necessary for effective consciousness
  - Never "unarousable" – a survival disadvantage!
- Fatigue – a symptom of stress or lack of sleep

Aiming at diminished consciousness

- Natural – to aim to sleep
  - Temporary
  - Restorative
- Medical – to aim to reduce consciousness to carry out a procedure
  - Temporary
  - Part of a restorative plan
- Human beings do not typically aim, benevolently, at permanently diminishing their own consciousness or that of others
- Human beings do not aim at a temporary state of unconsciousness in order to dissociate themselves from their suffering unless afflicted with a psychiatric disorder such as substance abuse

Consciousness is a good for dying persons

- Maintaining some control – attributed dignity
- Participation in medical decision making
- Spiritual issues
  - Meaning & hope
  - Value & intrinsic dignity
  - Relationship & reconciliation
- Byock – opportunities for growth at the end of life
- The dying as teachers: lessons for those who survive them

Immortal Love

The healing of His seamless dress
Is by our beds of pain;
We touch Him in life's throng and press,
And we are whole again.

Through Him the first fond prayers are said
Our lips of childhood frame,
The last low whispers of our dead
Are burdened with His Name.

O Lord and Master of us all,
Whate'er our name or sign,
We own Thy sway, we hear Thy call,
We test our lives by Thine.

John Greenleaf Whittier

Punch Line: Consciousness & care at the end of life

- Because it is a human good, one ought not intend to diminish a patient's conscious continually until death
- Might accept unconsciousness as an unintended side-effect for a very serious reason(s)
- Might be acceptable in extremely rare cases if symptoms have already effectively usurped the patient's consciousness

THE PHILOSOPHY OF MEDICINE: THERAPEUTICS

How Does Medicine Accomplish Its Therapeutic Ends?

- "Meta-rules" for therapy
- "Canons of therapy"
  - Proportionality
  - Parsimony
  - Restoration
  - Holism
  - Discretion

Canon of Proportionality

- The therapeutic response must "fit" the disease
- Both "means-end" & "benefit-burden" proportionality
  - Means-end—i.e.—butter knife for surgery
  - Benefit-burden—i.e.—interferon for a cold

Canon of Parsimony

- Do not use more therapy than is necessary
- Paracelsus—
  - All medicines are poisons. Therapy is a matter of dose.

When therapy goes awry, most often

"… it would not be because physical force or power was lacking or too little was exerted, but rather because there was actually too much force in play. But when the act works, suddenly everything seems to happen spontaneously, lightly and effortlessly. … Genuine success is accomplished in medical practice at just that point where intervention is rendered superfluous and dispensable. All medical efforts at healing are already conceived from the outset in light of the fact that the doctor's contribution consummates itself by disappearing as soon as the equilibrium of health is restored."

--Hans Georg Gadamer
The Enigma of Health

Canon of Restoration

- Therapeutic acts must have one of two intentions:
  - To restore right relationship completely (cure), or
  - To restore incompletely so as to mitigate suffering (relief or comfort).
- Right relationships are sometimes disrupted therapeutically, but either:
  - temporarily with a further intention of overall improvement
    - e.g. – bone marrow ablation before transplant

Canon of Holism

- A corollary of Restoration
- Normal parts may be permanently removed or functions permanently suppressed only for the sake of the overall survival or flourishing of the individual
  - e.g. – amputation of a gangrenous limb

Canon of Discretion

- Good therapy is also respectful of the limits of medicine
- Indiscretions of degree
  - Overestimate the power of medical therapy
- Indiscretions of scope
  - Expansionist view of medicine's discretionary space
  - "In this school, children are either gifted or on Ritalin"
- Indiscretions of expertise
  - Expansionist views of one's own expertise
  - "I can handle this without a referral"

Restoration, means-end proportionality, and discretion in action…

"Before we try assisted suicide, Mrs. Rose, let's give the aspirin a chance."

Two aspects of intention

- Intention-in-acting
  - End of the act
  - *finis operis*
  - When is the end of the act achieved?
  - Conditions of fulfillment of one's intention
- Further intention
  - End of the agent
  - *finis operantis*
  - Often the ultimate purpose or motive for acting

THE RULE OF DOUBLE EFFECT

The Rule of Double Effect

1. All reasonable alternatives have been exhausted
2. One action, two effects
3. Act itself is good (or at least indifferent)
4. One effect is bad, the other is good
5. The good effect is the end of the act, not the end of the agent
6. These good and bad effects are not mediated by intervening agents
7. One foresees the bad, but only intends the good
8. The bad is not the means by which the good is accomplished
9. The act is proportionate
   - Means to end
   - End to end (effect to effect)

Foundational premise: medicine does not radically change its aims and methods in palliative care

