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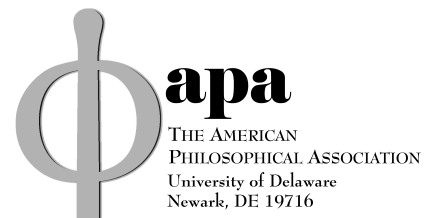
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FROM THE EDITORS

Plato is supposed to have defined philosophy as a meditation on death. What could be more appropriate, then, than the inclusion in this issue of your Newsletter of a symposium on death? The Committee on Philosophy and Medicine sponsored a surprisingly brisk and upbeat panel on some definitional details of that melancholy subject at the Pacific Division meeting in Vancouver in April. In a continuation of some recent discussions of personal identity in these pages, we include as well a contribution by David DeGrazia, "Suffering, Identity, and Progressive Dementia."

But not all is gloom. Faithful contributor Bernie Gert has contributed his response at the APA's Eastern Division meeting to Micah Hester's "Bioethical Pragmatism and Pragmatic Bioethics," which appeared in these pages in the Spring 2008 issue, and Hugh and Eva LaFollette contributed a version of their *Lancet* paper on conscientious objection. We include as well an exchange on paternalism, with particular attention to parental paternalism. Enjoy!

As we go to press our attention is being drawn once again to the continuing discussion over health care reform in this wealthiest of nations. Despite many excellent articles and op-ed pieces by various observers, the conversation seems to be tilting dangerously toward cost and away from access and quality—a pattern that has become all too familiar. To quote one of my favorite philosophers: decisions are made by those who show up. Complex issues call for our participation, as scholars, and as citizens. Whatever your position, let your voice be heard, by your neighbors and by your representatives. As an aid to deliberation, a selection of readings on this topical issue was solicited from Paul Menzel, and is found on p. 28 of the Newsletter.

Mary Rorty and Mark Sheldon, co-editors

FROM THE CHAIR

Reflections on philosophy and medicine

The session on "Is 'Brain Death' Death?" that the Committee on Philosophy and Medicine sponsored at the last Pacific Division meeting engenders reflection on the kind of contribution philosophers can make to such issues. When neurological criteria for determining death was introduced in 1968 by the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, its chair, Henry Beecher, was skeptical

of whether philosophers had anything useful to contribute. For Beecher, the matter of defining death fell within the province of medicine. In the next landmark report, *Defining Death*, by the 1981 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, there was explicit recognition that "the basic concept of death is fundamentally a philosophical matter" (p. 55). However, this same Commission immediately cautioned about journeying down "arcane philosophical paths which are at best somewhat removed from practical application in the formulation of law" (p. 56). Although the Commission considered alternative philosophical conceptions of death, it ultimately endorsed a biological one that treats the definition and determination of death as strictly biological matters. Again, the contribution of philosophers was marginalized. Most recently, in December 2008, the President's Council on Bioethics issued its *White Paper, Controversies in the Determination of Death*. Although the Council acknowledges that the definition of death is a philosophical question and "cannot be settled by appealing to clinical or pathophysiological facts" (p. 49), it is hard to detect an engagement of philosophical issues in the report. In contrast, the transcripts of the proceedings of the President's Council surprisingly contain a fair amount of discussion about the nature of the soul and how a proper understanding of ensoulment may be relevant to defining death. This talk of ensoulment, however, never made it into the Council's *White Paper*.

Why were grown men and women on a President's Council on Bioethics talking about the nature of soul in their deliberations about the very practical matter of determining death? What do ensoulment and other philosophical views about the nature of a human being have to do with the definition of death? In my view and as noted above in the explicit recognition by the governmental advisory bodies, it has everything to do with it. However, to admit that defining death is "fundamentally a philosophical matter" but to fail to journey down arcane philosophical paths is puzzling. There is an odd disconnect between the acknowledgment that the matter of defining death is a philosophical one and the failure to seriously consider alternative philosophical views about our nature. If the disagreement over the definition and criteria of death ultimately stems from philosophical disagreement over the meaning of death or the nature of a human being or person, then this disagreement should be forthrightly acknowledged. Moreover, the issue of how to legally manage such disagreement in a pluralistic society ought to be addressed, instead of obfuscating the issue by perpetuating the myth that defining death falls exclusively within the province of biology or medicine.

The papers from the session at the last Pacific Division meeting published in this Newsletter show how alternative considerations of our nature and what it means for us to die impact on the definition and determination of death. This is perhaps most clearly revealed in Bernard Gert's contention that an artificially sustained decapitated head that retained

consciousness would still be a living person, despite the fact that it may no longer be an organism as a whole; in Don Marquis's criticism of the mental essentialism that underlies Jeff McMahan's argument for a consciousness-related definition of death; in Ari Joffe's work that documents disagreement among health professionals over the justification for accepting "brain death" as death; in Robert Truog's criticism of the current whole-brain neurological criterion as failing to capture what it means for us, as biological beings, to die; and in D. Alan Shewmon's discussion of how disagreement over the definition of death is bound up with disagreement over human personhood.

There has been much more recognition of how views about human nature and personhood affect the definition of when life begins than when it ends. However, insofar as an understanding of our nature is relevant to both issues, the definitional problems of the beginning and end of life are essentially the same. The APA session brought together physicians and philosophers in an effort to engage the philosophical and the medical dimensions of one of the most fundamental problems dished up by advances in medical technology: the definition of death. We hope it will stimulate further work in the field.

The Midwestern members of the Committee on Philosophy and Medicine organized a session on ethics codes at the last APA Central Division meeting. Chaired by Kevin McDonnell (St. Mary's), Bette Crigger of the AMA gave a presentation on the work she is doing to revise the AMA code of ethics. A round table discussion followed with prepared comments by Mike Davis (IIT), Tod Chambers (Northwestern), and Jason Eberl (IUPUI). Jim Nelson has volunteered to lead the organizing of next year's Central Division session with Fritz Allhof and Kevin McDonnell assisting. The session will focus on the "Dead-donor" rule and include a joint presentation by Frank Miller (Johns Hopkins) and Robert Truog (Harvard).

The Committee on Philosophy and Medicine will continue its collaboration with the Association for Bioethics and Humanities by sponsoring a panel session on "Translating 'Brain Death'" at the next ASBH meeting in Washington, D.C., October 15-18, 2009. The panelists, James Bernat (Dartmouth), David DeGrazia (George Washington), and Stuart Youngner (Case Western), will address the practical difficulties and ethical issues involved with communicating "brain death" to patients and families, particularly in the context of organ donation.

For the next Eastern Division meeting, the Committee has organized a session on Health Care Reform that will feature Daniel Callahan (Hastings Center), Norman Daniels (Tufts), Leonard Fleck (Michigan State), and, hopefully, Ezekiel Emanuel (NIH and special advisor on health care reform in the Obama administration). Rosamond Rhodes (Mt. Sinai) will chair the session. We intend to allow ample time for discussion of this moving target with the audience. Plans for the next Pacific Division meeting are in the works. The Committee welcomes suggestions from the membership for topics for future sessions at the APA meetings. Please email to lizza@kutztown.edu.

John Lizza
Kutztown University of Pennsylvania

ARTICLES

*The Professional Conscience**

Eva LaFollette and Hugh LaFollette
University of South Florida, Petersburg

A growing number of medical professionals assert a right of conscience, a right to refuse to do any action they deem immoral and to do so with impunity. Ambulance drivers have refused to transport patients for abortions, fertility clinics have refused to assist gay individuals, and pharmacists have refused to give the morning-after pill to rape victims. Certainly some people have misgivings about these actions. But even these professionals' harshest critics are primarily interested in establishing mechanisms to ensure that people (usually women) who need health care are not obstructed or inconvenienced. Few openly challenge their claimed "right of conscience." In many ways, this is not surprising. There are good reasons why a government should respect an individual's conscience.

