

What and When Is Death?

Abstract This chapter is one of two conceptual chapters that set up the analytical foundation for the remaining empirical case studies which are mainly historical in character. The first chapter focuses on the question: what is death? The secondary question: when death occurs, depends on what we think death is. This chapter addresses a number of questions: What and when is biological death? Can biological death be understood as an absolute state and/or is it partially present in the process of dying? What is social death? When is social death co-terminus with biological death? When is it not? How can we characterise the meaningful similarities and differences between biological and social death? Why should this matter?

Keywords Biological and social death · Real and symbolic change

BIOLOGICAL DEATH

The commonplace notion of death is to characterise it as an end state: being dead. Nevertheless being dead is not the same as the event of death or the dying process (Scarre 2007, p. 5). Biological death can be understood as:

1. A final event.
2. An absolute state (being dead).

3. Part of the dying process.

Defining Death

The absolute state of being dead is synonymous with the idea of medical death. The definition of being dead, as proposed by the US President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research set up by Ronald Reagan (1981), is when:

...an individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. (Leming and Dickinson 2002, p. 43; Scarre 2007, p. 6)

Death: Absolute State, Final Event and Process

The difficulty with the above definition is capturing the irreversible final moment of death. It is worth critically interrogating both clauses of the above definition.

Clause (1) does not accurately capture the timing of the final biological death event. That is to say, irreversible and irreparable damage to heart and lungs will quickly and inevitably lead to entire brain death, but it is not quite synonymous with that final event. There is a time interval in which the brain is dying because of lack of a supply of oxygen-rich blood to keep it alive, at which point the human brain is dying but not yet dead (Scarre 2007, p. 6).

Clause (2) points to the timing of the final event. The certitude around entire (whole) brain death follows from a clinical assessment of total brain failure. However, the assessment of total brain failure has courted controversy.

The neurologist Alan Shewmon is a leading critic of equating total brain failure with human death. Shewmon identified many cases of patients who were diagnosed with total brain failure that nevertheless ended up surviving. Shewmon collected 175 case reports of patients that had survived against the odds, and whose bodies had stabilised long after the period accounted for by current literature on 'brain death'. The length of patient survival varied from a month to a year and even, in the exceptional Florida Boy Case, 14 years (Rubenstein 2009, pp. 37–38).

In certain cases, therefore, it may be possible to try to artificially sustain a body after so-called total brain failure has been diagnosed. As such, it is possible to distinguish total brain failure from chronic brain death.

Shewmon's arguments have thrown significant doubt over associating death with total brain failure.

This is illustrated in the famous Florida Boy Case. The boy survived for 14 years in an Intensive Care Unit (ICU) after an initial diagnosis of total brain failure. Following his parents' wishes, the boy was artificially ventilated, fed and hydrated in hospital, by which time his body had grown, recovered from wounds and even parts of his brain had become replaced 'by ghost-like tissues' (McMahan 2002, cited in Scarre 2007, p. 7).

The Florida Boy Case has shown that establishing death may be less about precise diagnosis of the brain state and more about understanding the resilience of the human organism as a whole. In other words, the Florida Boy's resilience was tied up with what Shewmon calls the organism's ability to function as an 'emergent property of the whole' (Rubenstein 2009, p. 38). This fits with what Aristotle calls '*entelechia*', his ancient term for the soul, which has biological connotations with what Joe Sachs has translated as the organism 'being-at-work-to-stay-itself' (cited in Rubenstein 2009, p. 41).

Chronic brain death, where a patient may continue to exist in a permanent vegetative state (PVS), is a notion that only shows up as mattering in the highly advanced technical environment of ICU where specialist clinicians can artificially hold medical death at bay. Arguably then a diagnosis of total brain failure (or indeed chronic brain failure) is:

...perfectly correlated with the permanent cessation of functioning of the organism as a whole because the brain is necessary for the functioning of the organism as a whole. It integrates, generates, interrelates, and controls complex bodily activities. A patient on a ventilator with a totally destroyed brain is merely a group of artificially maintained subsystems since the organism as whole has ceased to function. (Bernat, cited in Rubenstein 2009, p. 36)

To conclude, 'life' after extensive brain death is an ambiguous state, one where precise terms are necessary to establish what exactly a human life is constitutive of.