- The nature of human suffering does not change
- Consciousness is no less a human good
- The goals of medicine remain the same:
  - Cure sometimes
  - Relieve often
  - Comfort always
  - Tempered by clinical reality and the art of the possible
- The rules governing therapy do not change
  - Governed by the Canons of Therapy
  - Tailored to clinical reality and realistic goals
  - Informed by the Rule of Double Effect

All the real problems in EOL care come from failing to follow the basic rules of therapy

- Overtreatment
  - Disproportionate (burdens vs. benefits)
  - Non-parsimonious (too much drug)
  - Indiscretion of degree (failure to recognize limits)
- Inadequate symptom control
  - Ignorance of double effect
- Inattention to agent-narrative suffering

Suffering, End-of-Life Care, and the Canons of Therapeutic Responsiveness

- What should medicine do in end-of-life care?
- What medicine ought to do in all cases:
  - Recognize all the types of suffering occasioned by the patient's condition
  - Respond appropriately
  - Obey the canons of therapy

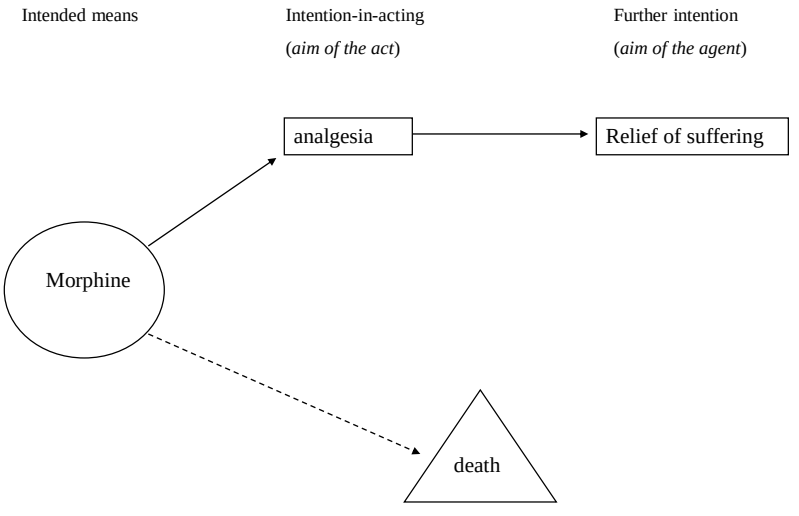


Fig. 1. Double Effect and Morphine: the Standard Case

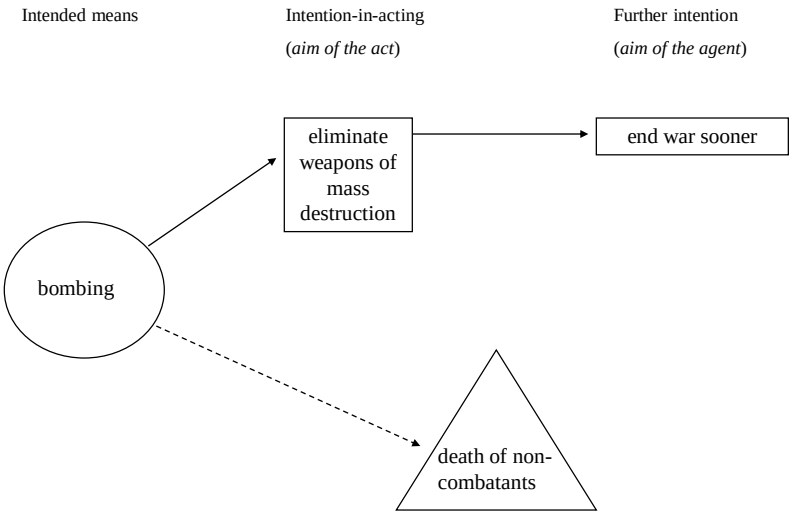


Fig. 2. Double Effect and Strategic Bombing: the Standard Case

Classical Practice: Double Effect Sedation

- Sedation as an instance of Double Effect
- Must use an appropriate agent for an appropriate symptom (means-end proportionality)
- Intention must be relief of symptom(s)
- Unconsciousness is a foreseen but unintended side-effect
- Patient is close to death