Respecting Conscience

Benefits of Conscience

There are personal and social reasons why a society should not ignore, quash, or demean individual conscience. Individuals want to live their lives as they think best, and for many of us our moral beliefs are very important. Most of us are repulsed at the idea of being forced to do what we think immoral. Moreover, by respecting conscience, societies empower individuals to think and act morally; they encourage the use of reason rather than force; and they exemplify and encourage tolerance. History illustrates these benefits of conscience. Brave individuals have refused immoral orders on grounds of conscience, often at considerable personal cost. Some Nazi doctors refused to kill Jews. During Apartheid, some South African police officers refused to participate in the torture and murder of blacks. A number of whistle blowers have risked their jobs to expose inappropriate corporate or governmental behavior. We are indebted to these moral heroes. They show us that we should not automatically do whatever our employers tell us to do. We must make informed moral decisions. However, from these examples we should not infer that all conscience is equal. Certainly we should not embrace the unqualified right of conscience advocated by some professionals.

Not all Conscience is Created Equal

Although acting on conscience is sometimes heroic, it is not invariably so. One of the essay's authors grew up "conscientiously" opposed to admitting African-Americans to white public schools and to letting black and white people drink from the same water fountains. No one should have respected his conscience since he was merely mouthing the prejudices of his day. Not all conscience is created equal. It differs in several relevant respects:

- **Focus:** Is it primarily self-regarding (private) or does it also significantly affect others (public)?
- **Choice:** Did the person volunteer to be in the position where she faces the obligation from which she now wishes to be exempt?
- **Centrality:** How important is this belief to the agent requesting the exemption?
- **Sincerity:** Is she sincere?
- **Morality:** Is her belief a moral belief?

- **Plausibility:** Can she explain and justify her belief or is she just parroting others' views?
- **Seriousness:** To what extent will respecting her conscience affect others?
- **Role:** Is the action one she is expected to perform in the normal course of her profession?
- **Reciprocation:** In asking others to respect her conscience, does she show similar respect to other members of her civil society?

We explore each dimension in this paper. We begin by discussing the first. If a normal adult's behavior is self-regarding, we cannot imagine forcing her to act contrary to her conscience. If she thinks having a blood transfusion is immoral, then we should not force her to have a transfusion, even if the doctors deem it medically necessary. And, directly relevant to the current discussion, if a medical professional thinks that taking some medication is immoral, she should not be forced to take it. It does not matter if others fail to see the wisdom in her moral views.

Likewise, we should not interfere with people merely because of their views. They might think parents should be able to stop their young children from receiving medically necessary blood transfusions or think that they should be able to stop others from taking prescribed medications. We can criticize those views. If they try to act on those views, then society can legitimately intervene.

For instance, some people still think inter-racial marriage is immoral. However, if their restaurant is open for public business, they cannot refuse to serve an inter-racial couple, no matter what their conscience tells them. If they find the thought of serving the couple too painful, then they can close their restaurant (if they own it) or work elsewhere (if they are employees). We should not recognize or protect their claim of conscience.

Since medical professionals' behaviors inevitably affect others, their claims to right should be scrutinized. That does not show their claims are mistaken. It does show that they should not baldly assert nor should we automatically grant an unqualified right.

The Professional's Conscience

Medical professionals' refusals have become sufficiently common that patients are seriously inconvenienced and quite possibly harmed. This is especially true of doctors who are reluctant to prescribe—and pharmacists who are reluctant to dispense—oral contraceptives and the morning-after pill. That is why these are the professionals on whom we principally focus. There are, of course, differences between the claims of physicians and or pharmacists, and perhaps greater differences between the claims of medical and non-medical professionals. Nonetheless, the similarities are sufficiently similar to justify discussing these professionals' claims as a way to think more generally about claims of conscience made by all professionals.

The Obama administration plans to reverse a rule, adopted by the Bush administration, that gives medical professionals an unqualified right of refusal. To evaluate this rule and Obama's plan to overturn it we explore the long-recognized right of conscientious objection to war (COW). Understanding the rationale for, conditions on, and limits of COW helps us better comprehend the professionals' claims, especially since advocates of COP (Conscientious Objection for Professionals) frequently cite COW in defense of their position.

Before we proceed, we want to be clear. We are not claiming that a professional should always do what her

employers ask her to do. A morally sensitive individual must sometimes refuse the demands of an employer, even if the costs to her are significant. Nor are we denying that some employer might reasonably accommodate an employee who is conscientiously opposed to doing some assigned task. Our focus is the public policy question: Do professionals have an unqualified right to refuse to fulfill some of their professional duties? Our answer: they do not.

Conscientious Objection to War

Many Western nations grant a right to conscientious objectors during time of war. The rationale for and conditions on COW relevantly differ from the claimed right of COP in at least five ways. Some differences are so obvious that it seems contrived to mention them. However, COP advocates do not seem to notice them. Moreover, by isolating these differences, we can better see what is wrong with the COP's proposal; we can identify constraints on any proposed right of conscience.

Conscripted, not Chosen

Citizens selected in a draft do not choose to enter the military. Still, they must serve as combatants unless they can establish that killing others in war violates their deeply held religious or moral views. In contrast, medical professionals volunteered to pursue their profession. If, at any point, they do not want to do what they are required to do, they can quit. Of course, no one wants to have to quit her job rather than act immorally. However, if she quits, at least she will not be court-martialed or criminally prosecuted—unlike an individual conscientiously opposed to war who is not granted CO status. A draftee is put in this position simply because he is a physically fit male of a certain age. If the professional is in this position, it is because she chose her career.

Despite this profound difference, COP advocates claim that they have a right to refuse any professional duty to which they conscientiously object. They claim that they should not be fired or reprimanded, nor should they lose promotions or raises because of their refusals. Their demand is akin to someone who voluntarily enters the military, announces that he morally objects to shooting at the enemy, demands that the military respect his claims of conscience, and then expects not to lose any raises or promotions. No one does or should take such a claim seriously.

A defender of COP might try a different tack. The medical professional, she might contend, is not opposed to performing all procedures or dispensing all prescriptions, but only some of them. The professional's choice is more like a soldier who disobeys an order she deems "illegal." This is not a plausible tack. First, the "illegal orders" defense in the military is permitted rarely. It is not something most soldiers would claim even once over an entire career. In contrast, any professional entering the relevant medical fields in the past decade knows that she will be expected to prescribe or fill prescriptions for the morning-after pill; anyone entering the profession in the past forty years would expect to prescribe or dispense oral contraceptives.

Second, when a soldier disobeys an order on these grounds, he will have to defend his action to the military, showing how the order directly violates current standards of military practice. He would have to show that any reasonable soldier in the same circumstances should refuse to follow said orders. If he fails, he will be court-martialed. A medical professional could never defend her refusal using current standards of medical practice since these procedures and drugs are legal.

Establishing the Plausibility, Sincerity, and Centrality of One's Beliefs

No one has a right to be exempt from military service simply

by asserting that he is conscientiously opposed to war. He must give a clear rationale for his beliefs to a neutral administrative body; he must show that this is a core belief consistent with other things he says and does. Thus, the military tribunal or draft board would be skeptical of an applicant who vocally advocated capital punishment. Perhaps that applicant could explain why he supported capital punishment while being categorically opposed to war. We suspect that would be difficult to show. However, it is something that he must show.

In contrast, the objecting professionals want to assert (not establish) that they are conscientiously opposed to performing some procedure—or opposed to writing or dispensing some drug—and then to be straightway exempt from these professional responsibilities. Were COP and COW treated similarly, physicians who object to prescribing the morning-after pill or oral contraceptives (or pharmacists who object to filling said prescriptions) on the grounds that those taking the pill are killing another human should oppose taking human life except under demonstrably justified circumstances. Barring a convincing argument, these professionals should oppose capital punishment and modern warfare (since 90 percent of the casualties are civilians).

The Cost of Conscience

Although a drafted COW may be exempt from combat, he must serve within the military (as a medic) or do “alternative service” (in a charity). He must serve as long as he would have served in combat, usually two years. Neither option is attractive. Being a medic is one of the most dangerous military assignments, while the person who does alternative service does not receive veterans’ benefits.

We require COWs to perform alternative service for two reasons. One, it demonstrates their sincerity; two, it demonstrates their commitment to democracy, tolerance, and the common good. In contrast, COP advocates do not think that a medical professional must compensate for her failure to discharge her responsibilities. These want others to respect their conscience but are unwilling to reciprocate by respecting the conscience of others, especially those needing medical services.