A philosopher that is clear about what *bare* life entails is Leon Kass. He describes life at its most basic as a ‘series of preconscious needs.’ From Leon Kass’s book *The Hungry Soul* (1994):

What moves an organism to feed is not merely the sensed and registered presence or absence of a certain chemical or edible being in its environment but the *inner needy state* of the organism, for which such an absence is a lack, an absence to be overcome and remedied... The organism would not ‘respond’ to perceived food ‘stimuli’ were it not ... ‘appetitive’ being ... internally ordered toward the necessary activities of self-nourishing. (Leon Kass, cited in Rubenstein 2009, p. 43)

As the Florida Boy Case illustrates, the organism as a whole retains a pre-conscious and ‘inner needy state’ for basic appetitive functions. That is, the need for air, hydration and nutrition. This inner state of neediness is met at the threshold of life in ICU, where the organism is not only maintained but even grows, adding to the illusion of recovery.

What and when is death here? It depends on one’s perspective of life.

From an understanding of *bare* life, the Florida Boy was a biologically living, growing organism with pre-conscious needs and an inner needy state. From the perspective of a living *person*, the Florida Boy is likely to have died well before his parents projected their hope on to his recovery.

To elucidate further, patients in the UK, who remain comatose and unresponsive and who have made no significant recovery after 12 months from a serious brain injury of this sort, are categorised as being in permanent vegetative state with a statistically improbable chance of recovery (<http://patient.info/doctor/vegetative-states>).

What is surprising in the Florida Boy Case is how he survived in ICU for 14 years. The ambiguity of his state of existence was probably obscured within the ICU environ. Steps may have been taken to establish how he may have fared without a ventilator, establishing whether or not the boy’s brain had the necessary integrative function to sustain autonomous biological life beyond life support. This throws up another distinction: between *bare* life in the technological setting of intensive care and the *bare* life of a deeply brain-damaged individual who may survive for years afterwards with constant care from family and social care professionals.

In the case of bare life the patient can be described as *already* being in a state of ‘techno-death’, where machines, like ventilators, take over from biological sub-systems that have permanently and irreversibly failed.

Some thinkers regard the neurological standard of whole-brain death to be unnecessarily restrictive (e.g., Green and Wikler 1980). Even if a body could survive technologically unaided, ‘neocortical’ (or ‘higher’ brain) death may have occurred anyway, meaning that what remains is a severely mentally and physically disabled individual whose personhood is barely recognisable.

Personhood is characterised by having the mental capacity to be self-aware, communicate with others, and self-create a meaningful life. Once that is gone it is difficult to relate to that human being in the same way. The person who one may once have known has died, presenting the challenge of forming an altogether different relationship with another being. Again the Florida Boy provides an example: while his *autobiographical* life as a *person* was over, destroying who he had been, his *biographical* life was sustained through the narratives of hope his family harboured in his recovery.

Death as Change—A Historical Long-View

The conundrum of understanding biological death is not a new one. It has a long historical root. This is evident in how medical men of the past understood death as both a *state* and a *process*.

Hurren (2013a,b) reminds us of the work of Dr Philips. Dr Philips, in a paper given to the Royal Society in 1834 called *The Nature of Death* describes death in two ways: ‘the name of death’ where ‘sensorial, nervous and muscular systems’ were in the process of shutting down. This is roughly equivalent to what we may understand today as a ‘living death’, inimitable within the process of dying. Philips contrasted this process with a permanent physiological shut down or ‘absolute death’ (e.g., Philips 1834, cited in Hurren 2013a,b).

Moreover, the idea that dying was sometimes reversible was demonstrated through very early resuscitation techniques. Indeed as early as the 1760s, there were mechanical ways to resuscitate dying persons through artificial respiration in the case of drowning. By 1796 the London Humane Society, for example, claimed to have resuscitated over 2000 people (Hurren 2013a).

