Practical Viewpoint

Two concepts of death reconciled

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Introduction

The notion of death has become subject to much strain in modern medicine. Some would say that the notion has proved so muddled, that we had better give it up. Others claim that the old notion will do, only that now we can see more clearly what it really amounts to (we can ascertain whether it obtains, aided by the brain death criterion). However, there is also a third position available. We need two different notions of death, the old one cast in terms of the cessation of circulation and breath, and the new one cast in terms of brain death.

Obviously, the first option, to give up the notion as much too muddled to be of any use, is not a very palpable one. We should adopt it only as a last resort. The idea that there is only one notion of death leads to the problem *which* notion we should adopt as our one and only notion of death. Therefore, the third tack is the most promising one. We should acknowledge that there are two different notions of death. This is the tack I will take in the present paper. However, this tack is fraught with difficulties as well, or so it may seem. If we use two different criteria to ascertain whether a certain patient is dead or not, will we not end up with inconsistent judgements?

This is the main challenge to meet for the two-notion-approach. However, this challenge can be met, or so I will argue in the present paper. The two notions of death can be reconciled.

I will now briefly consider the problem with the one-notion-approach and then move on to a defence of the two-notion-approach. The main thrust of my argument is that the two notions of death, both needed in modern medicine, can be reconciled.

The one-notion-approach

The traditional criterion of death is cast in terms of the irrevocable cessation of circulation and breath. Let me refer to this as the Circulatory and Respiratory Criterion of Death or, for short, the CR-criterion.

Today, we speak also of patients whose brains have ceased to function as dead. Let me refer to this as the Brain Death Criterion or, for short, the BD-criterion. If these criteria are thought of as giving both sufficient and necessary conditions of death, they seem to conflict. Not only are they different, but they are not even extensionally the same. A patient whose brain has ceased to function, but whose respiration is supported and whose heart continues to beat is dead on the BD-criterion but alive on the CR-criterion. This seems to force us to select at most one of these criteria. But, the one-notion-approach is also fraught with difficulties, for if we are to accept only one notion of death, which one should we opt for?

This is a hard question. While one criterion seems to fit some of our purposes, the other fits other purposes. There are three situations in particular, where the criteria are of importance. It is a desideratum that a criterion of death should allow us correctly to say the following three things:

- (1) When a patient is dead (and no earlier), it is appropriate to dissect (if there are reasons to do so and no special reasons against doing so) and to bury him or her.
- (2) When a patient is dead (but no earlier), no further treatment whatever should be given (unless there are very special reasons for doing so, reasons to which I will return).
- (3) When a patient is dead (and no earlier), it is appropriate to take (vital) organs from him or her for transplantation purposes (if a previous or presumed consent has been obtained for doing so).

Now, on the BD-criterion (3) sounds perfectly reasonable, but (1) is outrageous. We do not want to dissect a patient whose heart beats and whose circulation is kept going. On the other hand, while on the CR-criterion, (1) sounds perfectly reasonable, (3) becomes ridiculous. When the circulation and respiration has stopped in an irrevocable manner, it is too late to take at least some vital organs (in particular, the heart) from

the patient for transplantation purposes.¹ On the CR-criterion, (2) seems to draw the line too late, in many cases. Why go on to give treatment to a patient, when the patient has lost consciousness and there is no hope that the patient will ever regain consciousness. Here the BD-criterion seems to be in place.

We seem to be presented with a genuine dilemma. Neither criterion satisfies very reasonable desiderata. What are we to do about the problem?

In most countries the solution to the problem has been to opt for the BD-criteria, in order to render possible transplantation surgery. The CR-criteria have been acknowledged as sufficient, of course, but not as necessary. It has been claimed that a patient can be dead in spite of the fact that his or her heart beats. No very good rationale has been provided for this option, however, other than that it is necessary if we do not want to waste lives because organs for transplantation are not forthcoming. A lot of bad arguments have been put forward in defence of the BD-criteria. Originally, it was insisted that brain death meant the irrevocable destruction of the *entire* brain, but it is clear that, considering how the diagnosis is actually being made and must be made, in the best interest of the patients who need organs for transplantation this is not quite true. Some electric processes take place in the brains of patients who have been diagnosed as brain dead and some hormones are produced by their brains.²