Evaluating the Claim to an Unqualified Right

The arguments so far show that what objecting professionals expect—and often get—is far more than what conscientious objectors to war expect or receive. The COW can obtain an exemption from the armed services only if (a) he convinces an administrative body that he sincerely believes such service is immoral, (b) he can defend that belief, and (c) he can show the centrality of that belief by, among other things, his willingness to serve his country in another way. In contrast, the objecting professional wants to simply state that she is conscientiously opposed to performing certain professional acts without defending her views and without doing anything in lieu of discharging her professional duties, duties she voluntarily assumed. Her position is indefensible. She does not have an unqualified right of conscience.

We Could not Consistently Recognize Such a Right

We should not recognize claims of rights ad hoc. Were we to grant medical professionals the right not to prescribe or fill a prescription for the reasons and the ways they want, we must, on grounds of consistency, permit conscientious objection for similar reasons in similar cases. We should also grant rights of conscience to:

- vegans who do not want to serve meat at Burger King;
- fire fighters who do not want to extinguish a fire at a Santeria Church;

- policemen who do not want to investigate gay bashing;
- emergency medical technicians who do not want to treat Wiccans;
- real estate agents who do not want to sell a house to an inter-racial couple;
- telephone linemen who do not want to connect services for Muslims; and
- teachers who do not want to teach atheists.

Obviously, we could not excuse all these people from performing part of their normal duties just because they claim to be conscientiously opposed. Neither should the state protect them from reprisals by their employers. In short, we should not recognize an unqualified right of conscience for people in critical jobs, particularly those in the paradigm professions. This is true of all employees, not just ones whose actions we personally find suspect. Suppose that a construction worker is opposed to building an ammunition factory because she thinks that in so doing she facilitates something immoral. Although it is arguably morally laudable for her to refuse to participate on moral grounds, she has no unqualified right of conscience. She should not automatically be exempt from such work and legally immune from action by her employer. Perhaps her employer thinks that she is a sufficiently valuable employee that he will accommodate her as a courtesy. Or perhaps she has a qualified right.

Do Professionals Have A Qualified Right Of Conscience?

The argument so far shows that professionals do not have an unqualified right of conscience. Perhaps, though, the previous argument can be extended to show that they have a qualified right of conscience. Perhaps they have a right to be exempt from some responsibilities if they defend their claims and are willing to do “alternative service.” This qualified right is more plausible. Far fewer professionals would assert this right and the negative impact of granting the right would be far less. Although such a right would resemble a right to COW, there are further differences between it and COP that give us some reason to reject even an unqualified right to COP. These differences help us to better understand and evaluate the claimed right of conscience.

Further Differences between COP and COW

Doing Wrong or Facilitating Wrong

Although the conscientious objector to war wants to be exempt from actually killing someone, a professional objector wants to be exempt from doing an action that she thinks might facilitate someone’s death. For even if taking the morning-after pill does kill a “person,” prescribing or dispensing the pill does not. To say that one facilitates—rather than does—an immoral act is to acknowledge that someone else must perform the immoral act. Although facilitating an immoral act may be immoral, it is not the same thing as doing the immoral act oneself.

However, some might argue that the moral gap between doing and facilitating may be miniscule if the physician or pharmacist has good reason to think (a) that the patient will take the pill, (b) that taking the pill will stop implantation of a fertilized egg, and (c) that stopping implantation is murder. However, the gap widens as our doubts about each element increase. We have serious doubts about each.

Many gynecologists recommend that women of childbearing years keep these pills on hand in case they have unprotected sex or have reason to think that their birth control failed. Hence, many patients who purchase these prescriptions will

not take them. Additionally, some who take the pills would not have become pregnant; therefore, taking the pill will not stop implantation. In short, many (and perhaps the majority) of the women who receive and fill these prescriptions will not stop the implantation of a fertilized egg.

Of course, neither will every soldier kill another person, not even during war. Yet we allow conscripted soldiers to be exempt from serving in combat given the probability that they will have to kill an enemy soldier. So why, advocates of COP might wonder, should not we treat medical professionals similarly? This is a fair question if stopping implantation were a clear instance of killing another human being. It is not. We think that claim is almost certainly false. The current argument, though, does not depend on its being false. It is enough that the claim is highly contentious. Although people may think that killing in war is justified, no one denies it is killing. In contrast, most people, even in a conservative country like the U.S., deny that aborting a conceptus is killing (let alone murder). An even greater percentage of people deny that preventing implantation kills a person. That relevantly distinguishes COP from COW.

The Locus of Moral Disagreement

A belief is a matter of conscience only if it is a moral belief and not every purported moral belief is a moral belief. We should distinguish “between positions we must respect, although we think them wrong, and positions we need not respect because they offend some ground rule of moral reasoning.”¹ People should have “reasons” for their moral views. Real reasons cannot merely express a prejudice or emotional reaction, parrot another’s views, or contain demonstrably false empirical claims.² However, since we may disagree whether a view is a prejudice or whether someone is parroting another’s views, then we should be charitable when applying these requirements. We should demand only that someone who claims to take a stand on conscience have views and employ reasoning reflecting values and empirical beliefs broadly similar to recognizable moral views. If they don’t, it makes the notion of a “moral belief” meaningless. For instance, if someone said that she was conscientiously opposed to feeding her children or stopping at traffic lights, then, barring some powerful explanation, we would not think that she is forwarding moral beliefs, no matter how sincerely uttered. If someone said that she was conscientiously opposed to paying parking fines because doing so killed humans, then barring some powerful explanation, we would deny that she is making a moral claim.

This requirement resembles the legal notion of the “reasonable person.” For instance, we have laws protecting people from nuisances. However, we do not let each individual determine what counts as a nuisance. Someone’s behavior is a legal nuisance only if a reasonable person would consider it so. Loud music outside a person’s window at 3 a.m. would be a nuisance (in the legal sense), whereas someone’s belching while walking down the street would not be. That is not to deny that many of us would be annoyed if the person walking in front of us continuously belched loudly. However, anyone who was seriously annoyed would be unduly sensitive, and the law should not accommodate such sensitivities. Likewise, the law of self-defense claims that someone can use deadly force to defend herself only if a reasonable person in her shoes would fear serious bodily harm. Thus, someone could use deadly force to defend herself from a grown man wielding a magnum, but not from a three-year-old wielding a celery stalk. That is not to deny that some unusual person might be frightened of this celery-toting toddler. However, although the courts would allow the first person to kill her attacker in self-defense, they would charge the second person with manslaughter.

Why does this matter for the current discussion? Because while COW advocates clearly hold moral beliefs, COP advocates may not. The conscientious objector to war agrees with society (a) about what the relevant act is (killing another person) and (b) that that act, unless justified, is morally wrong. Although he disagrees whether war provides an exception to the general prohibition against killing, he shares significant moral and factual beliefs with the majority. That is why we have no doubt that the COW holds a moral belief, even if we disagree with it. By contrast, the society does not think that prescribing or dispensing oral contraceptives or the morning-after pill kills a human or that prescribing or filling these prescriptions is wrong unless specifically justified. The public holds empirical beliefs that differ relevantly from those of COP advocates. Few people think that preventing fertilization or implantation are killings, let alone the killing of a human being.

Although this does not necessarily show that advocates of COP do not hold moral views, it amplifies rather than diminishes their need to show that these are sincere moral beliefs. Finally, the objecting professional must show that in refusing to act she does not impermissibly harm others. That will be especially difficult since she voluntarily chose her career and is a member of a paradigm profession.

The Nature of a Profession

Defenders of COP often claim that their professional status gives a compelling reason why they should not be required to do what they think immoral. Consider this claim made in favor of objecting pharmacists:

A pharmacist is not an automaton or a physician’s valet, but a necessary member of the health care team. Pharmacists complete at least 6 years of rigorous education and clinical training and prove their knowledge by passing a licensure examination. ... To manage the risks of adverse outcomes or treatment failure, most patients need an informed, vigilant and caring pharmacist to exercise independent, professional judgment. Wouldn’t we question the competence or diligence of a pharmacist who unquestioningly dispensed prescriptions as written, who rarely found any prescriptions “objectionable” on therapeutic grounds?³

Of course not. We want these medical professionals to stay current about contraindications for drugs, detrimental effects of which a physician might be unaware. That is precisely why we license them. However, these factors have nothing to do with claiming a moral exemption from a professional duty. The objecting pharmacist does not claim that there is a contraindication of which the doctor is ignorant. She has no medical facts to which the prescribing doctor is not privy. She is not using scientific methodology or making a pharmaceutical judgment based on education and clinical training. She objects to the prescriptions solely on religious or moral grounds. Were that not so, it would make no sense for her to claim an exemption on grounds of conscience.