Our understanding of the state and process of death has greatly evolved, partly as result of a more sophisticated understanding of brain death in the twentieth century, and partly as result of more advanced resuscitation techniques pioneered by Peter Safar’s ABC of

cardio-pulmonary resuscitation (CPR), which are now standard practice in emergency medicine (Acierno and Worrell 2007).

Today we have a nuanced understanding of the process of dying, which in its crudest form may be subdivided into roughly six categories:

- Reversible and natural. For example, death may be part of the natural cycle of regenerating the body;
- Irreversible and natural. Death, for example, is part of ageing;
- Reversible and catastrophic. Having a cardiac arrest is reversible, in that the patient can be resuscitated. At this point the patient may be described as clinically but not medically dead;
- Irreversible, catastrophic and unambiguously fatal. Total brain failure that is not redeemable in an ICU environment and is characterised as medical death;
- Irreversible, catastrophic and survivable if technologically aided. Serious brain injury may not necessarily be fatal—persons affected by serious brain injuries survive and sometimes make remarkable recoveries in ICU;
- Irreversible, catastrophic and survivable if technologically unaided. Survivors of major brain injuries that eventually make it out of ICU may be severely mentally and physically disabled requiring life-long support and care. Those who survive the initial crisis and are eventually discharged from ICU and hospital care may have personalities that are barely unrecognisable from before.

A More Conceptual View of Death

On a more conceptual level, death may be theorised in the following ways:

- as a form of change;
- as a particular kind of personal identity.

Death as Change

Geatch (1969) distinguishes between *Oxford* and *Cambridge* changes, characterising Oxford changes as real changes in the intrinsic nature of things and Cambridge changes as relational changes that happen as a consequence of real changes (e.g., Lowe 2002).

Death therefore, takes on a dual aspect: a biological and social aspect. If biological death can be understood as a *real* change in the intrinsic matter of biology, then social death, by contrast, is a relational or narrative change that happens as consequence of real changes in the intrinsic nature of biological materiality.

So, if Maud suffers a brain injury and she is left in a permanent vegetative state, then as a consequence of real changes in the intrinsic property of her brain she will have undergone an irreversible form of biological death. Now a real change in the intrinsic integrity of Maud's brain will result in a relational or narrative change in who we understand Maud to be after her brain injury. Maud might be in a permanent vegetative state (PVS), in which her brain that is responsible for her personality has died before the rest of her body has.

So, implicit in the so-called scientifically neutral language of intrinsic changes in biological properties of her brain, there is also a 'narrative' understanding about who remains. In this way social death is already inextricably linked with biological death.

SOCIAL DEATH

Social death is a relational or narrative change in the meaning of a human life. It involves a change in the narrative identity of persons that either *still* exist or have *once* existed.

Narrative Identity

One way of conceptually fleshing out the difference between social and biological death is to think through two senses of personal identity.

Paul Ricoeur (1992) reminds us that Latin has two meanings for the word identity: identity understood as 'being the same' (*idem*), usually interpreted as the question 'what am I?'; and 'oneself as the self-same' or 'self-constancy' (*ipse*), understood in the question 'who am I?' (e.g., Simms 2003, p. 102).

Now biological death primarily concerns *idem* identity, where death marks a real change in the intrinsic properties of 'being the same' biologically.

Moreover, the death of 'what I am' (*idem*) is inextricably linked to being able to self-configure the story of one's life. In short, the physical end of 'what I am' as a living person spells a particular kind of social death: the autobiographical death of one's narrative identity.

Traditional definitions of medical death are unambiguous, describing a final event that leads to the absolute state of being dead—in which case the biological death of a human being (*idem* identity) is co-terminus with the social death of the person (*ipse* identity).

The biological death of a person has narrative consequences in how we may configure personal identity. In the most formal terms this involves correct signification. Being dead signifies a corpse, a state of non-being, for which the personal pronoun in the phrase ‘I am (a corpse)’ is no longer correct. A corpse refers to a husk, and a husk is no longer a person that actively possesses a body. Furthermore, physical death has relational consequences for others. My death, for example, would mean that my wife would undergo a relational/narrative change: that is, my wife would become a widow.

Social death concerns our *ipse* identity—the narrative identity of who we are. While social death is dependent on having existed, it is not necessarily co-terminus with existing as a biological entity.