It has also been claimed that, even if it is possible for a very short time to keep the heart of a brain dead patient going with intensive support and a ventilator, it is impossible to do so for very long. Thus, the temporal gap between brain death and traditional, respiratory and circulatory death, is by necessity small. Even when it had become known in the scientific world that this was not true, even after it had transpired that bodies of brain dead patients could be kept alive for months, experts in committees discussing brain death publicly stubbornly cling to the opposite view as “received wisdom”. I will give just one striking example from my own country, Sweden. Only a few years ago, when a German patient, Marion Ploch, who was pregnant and diagnosed as brain dead, was kept on the ventilator in order to render possible the delivery of her child, the main Swedish experts, Professor David Ingvar and Professor Sven-Eric Bergentz, publicly repeated the myth that it was impossible through intensive care and a ventilator to keep a brain dead patient “alive” more than a couple of weeks. They suggested that media had misunderstood the situation. Marion Ploch was not really brain dead, they conjectured.³ However, she had been correctly diagnosed as brain dead (together with Swedish experts I have looked through her medical journal). This is not at all unex-

pected. As a matter of fact, there is a series of reported cases where the bodies of brain dead persons have been kept alive. For example, in a Japanese controlled experiment, some bodies of “brain dead” patients were kept alive for as long as 54 days.⁴ An American woman has even been reported to having given birth to a child 107 days after having being diagnosed as brain dead.⁵

All this has put the BD-criterion into some disrepute and people taking part in the discussion now seem prepared to return to the traditional CR-criteria. This position has, for example, been taken up by Peter Singer⁶ and has recently been defended by Robert D. Trog.⁷

Does this mean that they want to give up transplantation surgery? No, these people have adopted the reasoning that was widespread among the critics when the BD-criteria were at first suggested. Singer, Trog, and others want transplantation surgery to continue, but, they insist, it should be admitted that when organs are taken for transplantation purposes from a so called brain dead patient, the patient gets killed. This is innocent killing, however, since the patient has no further interest in his or her organs.

This conclusion is unsought for, however. As we will see below, we need not have recourse to it. If we had to have recourse to it, then probably the consequences for transplantation surgery would be devastating. It is not very far-fetched to assume that few people would consent to having their organs removed for transplantation purposes (should they come to suffer serious brain damage) if they were informed that the destruction of their brains did not mean that they were dead. Much fewer organs for transplantation would be forthcoming if society took this tack and informed people that when their organs were removed for transplantation purposes, this means that they were being killed. In particular, few organs would be forthcoming, if we were to make very strict demands on informed previous consent (in writing, say) from the relevant patients. Such strict demands seem only reasonable to make in the case of killing. Society could not operate in the way it does, for example in Sweden, with a *presumed* consent to donation. It is not reasonable to *presume* that a patient wants to be *killed* under any circumstances whatsoever.

We seem to be trapped by a dilemma, but appearances are deceptive. We only need a couple of distinctions to realise that we can have both criteria. As a matter of fact, they are compatible. In order to see this, we need to realise that they have different ranges of application.

As a way of foreshadowing what will come in this paper, the following brief characterisation will be enough. The distinctions we need are, on the one hand,

between a *person* (or a self) and a *body*, and, on the other hand, between the *meaning* and the *criteria* of death.

The use of the distinctions is as follows. For a person (or a self) to “die” is for this person (or self) to *cease to exist*. A criterion of when this has taken place is the BD-criterion. When the brain is dead there is no consciousness anymore and the person is gone.

For a body to “die” is *ceasing to function as one unified organism*. In contradistinction to persons, bodies can continue to exist after death, there are dead bodies. And the CR-criterion is a fairly good criterion if we want to ascertain whether a body has ceased to function as one unified organism; i.e. if we want to ascertain whether it has died.

The two notions-approach: Persons and bodies

A crucial step in my argument is a distinction between the patient *qua* person (or self) and the patient *qua* body. To make such a distinction may seem dualist to the extreme, and not only wrong but extravagantly wrong. However, I think it is a fact that such a distinction can and must be upheld. We (*qua* persons) are not identical with our bodies. There is a simple and very convincing argument to this effect. It has been put forward by Eric T. Olson,⁸ and I repeat it in a brief form here. Remember that what we are talking about is numerical identity. Numerical identity is a transitive relation, i.e., if X is identical to Y, and Y is identical to Z, then X is identical to Z. Now, assume (for a *reductio*) that my person is identical to my body. It is true of my body that it is identical to a certain fertilised egg that existed some fifty years ago. For there is physical continuity of the right kind between these two bodies. But my person is not identical to this fertilised egg. This fertilised egg is a body, but it is not a person, so my person cannot be identical to it. Being a person takes capacity for consciousness and personal identity is a matter of psychological continuity and connectedness.⁹ However, identity is a transitive relation, so we can deduce from our assumption that my person is identical with my body, that my person is identical with this fertilised egg. So my person is and is not identical with this fertilised egg. Contradiction. We have to give up the assumption that bodies and persons are identical (Q.E.D.).