However, although it is appropriate for a professional to let her conscience be her guide when she is acting as a private individual, when she is performing her professional duties, she should reason and act as a member of a justified profession in a democratic and largely just society. We establish professions to perform activities (a) that serve a vital public interest, (b) which cannot be safely and competently performed by just anyone, and (c) for which we have some reliable mechanism to determine aspiring professionals’ competence. The profession is justified inasmuch as it serves those public interests, and individuals are permitted to be professionals only if they act to

effectively serve those interests. Her role within the profession gives her special rights (in this case, exclusive right to prescribe or dispense controlled medicines). It also imposes special responsibilities: to serve the interests of her clients even if it clashes with what she, as an individual, might do.

This is true for anyone performing a job that protects a vital public interest, and, in virtue of which she has the principal—if not sole—power or authority to promote those interests. If a fire fighter's company is called to put out a fire at an abortion clinic, she would immediately lose her job if she stands by while the clinic burns. The same is true of police officers, emergency room physicians, EMTs, and ambulance drivers. If the need for action is immediate, we cannot tolerate a rule authorizing exceptions.

Of course, there may be circumstances in which those served by the professionals are not harmed, and perhaps not even inconvenienced. Other professionals might be able and willing to perform her job. For instance, if a professional states her objections in advance, defends her claims, and is willing to do alternative service, then some employers might work out procedures to ensure that the patient (or client) is served. In these limited cases, where the professional shows reciprocal regard for other members of a democratic society, we might be able to accommodate her claims of conscience. However, when the actions which people do not want to do are central requirements of their jobs, they should not demand nor expect to be exempt from task, especially when, if so doing, they harm others.

Revisiting the Private and the Public

We are not saying that professionals should never morally evaluate what they are expected to do as professionals. Of course they should. However, they should understand that their moral responsibilities as professionals are not identical to their responsibilities as individuals. As individuals they may legitimately do things they should not do as professionals. One should drive by the scene of an accident when the police are already present. In contrast, a doctor should stop and see if her services are needed. On the other hand, professionals may legitimately do things individuals should not do. A lawyer should, within the rule of law, diligently work to get her client acquitted, even if the client is guilty. As an individual (say, a witness to a crime), she should not

Thus, although my private conscience may tell me that I should not perform an act, I should not straightforwardly infer that it is also improper for me to do that act as a professional. Professions are established to serve vital public interests; those interests can be best served only if professionals fulfill their responsibilities, even by doing actions she would not do as an individual.

One way to see this is to think of civil servants' choices. During their careers, most civil servants will work for different elected governments. They will personally support some and disagree with others. When they are working for governments with whom they disagree, they will sometimes be asked to do things that they would consider immoral were they acting as individuals. They may be asked to support a policy that would cut critical funding to underprivileged children to send money to support a war they think morally questionable. In so doing they would facilitate what they consider immoral actions.

However, they are not acting as individuals; they are fulfilling a vital professional role. They cannot reasonably refuse to do every action they dislike. A democratic government can survive only if civil servants standardly fulfill their assigned duties, even when they thereby help implement what they consider immoral policies.

Of course, a civil servant might sometimes think that the government is morally bankrupt. If so, then arguably she should refuse to fulfill (some of) her assigned duties. However, if she does so, it would then be silly for her to expect this (presumably) unjust government to permit her to do so with impunity.

Conclusion

Society should not regularly constrain, quash, or ignore conscience. If a matter of conscience affects only the agent, then the state has no business interfering. However, if her actions significantly affect others, then we should determine whether her claims are sincere, plausible, and consistent, and whether she shows reciprocal respect for others. We should determine the degree to which her exercise of conscience harms others, especially if she is a member of a justified profession in a democratic and basically just society. We should not recognize—nor should medical professionals claim—an unqualified right of conscience.

Could professionals have a qualified right of conscience? Might it be that we should exempt them from fulfilling some part of their professional duties if they can articulate and defend their views, show that they live their lives according to such views, and that they are willing to do alternative service demonstrating their reciprocal respect for others? That claim is far more plausible. But also far from overwhelmingly convincing, in large part, because they entered the profession voluntarily, and because what they are being asked to do is a core part of their respective professions.

We would urge that the professionals reconceptualize their choices: that they see that when they are acting as professionals they should reason as professionals. They must understand that some actions they would not do as individuals, they should do as professionals fulfilling a vital public role. If they cannot successfully reconceptualize their choices, then they could request—not demand—that the rest of us honor their conscience. If they were willing to state and defend their views and agree to doing alternative service, then the public might find ways to accommodate them, at least if that did not burden their clients—almost always women.

* This is a slightly altered version of "Private Conscience, Public Acts," published in the *Journal of Medical Ethics* 33 (2007): 249-54. Reproduced by Permission of the BMJ Publishing Group. You can find more complete references in the original essay.

Endnotes

1. R.M. Dworkin. "Liberalism and Moralism." *Taking Rights Seriously* (Cambridge, MA: Harvard University Press, 1977), 249.
2. J. Harris. "Introduction." *Bioethics* (Oxford: Oxford University Press, 2001), 10-13.
3. C.D. Hepler. "Balancing Pharmacists' Conscientious Objections with their Duty to Serve." *J Am Pharmacists Assoc* 45 (2005): 434.

Definition of Death¹

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Ordinary Features of Death

The definition of death must capture our ordinary use of the term, for "death" is a word used by everyone, and is not primarily a medical or legal term. In this ordinary and literal use, certain facts are assumed, e.g., that all and only living organisms can die, that the living can usually be distinguished from the

dead with complete reliability, that the time when an organism leaves the former state and enters the latter can usually be determined with a fairly high degree of precision, and that death is permanent (irreversible). Recent advances in science have not called into question any of these assumptions, but they have made plausible some scenarios that were formerly regarded as limited to science fiction. It now seems that not only can the body of an animal be kept functioning for a significant time even when its head has been severed from its body, but also that the head can continue to respond to stimuli.² In this scenario the organism is no longer functioning as a whole, but to claim that the animal is dead, even though its head responds to sounds and sights, is incompatible with the way in which almost all would extend our ordinary understanding of death.

The following is my proposed definition of “death”: death is the permanent (irreversible) cessation of all observable natural functioning of the organism as a whole and the permanent (irreversible) absence of consciousness in the organism as a whole and in any part of that organism. Including as part of the definition of death “the permanent absence of consciousness in the organism as a whole and in any part of that organism” is compatible with “death” meaning the same for all animals, including those that were never conscious. The importance of consciousness to a conscious organism has no counterpart in non-conscious animals. Thus, it is not inappropriate for the definition to acknowledge the importance of consciousness in the life of conscious animals. Indeed, this seems especially true as technology advances and if, as now seems likely, it becomes possible for a part of the organism, i.e., the head, to remain conscious while the organism as a whole ceases to function. Death, as almost all understand it, requires both a permanent (irreversible) cessation of the organism’s natural functioning as a whole and the permanent (irreversible) absence of consciousness in the organism as a whole and in any part of that organism. A dog whose head has been separated from its body does not count as dead if that head continues to manifest consciousness. Even though there has been a permanent (irreversible) cessation of all observable natural functioning of the organism as a whole, an identifiable part of that organism continues to be conscious.