Real changes in our biology certainly prompt relational changes in how we may configure the narratives of our lives. After a heart attack, for example, there may be a subtle shift in who we understand ourselves to be through what we believe we are realistically capable of doing. This may signal a subtle shift in our personality. Less subtly, brain injury, as argued earlier, can lead to narrative inversions in our clinical status: from a living person that is self-conscious and aware of others, to a living human organism which in PVS is not conscious in this way.

A relational change in the meaning of who a person is has both an existential as well as a biological dimension. The narrative of who we are is *existentially anticipated* in the face of our physical mortality. We existentially configure the meaning of our lives in anticipation of our physical death. This has a secular and religious dimension.

In secular terms the meaning of our life matters beyond its physical annihilation. For example: we might suffer a serious brain injury that marks our autobiographical death destroying our dignity; we reasonably anticipate being respectfully treated and honestly remembered after our physical life has ended.

In spiritual/religious terms we may anticipate who we are and how we might continue in a life hereafter. If one believes that how we treat mortal remains matters for a disembodied life hereafter, then the burial rituals associated with keeping the corpse intact take on a special ‘narrative’ significance.

The narrative identity of the dead is also *refigured* by others who survive them. The narrative identity of the dead is refigured for good and ill through memory and biography by those who survive the deceased. Informally, we are remembered by family and friends, while formally we may be remembered through the social impact of our past actions. In short, who we are survives our physical death in narratives of remembrance.

Similarity and Difference: Biological Versus Social Death

There are both fundamental similarities as well as underlying differences when comparing social with biological death.

- Biological and social death both involve change.

However, how we understand ‘change’ differs in each case. Biological death involves understanding *intrinsic* or *real* changes to the material what-ness of existence, whereas social death involves an understanding of *narrative* change of who we are.

- Biological and social death depend on an existence condition. Death is unintelligible without ever having existed, or never having changed.

How we interpret the existence condition is different depending on context; that is, it has different meanings in the context of biological and social death. Biological existence primarily concerns changes in the material what-ness of life. In the case of social death however, existence primarily concerns a narrative self-constancy of who-ness over time.

Narrative identity is *not* necessarily co-terminus with physical existence; that is, a human being, either existentially anticipates and configures the meaning of who they are beyond their physical annihilation, or their narrative identity changes through its refiguration by others who survive them.

- Biological and social death can be understood as a state or a process.

Being dead is a physical state to be contrasted with dying, which is a biological process. In social terms, the absolute state of being dead is the equivalent to being completely forgotten and expunged from the

historical record altogether. Moreover, the social equivalent of physically dying is being slowly forgotten, misremembered and, most damagingly of all, being harmfully remembered (disremembered). In this volume the focus is on the process of being disremembered, which is a form of social death.

- Understanding when biological death is socially contested.

Biological death is simply a value neutral intrinsic change in a person's biology. How one interprets this, however, is socially contested: what biologically dies is inextricably linked to how we interpret and value the existence of who it is that dies.

In an effort to establish formal legal clarity, standard definitions attempt to make biological death as straightforward as possible, by making it an end to an individual's life and narrative. For example, the standard definition of a person's death is of 'an individual who has sustained either... irreversible cessation of circulatory and respiratory function, or irreversible cessation of all functions of the entire brain...' (e.g., see the first page of this chapter). This is incorporated into current US law, under the Uniform Determination of Death Act (UDDA [1980](#)) and signifies being unequivocally dead.

However, in the UK legal precedents pre-empt the social death of a human being before physical biological life has actually ended. Take the example of Tony Bland.