Something like this argument may have been lurking in the background when Descartes put forward his kind of dualism between body and mind. However, his ontology is extravagant in that it places the person or soul “outside” space. Today, we can do better. We can go four-dimensional and conceive of both bodies and persons as material objects having temporal parts. As

a matter of fact, the above presented argument seems to be a *reason* for going four-dimensional (if we want to avoid the belief in non-corporeal spirits). We can think of both bodies and persons as “perduring” entities, with temporal parts, rather than as “enduring” entities “travelling” in time. If we do so, then we have to acknowledge that, while our persons overlap with our bodies to a large extent, our bodies have temporal parts where no persons exist. This is true of all of us, as far as the beginning of our lives goes, and of many of us, as far as the end of it goes.

We can now define death of a person as the point at which the person in question ceases to exist. This happens when there is too little psychological continuity and connectedness left over. If there is no consciousness at all, then there is no person at all. And we can define the death of the body as the point at which the body ceases to function as a unified organism. This means that bodies, in contradistinction to persons, often continue to exist after their death. There are dead bodies, but there are no dead persons. To be sure, eventually even bodies cease to exist. They do so when they disintegrate to a sufficient degree (they definitely cease to exist when they are being cremated, of course).

But, could it not be objected that to have a beating heart is to be a person? I do not think that this is a plausible move. First of all, it could simply be rejected on linguistic grounds. Most of us would not call someone without a working brain, someone whose brain had irreversibly ceased to exist, a “person”.

Secondly, and more importantly, even if some would do so, they would still have to admit that something of importance was gone once someone’s brain had ceased to exist. In particular, even those who reject the brain-death criterion do typically accept that we stop ventilating people whose brains have irreversibly ceased to function. What they object to as manipulative is merely the saying that these people are “dead” (simpliciter). So they should be satisfied if we say that “person” is a technical term, denoting only people with consciousness.

I have indicated that I make a distinction between meaning and criteria of death (of persons and bodies). The meaning of death has been sufficiently and clearly stated (for the present purposes) above, in terms of cessation of existence (of persons) and in terms of cessation of the functioning as a unified organism (of bodies). But, how do we *decide* whether a persons has ceased to exist or whether a body has ceased to function as a unified organism? Here we need down to earth criteria to refer to. As rough first approximations, I think the BD- and the CR-criteria, respectively, can do the job. The BD-criterion captures the idea that personal identity is a matter of mental continuity

and connectedness in ways indicated by Derek Parfit and others. At least it does so in non science fiction situations. For in non science fiction situations it is our *brain* that sustains our conscious existence. In science fiction situations (and in situations taken for granted by various different religions), we may need a criterion explicitly cast in psychological terms, but these are complications which we need not consider in the present context. The CR-criterion captures the point when the bodily functions fall apart, i.e. the point where the body ceases to function as one unified organism.

Armed with these distinctions we may now return to the three propositions I said that a criterion of death should render true.

The dissolution of the dilemma

Consider first, the first proposition that should be rendered true or plausible by a criterion of death:

- (1) When a patient is dead (and no earlier), it is appropriate to dissect him (if there are reasons to do so and no special reasons against doing so) and to bury him or her.

This is appropriate if the patient in question is identified with the body and it is clear that it is the body which we are considering. We do not want to do anything to the body that would be abhorrent or lacking in respect. The reason for this, I suppose, is that the body has belonged to a loved person. The crucial thing then is that the body is dead before we tamper with it. We do not want to do anything abhorrent to the living body that has belonged to a loved and now deceased person.

When the body is dead (as well as the person to whom it used to belong), we have more licence in our dealings with it, but we are still not allowed to do anything that may seem offensive. However, if there are reasons for, say, dissecting the body, we may do so, provided the dissection takes place in an orderly manner and provided the dead person can be presumed to have agreed to this procedure.

The exact details in this respect, i.e., what exactly is considered appropriate and what is considered inappropriate, in our dealings with living and dead bodies of deceased persons, vary from culture to culture, of course. And, I conjecture, clearer understanding of the two notions of death may even come to bring about some cultural change.