Any plausible definition of death must allow for consciousness in any part of the organism to be sufficient for that organism to count as still living even though our present concept of death did not consider this possibility. Thus, our proposed definition applies to plausible science fiction speculations, for example, about a head manifesting consciousness even when separated from the rest of the organism. Consider being presented with a person whose head has been severed from his body, but both the headless body and the head are still functioning because of artificial support. If the head manifests consciousness, the most plausible development of our concept of death is that it is the conscious head, not the headless body, that counts as the living person. It would be helpful to create a new term that refers to the artificially supported headless body to distinguish it from a normal dead body. I acknowledge that the headless body may grow and develop in very similar ways to that in which a normal human body grows and develops, but the phrase referring to the headless body must make clear that it does not refer to a living human being or a living natural organism. Given that the headless body resembles the living organism in so many ways but that it satisfies the proposed definition of death, it might be referred to as a living corpse. The oddity of this phrase captures the oddity of the being referred to by the phrase. No plausible science fiction story requires us to regard a headless, or brainless, or brain dead body, as a living human being or even as a living natural organism.³

The legal definition of death, which is not really a definition of “death” but a statement of the medical criteria of death, requires either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem. Criterion (1) does not distinguish between (a) irreversible cessation of natural circulatory and respiratory functions and (b) irreversible cessation of artificially supported circulatory and respiratory functions. Thus it requires that there be cessation not only of natural circulatory and respiratory functions but also of artificially supported circulatory and respiratory functions. The proposed definition is always satisfied when either of the present medical criteria of death apply, i.e., either the neurological or the circulatory and respiratory. However, sometimes the definition is satisfied when neither of the medical criteria apply. The definition conflicts with both the circulatory-respiratory and neurological criteria of death in a few unusual cases. It defines as dead a person in a permanent vegetative state (PVS) when that person’s circulatory and respiratory functions, which are completely dependent on artificial support, would almost immediately cease when the artificial support was removed.⁴ A hospital that strictly abides by the circulatory-respiratory and neurological criteria of death, which make up the legal definition of death, would not declare a person in a PVS, whose circulation and respiration are being maintained with artificial support, to be dead. However, when all relevant parties agree, artificial support is withdrawn and if the person’s heart stops within an hour, then after seventy-five seconds to five minutes, he is declared dead. Even prior to his being declared dead, if he is to be an organ donor, sometimes he is injected with heparin to keep the organs that will be harvested in the best possible condition.

In the literal use of the term “die” death is permanent (irreversible). Some people may claim to have been dead for several minutes and then to have returned to life, but this is only a dramatic way of saying that both consciousness and all observable natural functioning of the organism as a whole were temporarily lost (for example, because of a brief episode of cardiac arrest). But a temporary absence of consciousness and a temporary loss of all observable natural functioning of the organism as a whole are not sufficient for what is meant by “death.” Death must be permanent (irreversible). Most people do not distinguish between death being permanent and death being irreversible. However, the failure to make two important distinctions, (1) between the definition of “death” and the medical criteria of death, and (2) between natural circulatory and respiratory functions and artificially supported circulatory and respiratory functions, have forced physicians to distinguish between death being permanent and death being irreversible.

It has commonly been assumed that physicians in a hospital declare a patient to be dead only when at least one of the medical criteria of death has been satisfied. The medical criteria of death are (1) irreversible cessation of circulatory and respiratory functions, and (2) irreversible cessation of all functions of the entire brain, including the brain stem. However, as stated earlier, the first criterion, the irreversible cessation of circulatory and respiratory functions, does not distinguish between natural and artificially supported functioning. Thus, when the brain stem is still functioning a person cannot be declared dead when circulatory and respiratory functions are continuing, even when they are functioning only because they are artificially supported. However, doctors in hospitals have for some time declared persons who are irreversibly unconscious but whose brain stem is still functioning to be dead when the loss of artificially supported circulatory and respiratory functions are not irreversible. They have done this

when it is unanimously agreed by all relevant parties that the loss of these functions would not be reversed. This requires a distinction between death being permanent and death being irreversible. “Irreversible” means “cannot be reversed”; “permanent” means “will not be reversed.” Thus, although no one wants to say so, we now have death by decision. Doctors decide to declare a patient dead when they decide that they will not restart the artificial support that makes circulatory and respiratory functioning possible.

Definitions, Criteria, and Tests

Much of the confusion arising from the current brain death controversy is due to the failure to distinguish among three distinct elements: (1) the definition of death, which should be determined so as to capture the ordinary use of the term “dead” and related terms; (2) the medical criteria for determining that death has occurred, which must stay current with changes in our scientific understanding of the organism, and which are now taken as the legal definition of death; and (3) the tests to prove that the criterion or the definition has been satisfied, which often change with improvements in medical technology. It is a source of some confusion that the new “statutory definitions” of death are not actually attempts to describe what the term “death” means in ordinary usage. Rather, these “legal definitions” are actually statements of the medical criteria by which physicians are supposed to determine when death has occurred.

Because there has been so much more attention paid to the medical criteria or legal definition of death than to the actual definition of death, doctors seem to hold that a person is dead if and only if one of the medical criteria has been fulfilled. When there is any doubt about whether a person in the hospital is dead, it is a medical criterion that seems to be used to determine whether the person is dead. It ought to be the case that the definition of death determines what criterion should be used, but death so often occurs in a medical setting that some claim the ordinary meaning of “dead” is irrelevant, and that the medical criteria should always be used to determine whether a person is dead.

When either of the present medical criteria of death applies, the definition of death is always satisfied, so that there is no problem with taking the medical criteria to be sufficient for death. In these cases there is no conflict between the medical criteria of death and the definition of death. However, many, including us in our earlier writings, are not satisfied with the fulfillment of medical criteria being sufficient for the definition of death to be satisfied. Many still claim that the fulfillment of medical criterion is not only sufficient but also necessary for the definition of death to be satisfied. They hold that if neither of the medical criteria applies, then the person is not dead even if the definition is satisfied. This results in some physicians making the following distinction: a patient whose total brain is permanently (irreversibly) nonfunctioning, but whose circulatory and respiratory functions are being maintained by artificial support, is dead, but a person with a functioning brain stem whose circulatory and respiratory functions are still totally dependent on artificial support is not dead. The implausibility of this distinction has led some to hold that even a person whose total brain is permanently (irreversibly) nonfunctioning, but whose circulatory and respiratory functions are being maintained by artificial support, is not dead.

Contrary to what is explicitly claimed, standard hospital practice now is that a person in PVS is declared dead when there is a permanent (irreversible) cessation of all natural circulatory and respiratory functions and a permanent but not irreversible cessation of artificially supported circulatory and respiratory functions. When the permanence of the cessation of all circulatory and respiratory functions is due to a decision

not to restart the artificial support, it is not irreversible. Such a person is not dead by either the neurological criterion, or the stated circulatory and respiratory criterion. Some physicians claim that “irreversible” in the statement of the medical criteria means “permanent. However, others hold that it is stretching the term “irreversible” to say that a patient is dead by the stated circulatory and respiratory criterion when it is possible to reverse the cessation of circulatory and respiratory function with artificial support.

Given the current legal definition of death, declaring such a patient to be dead must be regarded as death by decision. However, if the definition of death that I have provided is accepted, there would be no need of death by decision. Rather, a person in a permanent vegetative state who is totally dependent on artificial support for circulatory and respiratory functioning would be dead. This would not change the standard practice of declaring a person dead in the hospital, for the tests of death would remain what they are now. It would still be necessary for the procedure of removing the artificial support to guarantee that there is an irreversible cessation of all observable natural functioning of the organism as a whole. When this occurs, and there is a permanent (irreversible) absence of consciousness, on the proposed definition, the organism is dead and there is no need for death by decision.

I have maintained that the correct definition of death is the permanent (irreversible) cessation of all observable natural functioning of the organism as a whole and the permanent (irreversible) absence of consciousness in the organism as a whole and in any part of that organism. In order for this definition to be applied to actual cases of death, it is useful to have a criterion that establishes with complete certainty that the definition has been satisfied. Four criteria of death have been put forward: (1) the permanent (irreversible) loss of circulatory and respiratory functioning, (2) the total and permanent (irreversible) loss of functioning of the cortex, (3) the total and permanent (irreversible) loss of functioning of the brain stem, and (4) the total and permanent (irreversible) loss of functioning of the whole brain. Two of these four proposed criteria, (1) the permanent (irreversible) loss of circulatory and respiratory functioning and (4) the total and permanent (irreversible) loss of functioning of the whole brain, guarantee that the above definition of death is satisfied. Thus, they are the only acceptable criteria of death. However, it is possible for the definition to be satisfied when neither of these criteria applies. No one doubts that the medical criteria must be such that when they apply, the definition of death must be satisfied. However, as is shown by what has become standard hospital practice, it may be possible for the definition of death to be satisfied when the medical criteria do not apply. In these cases, completely reliable tests must be used to determine that there is a permanent (irreversible) absence of consciousness in the organism as a whole and in any part of that organism and that there is a permanent (irreversible) cessation of all observable natural functioning of the organism as a whole.