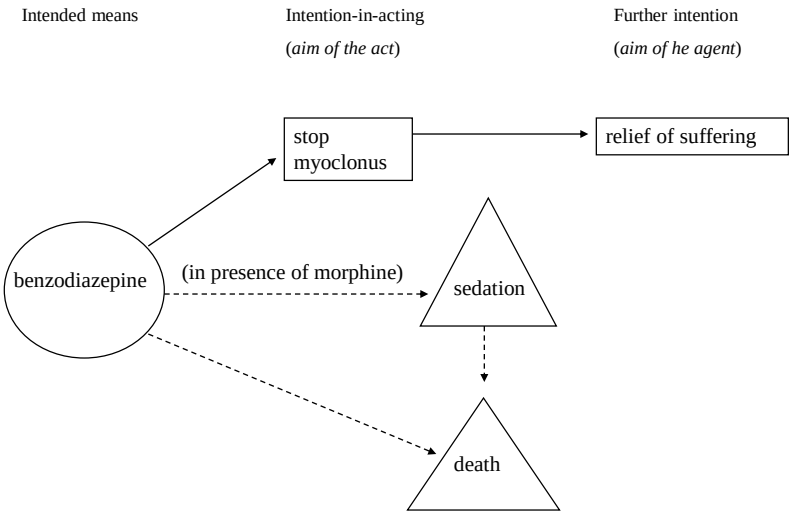


Fig. 3. Why the Intentional Structure of the Classical Practice of Sedative Palliation *is* an Application of Double Effect

What if one says that:

- I *do* intend the sedation
- But I only intend that the sedation relieve suffering
- I do not intend the unconsciousness that could follow sedation
- I do not intend the death that is a side-effect of the sedation and unconsciousness
- Quill, Brock, and Meisel call this "Proportionate Palliative Sedation" and claim it is justified by the RDE
- I call it "Parsimonious Palliative Sedation" and will show that it is not justified by the RDE, but the Canon of Parsimony

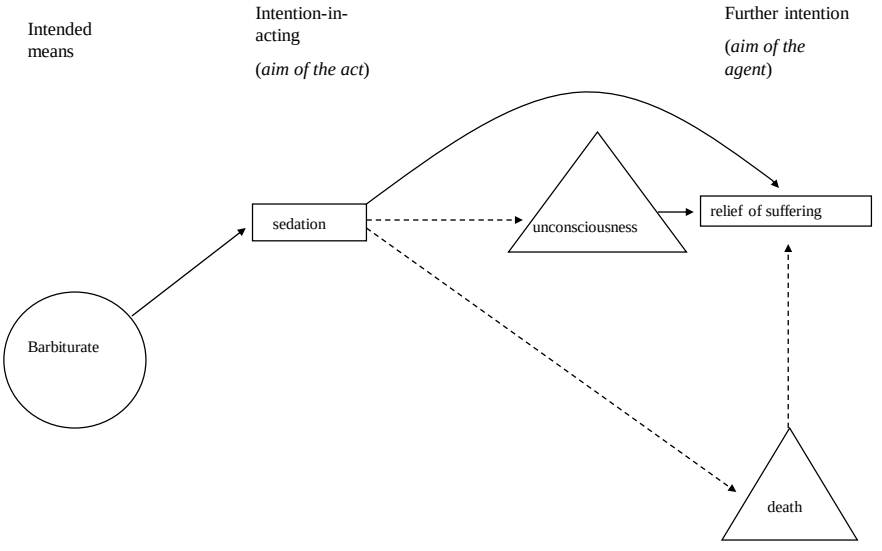
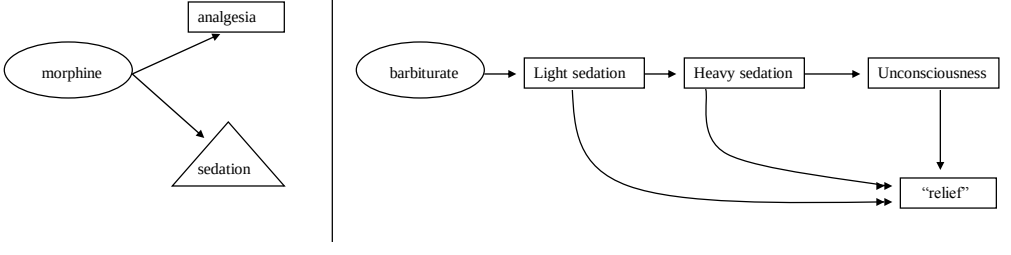


Fig. 4. Intentional Structure of Parsimonious Direct Sedation ("Proportionate Palliative Sedation")

= intended = unintended

Fig. 5. Problems with "proportionality"

- "I intend sedation, not unconsciousness" -- a causal continuum, not a causal fork
- Not two different means to be considered in proportion to the intended effect
- Not two different effects
- But "Graded Sedation" -- various degrees of the same effect
- Not "Double Effect" – there really aren't two effects
- Confuses the Canon of Proportionality with the Canon of Parsimony