Consider next the second proposition:

- (2) When a patient is dead (but no earlier), no further treatment whatever should be given.

This is most plausibly thought of as a statement about the person, not the body. When the person is dead, i.e., gone, there is no reason to continue the treatment of the body of the deceased person. On the contrary, it would be abhorrent to do so. Why keep the body of a deceased person alive? This could hardly be in the interest of the deceased person (who is not there any longer to have any wishes at all). It can hardly be in accordance with any previous wish of the patient. Why should we want hospitals to meddle with our bodies when, *qua* persons, we are gone? There are no cultural rules or habits that I know of, at any rate, that could call for such a treatment.

I did indicate that there could be special reasons for treating the living body of a dead person in some rare circumstances, however. I think of situations where organs from the deceased person's living body can be used for transplantation purposes and where it is necessary to keep the body of the dead person alive for some time in order to prepare for the operation where organs are taken from the body. I also think of the kind of situations in which Marion Ploch had ended up. She was gone (*qua* person), but her body was alive and she (it) was pregnant. There was a chance that her child could be saved. There may even exist situations where dead bodies of deceased persons should receive "treatment". I think of cases where organs are being taken from non heart-beating donors.¹⁰

However, these circumstances are exceptional. In ordinary circumstances, it is imperative to cease with all kinds of treatment when the patient, *qua* person, is dead, even if his or her body is still alive. As was noted above, even those who use the word "person" differently from how I am here (and from how it is *usually* used), and claim that to have a beating heart is sufficient to being a "person", will concur in the opinion that people whose brains have irreversibly ceased to function should not be kept on ventilators.

Consider lastly, the third proposition:

- (3) When a patient is dead (and no earlier), it is appropriate to take (vital) organs from him or her for transplantation purposes (if a previous or presumed consent has been obtained for doing so).

Here again the patient is conceived of as a person rather than as a body. When the person is gone (and no earlier), it is appropriate to take (vital) organs from his or her living body for transplantation purposes. The reason that in some cases this should be done while his or her body is still alive is, of course, that otherwise the transplantation will fail.

Is it not abhorrent to take organs from the living body of a deceased person? Does this not signal disrespect for the deceased person? I think not and

many people seem to concur. At least we may do this, without being disrespectful, if this is what the deceased person wanted us to do.

Note once again that those who believe that having a beating heart is sufficient to being a “person” typically concur in the statement that, when the brain has ceased irreversibly to function, it is appropriate to take organs for transplantation purposes. What they object to is the statement that the patient is “dead” (simpliciter). On my two-criteria approach, we do not say that these patients are “dead” (simpliciter). Therefore, they should have nothing to object to it.

Are persons in a permanent vegetative state dead?

I have said that the CR- and BD-criteria are good rough approximations of death of bodies and persons respectively. However, this is not quite true. It seems that the argument behind allowing that organs for transplantation be removed from brain dead patients pushes us further. Why not take organs also from persons who have *parts* of their brain functioning, but who are in a permanent vegetative state? Are they not dead too?

They are indeed dead and gone. Personally, I tend to think that it is squeamish not to take the indicated step. However, I am reluctant to argue that this be adopted as public policy. The main reason for this reluctance is that, even if such a step would be reasonable, I foresee strong public opposition to it and such public opposition may put into jeopardy the lives of patients who have vital needs for organs for transplantation. Transplantation surgery could come into disrepute if we prematurely took this step. However, if no such opposition were actually forthcoming, I would welcome such a step being taken.

It could be said that there are not only “tactical” reasons against removing organs from people in a persistent vegetative state (provided they had previously agreed to the procedure), there are also medical and scientific reasons against doing so. While the diagnosis of brain death is for all practical reasons certain, the diagnosis of persistent vegetative state is less certain. We do not know exactly in what parts of the brain consciousness resides. It may reside exclusively in the higher brain or cerebral cortex, but, for all we know, it may just as well be a “global” neural phenomenon. Moreover, there are scientific reports to the effect that, in some cases, what has been called a locked-in syndrome has been mistaken for a vegetative state.¹¹

Personally, I do not find these arguments convincing. A locked-in state strikes me as *worse* than death, so if I happened to become locked-in, I would like to

have my organs taken from me (and to have not only my body killed, but my person as well). A life with only fragmentary consciousness does not strike me as very valuable either. If I were to end up in such a situation I think it only fair that someone who could make better use of my vital organs should have them.