Actual medical practice shows that physicians do not regard the stated legal definition of death, that is, the medical criteria, as needing to be satisfied before declaring a patient to be dead. They do regard the stated legal definition of death, that is, the medical criteria, as sufficient for declaring a patient to be dead. This is as it should be, for the medical criterion of death must establish beyond any doubt that the definition of death has been satisfied and that it is appropriate to declare the person dead. However, physicians need not regard it to be necessary for the medical criteria to apply in order for the definition to be satisfied. It is sufficient to use completely reliable tests to determine that the definition is satisfied. These tests are those

that are now done to establish that a person is dead when the person's organs are going to be harvested. Thus, accepting the proposed definition of death not only does not require any change in hospital practices, it also has the benefit of eliminating the troubling practice of death by decision.

Endnotes

1. This paper is a modification of the view presented in Chapter 11, *Death*, of *Bioethics: A Systematic Approach*, by Bernard Gert, Charles M. Culver, and K. Danner Clouser, (Oxford University Press, 2006). I have benefitted from the comments of the other people on the panel on death at the 2009 Pacific Division meeting of The American Philosophical Association and from many conversations with James Bernat, although he may not share the conclusions that I reach.
2. See R.J. White, L.R. Wolin, et al. "Cephalic Exchange Transplantation in the Monkey," *Surgery* 70 (1971): 135-39, and B. O'Shea, "Brain Transplants: Myth or Monster?" *British Journal of Psychiatry* 156 (1990): 645-53.
3. See Bernard Gert, "Can the Brain Have a Pain?" *Philosophy and Phenomenological Research* 27 (1967): 432-36, and "Personal Identity and the Body," *Dialogue* 10 (1971): 458-78.
4. (1) A patient who was in a permanent vegetative state (PVS) ten years after traumatic brain injury (TBI) who then contracts a viral infection like poliomyelitis that selectively damages breathing requiring permanent ventilator therapy; (2) a patient with TBI causing PVS but who also sustained high cervical spinal cord injury destroying the phrenic nerve nuclei causing respiratory arrest requiring permanent ventilator therapy. I owe these examples to James Bernat.

Is There Good Justification for the Universal Medical Acceptance of Brain Death as Death?

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Background

Brain death (BD) is said to be the state of death. It has been generally accepted that there is a concept of death, medical criteria for death that fulfill this concept, and tests to determine that a medical criterion of death has been met.¹ The generally accepted concept of death is the irreversible loss of integration of the organism as a whole.² Brain death is said to be death of the supreme regulator of the organism, the brain, and therefore to be a state where dis-integration of the organism as a whole has already occurred.³ The tests of BD are said to diagnose this state of irreversible loss of all functions of the entire brain, including the brainstem.

Other concepts of death have been offered, but generally have not been accepted by medicine or society. Irreversible loss of consciousness is a concept of death that the so-called higher brain death criterion would satisfy. This is problematic for several reasons: it implies substance dualism in that you can be dead before your organism is dead, and that we could bury or cremate or autopsy a patient in a permanent vegetative state despite their breathing, moving, and having eyes open.⁴ Irreversible loss of the capacity for consciousness plus irreversible loss of the capacity to breathe is a concept of death that the so-called brainstem death criterion would satisfy. This is also problematic for several reasons: it is not a concept of death, but rather a restatement of a suggested criterion for death; and, why loss of breathing must be spontaneous is

unclear (many patients have no capacity to breathe, are totally dependent on artificial ventilation, and are clearly alive; and many patients lack a vital capacity such as heartbeat, kidney function, or pancreas function, and are totally dependent on artificial support such as a pacemaker, dialysis, or insulin, and are clearly alive).⁵

There is medical dogma regarding BD that has been consistently taught to physicians during their training. The dogma is as follows: a) BD is death; b) BD is the irreversible loss of all functions of the entire brain, including the brainstem; and c) when BD is diagnosed by our tests, the patient is dead, and the family can either donate organs, or we stop artificial support.⁶ Physicians are also told that BD is accepted almost universally; therefore, we are led to believe, there must be good justification for the concept.⁷ In other words, physicians are left with the question: How could BD be accepted if it is a flawed criterion for death?

There are several potential answers to this question. When BD was initially accepted there were two explicitly stated reasons: to allow discontinuation of life-support in these profoundly brain damaged patients without being accused of murder; and to allow vital organ donation and transplantation without the surgeon procuring the organ being accused of murder.⁸ The first reason is no longer necessary because withdrawal of life support in patients with poor prognosis and unacceptable quality of life is routinely done with patient or surrogate consent and without this being considered murder. The second reason is still necessary in order to meet the dead donor rule. The influence of the transplantation enterprise should not be underestimated. Physicians work in an environment where their institution and their work gains prestige by participation in life-saving organ transplantation, they see the transplant candidates suffering and dying and the sometimes miraculous improvement in quality of life after transplant, and they sense the "futility" of continued life-support in the BD patient in a medical environment of scarce resources and routine pronouncement of death based on the BD criterion. All of these act as potential conscious and unconscious conflicts of interest in taking seriously any challenge of the BD criterion of death. Physicians also may simply echo previous statements on BD, assuming that the concept has been well worked out. For example, a recent Canadian forum to clarify issues surrounding BD published the following: "Concept and definition of neurological death: We recommend that neurologically determined death be defined as the irreversible loss of the capacity for consciousness combined with the irreversible loss of all brainstem functions including the capacity to breathe."⁹ This is simply restating the criterion of BD, and not giving a concept of death that it fulfills; it is equivalent to stating that "BD is BD." Another possibility is that perhaps physicians are simply not aware of the problems with the BD criterion, and maybe there is not a good justification for the concept used by physicians.

With this background, we can now ask the following questions: Do physicians managing BD: a) understand why BD can be said to be death? (have a consistent concept of death that the criterion BD fulfills); b) understand the empirical state of the brain in BD? (understand the tests used to confirm the criterion of BD); and c) agree that the BD patient is dead?

Physician Surveys

An early survey in the late 1980s was published by Youngner et al. in the United States.¹⁰ They asked a group of 195 physicians and nurses working with potential organ donors several questions. First they asked a factual multiple choice question, "What brain functions must be lost for a patient to be declared BD?" Only 63% answered correctly that it was irreversible loss of

all brain function; some answered that it was irreversible loss of all cortical function (18%) or severe brain damage with minimal residual function (7%). Respondents were then presented with a patient with irreversible loss of all brain function and asked if that patient was legally dead; 82% of physician decision makers, and 65% of other physicians/nurses answered correctly. When presented with a patient with irreversible vegetative state, 95% of physician decision makers, and 70% of other physicians/nurses answered correctly. Combining all three questions, only 25/39 (64%) of physician decision makers, and 43/156 (28%) of other physicians/nurses had all answered correctly. The authors then determined the concept of death used by the 185 respondents that considered the irreversible loss of all brain function patient dead: 36% used a higher brain concept, 26% a whole brain concept, 32% a concept suggesting the patient was really alive (e.g., a dismal prognosis, or very poor quality of life), and 5% could provide no coherent concept. When combining explanations given for the two patient cases, only 42% used a consistent concept of death for both.

More recently (in 2004-2006) a survey was administered to pediatric intensivists in Canada, and to adult and pediatric neurosurgeons in Canada.¹¹ When presented a patient who unequivocally meets all BD criteria, they were asked: "Conceptually, why are they dead (i.e., in your own words, what is it about loss of brain function including the brainstem that makes this patient dead)? Of the 54 pediatric intensivists, 17% used a higher brain concept, 22% a loss of bodily integration concept, 22% a prognosis "concept" (prognosis of certain death, or poor quality of life), 24% simply restated the criterion (loss of all brain function), and 11% left no response. Similarly, of the 128 neurosurgeons, 27% used a higher brain concept, 16% a loss of bodily integration concept, 20% a prognosis "concept," 30% simply restated the criterion, and 13% left no response. This suggests that more than half had no concept of death to justify the BD criterion (i.e., prognosis of death is not a diagnosis of death; a criterion of death is not a valid concept of death; and providing no response suggests many had no concept to articulate).