Anthony Bland was allowed by the high court to be medically euthanised, setting a precedent for passive non-voluntary euthanasia in UK hospitals. Bland was fatally injured at the Hillsborough football stadium in 1989, developing serious injuries in the crush at the Leppings Lane terrace that caused an interruption to the supply of oxygen to his brain. As a result he was left with irreversible brain damage to the higher centres of the brain that support personhood, but the brain stem function was left intact. In short, whilst Anthony Bland wasn't strictly biologically/medically dead, the person who was Anthony Bland was dead. This led his family to petition the high court to carry out a form of passive non-voluntary euthanasia; that is, euthanising Tony Bland by withdrawing artificial nutrition and hydration. The high court ruled in favour of the family, acknowledging that it was highly improbable that Bland would ever emerge from his persistent vegetative state (known today as 'permanent vegetative state'). The court judged that passive euthanasia was

morally and legally permissible. This, the court judged was because ‘to his parents Tony Bland was dead,’ and in PVS, his ‘life was of no benefit to him as a person’ (cited in Robertson 1996, p. 723–746). In other words, the social death of Anthony Bland became the deciding factor in how to respond to the bare biological life that remained. So, in order to *redeem* the memory and dignity of who he was to his parents, it was necessary to prematurely end it.

- Only social death has a normative valence.

Biological death is an event, a fact. It carries no moral valence in and of itself. It is either a final event or it is a significant change that is already happening as part of a process of dying. How we socially interpret biological death as an event, however, is far from neutral. Biological death is narratively interpreted as ‘good’ or ‘bad’. This is because the meaning of social death has a moral valence that we project onto the physical event by way of the expectations we weave into how biological life has existential meaning for us. We might describe a ‘good’ death as one by natural causes, whereby a person dies peaceably in the fullness of time. This can be contrasted to the typical narrative of a ‘bad’ death, where a person might ‘suffer’ because they have a disease and choose to ‘fight’ for life regardless and ‘rage, rage against the dying of the light’ (Thomas 1971).

The normative valence of death as an existential challenge is not only narratively configured *before* the biological event actually takes place, it is also narratively refigured in how we are remembered by others. We hope to be well remembered or at least honestly remembered. This refiguration of our narrative existence is considered good and just. We hope not to be misremembered and certainly don’t want to be disremembered. This refiguration of who we were is considered bad and unjust.

- Social death is subject to redemption.

Death is a biological fact of the necessary impermanence of human life. In the neutral scientific language of biological changes, death may or may not be temporarily reversed, but cannot be avoided. Yet the language of medicine is laced with heroic and redemptive metaphors: doctors ‘cure’ and ‘save lives’ and are involved in medical ‘breakthroughs’ against ‘killer’ diseases.

The fight to ‘save life’ is a redemptive narrative that we project onto what is simply a value neutral biological event, where dying, biologically speaking, is either, catastrophic and irreversible, or not. In other words, there is little sense in talking about redemption in terms of death as a biological event that we will all succumb to, unless we have already added value to what it means for us to live rather than die.

The redemptive narrative of who a person was and what that means continues on after a person has ceased to physically exist. This narrative of remembering is rarely straightforward, because it involves a reconstruction of a person’s posthumous identity, which again adds an interpretive meaning about the value of a life lived. This may or may not be broadly resonant with how that person tried to live their life. If that refigurative narrative is true to the facts and spirit of a life lived, then there is a tendency to think that the deceased is well-remembered. If that posthumous narrative is deliberately harmed after they have died we tend to think of the deceased as having been disremembered.

Being historically disremembered, by being perceived as a notorious historical figure for example, may be time limited. In other words, it is possible to change our minds about whether historical figures deserve the self-same notoriety today. If this is the case then posthumous pardoning may be necessary. This, it is argued, is not so much about rewriting the past, but about re-evaluating the past in the present, where a ‘new’ narrative of forgiveness may, for moral reasons, legitimately exist alongside the notoriety of historic ones.

The Harm and Redemption of Death

The author’s main interest in the remainder of the short volume is in social rather than biological death. What follows is an examination of how narrative identity is subject to posthumous harm, punishment and redemption. In carrying this out, there is further conceptual examination of the possibility of posthumous harm and redemption.

SUMMARY

This second chapter has discussed what and when death is, conceptualising biological and social death both as a *state* and a *process*. The understanding of biological death as a process complicates what and when we understand death to be.

Death has been theorised two ways, as two forms change and personal identity. While the two kinds of death are certainly related, social death is not necessarily co-terminus with biological death. Narrative identity can both be existentially configured in advance of the physical event and/or narratively refigured by others who survive the deceased. Most importantly, social death has a normative valence that physical death as an intrinsic biological event does not.

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