However, I know that other people may think otherwise and this means that it would be bad policy to include people in a persistent vegetative state (with a dead cerebral cortex) as donors of organs, at least if they had not previously *explicitly* stated such a wish (in *which* case their will *should* be respected). So, while we may presume, in the way we do in Sweden, that people who are brain dead are willing to volunteer as donors of organs for transplantation purposes (unless they have stated otherwise), we should *not* presume that people in what has been diagnosed as a persistent vegetative state are willing to do so.

Yet, for all that, in order to avoid inconsistency we should not look upon the BD-criterion as necessary. We should be satisfied with laws stating that if the BD-criterion is satisfied, then the patient, *qua* person, is dead and gone. We should leave it an open question if there are also patients who are not brain dead, but who are dead in a persistent vegetative state. However, when organs are taken from such patients, no public claim that these persons are dead and gone should be made. Their organs should instead be removed for transplantation purposes as a way of honouring their previously expressed explicit wish. It should be left an open question whether this means that they, *qua* persons, are being killed or not.

Conclusion

In the present medical ethical discussion about the definition or criterion of death, many people seem to believe that we have to choose between traditional circulatory and respiratory criteria and modern brain related criteria – or give up the idea that there is any clear notion of death at all. Both traditional circulatory and respiratory criteria and modern brain related criteria cannot be necessary and sufficient, it is held. However, this is a mistake. We realise this when we realise that these criteria and definitions have different fields of application.

The traditional circulatory and respiratory criteria indicate when a body has died (ceased to function as a unified organism). The modern brain related criteria indicate when a person has died (ceased to exist). Therefore, we may very well hold on to both kinds of criteria. If we do, we can find a way out of the dilemma posed by the alleged fact that no definition or criterion of death seems capable of doing the proper job in all

contexts. A more flexible approach means that one of the two main definitions applies in each context.

However, a problem remains with the brain death criterion. It is a rough approximation of when a person ceases to exist, but a rough one only. There are numerous examples of persons who have ceased to exist, without having lost all their brain functions. So perhaps it is possible to find a more inclusive criterion, cast in terms of only the higher brain functions or the functions of the cerebral cortex. No such stipulation should be adopted in any act of law right now, however. We know too little about where our consciousness resides, for us to do this, and the diagnoses of states such as a persistent vegetative state are not certain.

However, this should not mean that people should not have a right to claim, in living wills, say, that, if they become vegetative, they do not want any further treatment and that their organs should be taken care of for transplantation purposes. Such living wills should be honoured by society.

For the time being, however, it should be left an open question whether these persons are being killed (as an act of mercy) or not (since they are dead already) when they have their advance will respected.

Notes

1. It has been thought that it is too late to take lungs too, but that may have been a mistake. In a present Swedish study (at Lund University), lungs are being taken from non-heart beating donors. If this study proves successful, new possibilities may open up in this field.
2. Troug, R.D. and J.C. Flacker: 1992, 'Rethinking brain death', *Critical Care Medicine* 20, 1705–1713
3. In a discussion I had with them in *Dagens Nyheter*, the leading Swedish newspaper. Their article was published on February 3, 1993.
4. *Neurosurgery*, 1986, pp. 565–567.
5. *Obstetrics & Gynaecology*, 1989, pp. 434–437.
6. Cf. for example his 'Is the sanctity of life ethics terminally ill?', In: C. Machado (ed.), *Brain Death*, Elsevier Science B.V., 1995.
7. 1997, 'Is It Time to Abandon Brain Death?', *Hastings Center Report* 27, 29–37.
8. 1995, 'Human People Or Human Animals?', *Philosophical Studies* 80, 159–181.
9. Admittedly, this view can be criticised. It is beyond the scope of this paper to defend it in any detail, of course. The reader is referred to modern defences of this Lockean position, such as Derek Parfit's; cf. mainly his *Reasons and Persons* (Oxford: Clarendon Press, 1984), Part III, but also his subsequent paper, 'The Unimportance of Identity' in Henry Harris (ed.), 1995, *Identity*. Oxford: Clarendon.
10. For example, in the example referred to in note 1, where lungs are taken from non heart-beating donors, it is crucial that before the lungs are removed from the deceased the body should be cooled down, therefore the dead body must be given an infusion.
11. *British Medical Journal*, 1996, p. 7048.