Counterargument: it is not bad to aim at diminished human consciousness

- Permanent vs. temporary
- Restorative vs. non-restorative
- Anxiolytic drugs & anti-epileptics (& others)
  - Effect is to diminish neuro-excitation
  - Therapeutic effect is restorative
    - Hyper-excitation of anxiety restored to normal
    - Hyper-excitation of seizure restored to normal
    - Sedation is a side-effect
    - To aim for more depression of neuro-excitation than is needed to return to normal suggests abuse

New Practice: Sedating to Unconsciousness and Death (STUD)

- Proposed by Quill, Brock, and Meisel
- Netherlands:
  - Euthanasia = 5%
  - "Palliative Sedation" = 18%

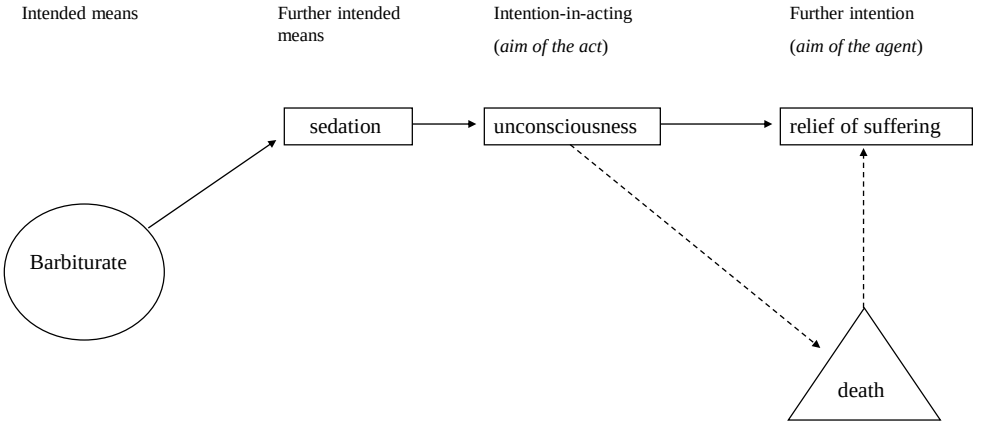


Fig. 6. Why the Intentional Structure of the new Sedation to Unconsciousness and Death ("Palliative Sedation to Unconsciousness") *is not* an Application of Double Effect

Problems with aiming at unconsciousness

- Aim is unconsciousness, which is a harm
- Unconsciousness and hastened death are not side-effects, so not double effect
- They are caused by achieving one's intention-in-acting rather than by the means one has chosen
- So a contradiction ensues:
  - No longer can say, "healing with harmful side-effects"
  - But "harming is healing"

Moreover, Sedation to Unconsciousness and Death (STUD) Violates the Canons of Therapy

- Violates the Canon of Restoration
- Violates the Canon of Parsimony if less drug would suffice

All suffering is not the same

- The "taxonomy" of suffering
  - Neuro-cognitive
  - Agent-narrative
- Physicians have responsibility for recognizing both and responding to both
  - Subject to the Canons of Therapy

Sedation for agent-narrative suffering: why is it wrong?

- Not parsimonious if less drastic measures suffice
- Means-ends disproportionality – the means are inappropriate for the symptoms
- Denies medicine's restorative goals – aims at diminished consciousness when spiritual and existential restoration and growth demand consciousness
- Indiscreet: the function of medicine is not to relieve the human condition of the human condition

One exception

- Suppose someone's pain were refractory to all treatment yet still conscious
- So severe as to have effectively "colonized" the patient's consciousness
- Robbing the patient of any of the possible goods of consciousness such as saying good bye, reconciliation, prayer, etc.

A Forced Choice Situation

- If one can argue that the patient has already effectively *lost* consciousness due to a symptom
- No intervention short of unconsciousness will relieve that symptom
- So that the patient either:
  - Dies with the symptom + without effective consciousness
  - Or, dies without the symptom + without effective consciousness
- Then sedation aiming at unconsciousness could be justified
- Only for neurocognitive, not agent-narrative distress

Extremely rare

- An example:
  - Opioid induced hyperalgesia
  - Giving more opioid makes pain worse
  - Not responding to change in opioids or adding adjuvant drugs
  - Proportionate sedatives not effective
- Likely no more than one per year for a full time palliative care or hospice physician

Conclusions

- Double effect sedation (DES)
  - common and good
- Parsimonious palliative sedation (PPS)
  - common and good
- Sedation to Unconsciousness and Death (STUD)
  - merely a form of slow euthanasia & wrong
- Sedation for agent-narrative (existential) suffering
  - violates canons of therapy and is the wrong approach
- Possible exception
  - Extremely rare
  - Consciousness already "lost" to a neurocognitive symptom
  - No lesser means will work