The respondents were also asked: "Which best describes why you are comfortable diagnosing death based on the criteria of BD?" Of the pediatric intensivists, 67% chose "the conceptual basis makes BD equivalent to death," 41% chose "it is a standard" (medical standard 24%; legal standard 26%), and 6% chose "it was taught to me during my training." Of the neurosurgeons, these respective responses were found in 70%, 34%, and 5%. In the respondents who felt they are comfortable diagnosing death based on the criteria of BD because "the conceptual basis makes BD equivalent to death," the concepts used for death were similar to the entire group. For the pediatric intensivists and neurosurgeons respectively, the concepts used by these respondents were: higher brain (18%, and 28%), loss of bodily integration (22% and 16%), prognosis (25% and 22%), restating the criterion (17% and 32%), and no response (18% and 11%).

In this survey, the physicians were asked about what empirical findings on testing the brain would not be compatible with the criterion of BD. It is important to emphasize that even if one was to accept that the criterion BD fulfills a concept of death, there are problems with the tests used to diagnose the criterion BD: irreversible loss of all functions of the entire brain including the brainstem. For example, in series of correctly diagnosed brain dead patients some functions of the brain continue: electro-encephalogram (EEG) activity in 20% (often a "sleep-like" EEG), evoked brainstem potentials to sensory stimulus to the skin (somatosensory evoked potentials) and/or auditory system (auditory brainstem evoked responses) in > 5%,

and hypothalamic function (such as temperature regulation, blood pressure regulation, antidiuretic hormone regulation of fluid and electrolyte balance [including lack of diabetes insipidus]) in > 50%.¹² These functions likely remain because there is not irreversible destruction of the brain in many with BD; for example, brain blood flow on testing remains in 5%-40% (depending on the test used; with radionuclide blood flow, or CT Scan angiography, blood flow can remain in up to 40%), and lack of brain destruction in > 15%-40% (with lack of brainstem destruction seen in up to 40% of autopsies).¹³ When presented patients with these functions or brain findings, the pediatric intensivists and neurosurgeons, respectively, responded that the finding is not compatible with BD in the following: 56% and 55% for EEG activity; 57% and 57% for brainstem evoked potentials; 6% and 10% for hypothalamic function; 61% and 41% for remaining brain blood flow; and 35% and 46% for lack of brain pathologic destruction. These results suggest a poor understanding of the actual state of brain function in patients diagnosed as dead based on the BD criterion.

Finally, the neurosurgeon survey asked: "Are brain death and cardiac death the same state (i.e., are both death of the patient)?" Of the 128 neurosurgeons, 45% responded to this question with "no." This is important because the standard rationale for BD is that it is the unitary state of death. Meaning, the circulatory criterion for death, so the argument goes, has always been used simply because it is a test to verify the irreversible loss of all brain function. According to this medically and legally accepted argument, BD and circulatory death are the same state of death.¹⁴ In a question indirectly asking if BD and circulatory death are equivalent, the survey asked what the physician would do if a patient with BD has a family that insists on continued "life support"; 31% of pediatric intensivists and 37% of neurosurgeons would continue the "life support." This is remarkably similar to a survey of pediatric intensivists in the United States, where 34% would continue "life support" in this situation.¹⁵ I believe that in a situation after death pronounced based on the circulatory criterion none of these physicians would honor a similar family request. It is generally unthinkable to continue ventilation of a corpse with absent circulation. This suggests that BD and circulatory death are not considered the same unitary state of death for many physicians.

Qualitative studies in the literature have results consistent with the survey results described above. Tomlinson found that "[physicians] use BD as a criterion for death, but they have ready to hand no clear concept of death which underlies their use of the BD criterion."¹⁶ In this study quotations from physicians included the following: "The machine is the way he would have to live the rest of his life"; "The machine is basically what's keeping him alive"; and "If kept on the ventilator, the patient will die of sepsis." Lock found that "[intensivists] are more ambivalent than many of them care to admit, however; about the status of a living cadaver. While they agree that brain death is irreversible, they do not believe that brain dead individuals are dead."¹⁷ In her study, quotations from the intensivists included the following: "...an in-between thing. It's neither a cadaver nor a person..."; "The body wants to die, you can sense that when it becomes difficult to keep the blood pressure stable and so on. ...We don't want this patient to expire before we can harvest the organs, so it's important to keep them stable and alive..."; "It's not death, but it is an irreversible diagnosis, which I accept..."; "I guess I equate the death of a person with the death of the spirit. ...I guess one would have to take it as meaning that part of a person which is different, sort of not in the physical realm...won't ever be the person they used to know."

Physician Experts and Their Statements

In official statements from physician professional societies a concept of death that BD would fulfill is conspicuously missing. For example, the American Academy of Neurology consensus statement, and the Canadian Forum consensus statement do not mention a concept of death.¹⁸ Respected experts in neurology who are proponents of BD often have been noted to describe BD in a way that suggests they do not really believe it is death. Allan Shewmon has pointed this out with the following examples. Fred Plum, neurologist and co-author of the textbook *The Diagnosis of Stupor and Coma*, said at a conference, in essence, “OK, I’ll grant you that the brain-dead body is a living human organism, but is it a human person?” In a recent review article on BD he wrote, regarding a series of 73 brain dead patients: “half experienced asystole by the third day but the bodies of 2 lived on until the 10th and 16th day.” Allan Ropper, neurologist and coauthor of *Principles of Neurology*, wrote when describing long surviving cases of BD: “In exceptional cases, however, the provision of adequate fluid, vasopressor, and respiratory support allows preservation of the somatic organism in a comatose state for longer.”¹⁹ In another publication, I had pointed this out with the following examples. James Bernat, well-known neurologist and defender of BD, wrote, “...while I am willing to acknowledge that whole-brain death formulation remains imperfect, I continue to support it because on the public policy level its shortcomings are relatively inconsequential.” Steven Laureys, neurologist and expert on severely brain injured patients, wrote that “[long] survivals [in BD] merely indicates that their bodily decomposition has been delayed until their circulation has ceased.”²⁰ All of these quotations suggest that the human being is still alive during BD, and there is not loss of integrative unity of the organism as a whole.

Implications

The findings described above suggest the following about physicians that diagnose BD and accept BD as death of the patient. Physicians in general: a) are confused about the concept, criterion, and tests for death; and b) use a wide variety of concepts to justify the diagnosis of death, many of which are incoherent (e.g., prognosis, quality of life, restating the criterion). The international medical consensus would seem to be very superficial.

To return to the initial three questions regarding physician acceptance of BD, the answers may be clearer: Do physicians managing brain death: 1) Understand why brain death can be said to be death? (have a consistent concept of death that the criterion BD fulfills): no; 2) Understand the empirical state of the brain in brain death? (understand the tests used to confirm the criterion of BD): no; and 3) Agree that the BD patient is dead?: no.

Based on anecdotal discussions, Allan Shewmon has come to a similar conclusion. He writes, “I daresay that doctors in general, and neurologists in particular, have come to an overwhelming consensus that brain death is death, not because they have examined the evidence and concluded it for themselves, but purely and simply from a professional herd mentality. When queried about it, few can give a coherent explanation why brain death is death itself, as opposed to deep coma in a dying patient.”²¹ I agree with this conclusion. If BD is death, it is now up to philosophy to provide a coherent concept of death that the BD criterion fulfills. Physicians are confused and do not have a consistent and coherent concept of death that would justify BD as a criterion of death.

Some Final Comments

My co-panelists are divided on whether BD fulfills a concept of death. Robert Truog argues that BD is not death, and that we

should abandon the dead donor rule to allow organ donation prior to withdrawal of ventilation as we do now. This, according to his argument, would be a form of “justified killing.”²² Allan Shewmon has shown that patients with BD can “survive” for years with little support other than ventilation and feeds, proving their ongoing “integration as a whole.”²³ I agree that death is the loss of integration of the organism as a whole, and the only current accurate medical criterion for this is the irreversible loss of circulation of oxygenated blood in the organism. John Lizza argues that we should accept a higher brain death concept based on a substantive view of personhood. I do not accept this argument for the following reasons: as Don Marquis argues, it can only be true if dualism is true, and we are not human organisms; and it would imply that a patient in a permanent irreversible vegetative state who is unconscious but wakeful with open eyes, breathing, and movement, is dead.²⁴ If they are dead then they can be treated as dead, having burial, cremation, or autopsy in that state. I think it is more appropriate to suggest that the loss of mental activity makes my life of value, my life worth living over; and hence it would be time to stop treatment and let me die. Lizza writes that we “would not wish to identify ourselves with artificially sustained brainless integrated human organisms.”²⁵ I believe this means that most of us would say, if ever in this state, to let us die, and not that we are already dead.

Gert suggests that a definition of death that reflects the common understanding and usage of the word “dead” is as follows: “the irreversible cessation of all observable natural functioning of the organism as a whole and the irreversible absence of consciousness in the organism as a whole and in any part of that organism.”²⁶ There are problems with this conception. First, it is unclear why functioning must be natural (spontaneous) in the irreversibly unconscious patient but not in the conscious patient. Many patients are dependent fully on artificial life support in the form of a ventilator, vasopressors (blood pressure drugs), a heart pacemaker, kidney dialysis, or insulin injections, and are not considered dead. Second, this would mean that the irreversibly vegetative patient who became dependent on one of these artificial life supports died at the instant they became dependent on that life support. For example, if they develop a brainstem tumor that affects respiration, or have a cervical spine injury that affects respiration, or develop kidney failure, or diabetes, or a heart rhythm problem that requires a pacemaker, they are now dead. This would be the case even though they continue to have eyes open periods of wakefulness, movement, and grimacing to painful stimulus. Third, this also means that not only organisms can die. Gert asserts that the severed head artificially sustained and with consciousness is alive yet not an organism, and dies when consciousness is lost, even though it was not an organism. I suggest that the artificially sustained head is a badly mutilated organism as a whole, and the artificial life support shows that the artificial (non-spontaneous) integration provided by the machine counts as integration of the organism as a whole. I believe that these problems make Gert’s definition of death inconsistent with our ordinary use of the term. As further evidence, I asked the panel if people (who understand the ordinary use of the word dead) would consider a patient with BD on a ventilator with ongoing circulation and integration appropriate for an open casket funeral, burial, cremation, or autopsy in that current state (on the ventilator). The suggestion here being that we know when someone is dead, and in general we know what to do with that body (such as burial).

A final concept of death was offered recently by the President’s Council on Bioethics: “cessation of the fundamental vital work of a living organism—the work of self-preservation, achieved through the organism’s need driven commerce with

the surrounding world.” This “depends on three fundamental capacities: 1) openness to the world, that is, receptivity to stimuli and signals from the surrounding environment; 2) the ability to act upon the world to obtain selectively what it needs; and 3) the basic felt (non-conscious) need that drives the organism to act as it must, to obtain what it needs and what its openness reveals to be available.”²⁷ Brain dead patients seem to be alive by this definition. For example, they can 1) have spinal reflexes to noxious stimuli, hemodynamic response to incisions, and immune system response to infections; 2) assimilate selectively what they need from feeds, fluids, electrolytes, and oxygen, and eliminate unneeded wastes to the environment in order to grow, mature, fight infections, and recover from adverse events; and 3) have the felt needs (drives) to circulate blood to organs to meet their needs, have gut peristalsis to eliminate solid wastes to the world, metabolize toxins from the outside world in the liver, excrete unneeded electrolytes and water into the environment, clot at an incision to prevent losing blood into the world, fight infections in order to eliminate bacteria invading from the outside world, keep bacterial flora in the throat from invading the body from the outside world. The President’s Council claims that the ventilator, by heaving “the lungs to fill,” only “mimics the authentic work of the organism.”²⁸ From this, it seems that to justify BD requires an ad hoc stipulation about what is authentic and important “work.”²⁹ Furthermore, this would imply the following organisms are dead: the fetus, the irreversibly vegetative patient without the ability to breathe (see above examples), the locked-in patient with consciousness but complete paralysis including of the cranial nerves, the pure brainstem dead patient (with intact cerebral hemispheres and hence the theoretical capacity to have consciousness), and the partially brainstem dead patient without the ability to breathe. However, the President’s Council explicitly rejects that the vegetative patient or the pure brainstem dead patient is dead.

I conclude that BD is not death. It is a devastating neurological state that is unlikely to be reversible to a state of sentience, and may be the time when life support should be stopped and the patient allowed to die.

Endnotes

1. See J.L. Bernat, C.M. Culver, and B. Gert, “On the Definition and Criterion of Death,” *Annals of Internal Medicine* 94 (1981): 389-94.
2. *Ibid.* See also President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Defining Death: Medical, Legal and Ethical Issues in the Determination of Death* (Washington, D.C.: U.S. Government Printing Office, 1981).
3. *Ibid.*
4. See D. DeGrazia, “Are We Essentially Persons? Olson, Baker, and a Reply,” *The Philosophical Forum* 33 (2002): 101-20, and “Identity, Killing, and the Boundaries of Our Existence,” *Philosophy and Public Affairs* 31 (2003): 413-42. See also: R.D. Truog, “Is It Time to Abandon Brain Death?” *Hastings Center Report* 27 (1997): 29-37.
5. I discuss this further in: Ari Joffe, “The Neurological Determination of Death: What Does it Really Mean?” *Issues In Law & Medicine* 23 (2007): 119-40. See also: D.A. Shewmon, “Brainstem Death, Brain Death and Death: A Critical Re-evaluation of the Purported Equivalence,” *Issues in Law & Medicine* 14 (1998): 125-45; and F.M. Kamm, “Brain Death and Spontaneous Breathing,” *Philosophy & Public Affairs* 30 (2002): 297-320.
6. See E.F.M. Wijdicks, “Determining Brain Death in Adults,” *Neurology* 45 (1995): 1003-11; and S.D. Shemie, C. Doig, B. Dickens, et al., “Severe Brain Injury to Neurological Determination of Death: Canadian Forum Recommendations,” *Canadian Medical Association Journal* 174 (2006): S1-S12.

7. See E.F.M. Wijdicks, “Brain Death Worldwide: Accepted Fact but No Global Consensus in Diagnostic Criteria,” *Neurology* 58 (2002): 20-25.
8. See “A Definition of Irreversible Coma. Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death,” *Journal of the American Medical Association* 205 (1968): 337-40.
9. See S.D. Shemie, C. Doig, B. Dickens, et al., “Severe Brain Injury to Neurological Determination of Death: Canadian Forum Recommendations,” *Canadian Medical Association Journal* 174 (2006): S1-S12.
10. See S.J. Youngner, C.S. Landefeld, C.J. Coulton, et al., “Brain Death and Organ Retrieval: A Cross-sectional Survey of Knowledge and Concepts among Health Professionals,” *Journal of the American Medical Association* 261 (1989): 2205-10.
11. See A.R. Joffe, N. Anton, “Brain Death: Understanding of the Conceptual Basis by Pediatric Intensivists in Canada,” *Archives of Pediatric and Adolescent Medicine* 160 (2006): 747-52; and A.R. Joffe, N. Anton, V. Mehta, “A Survey to Determine the Understanding of the Conceptual Basis and Diagnostic Tests Used for Brain Death by Neurosurgeons in Canada,” *Neurosurgery* 61 (2007): 1039-47.
12. For discussion of these findings, and complete references see *ibid.*; and Ari Joffe, “The Neurological Determination of Death: What Does it Really Mean?” *Issues In Law & Medicine* 23 (2007): 119-40.
13. *Ibid.*; and A.R. Joffe, “Limitations of Brain Death in the Interpretation of Computed Tomographic Angiography,” *Intensive Care Medicine* 33 (2007): 2218.
14. See President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Defining Death: Medical, Legal and Ethical Issues in the Determination of Death* (Washington, D.C.: U.S. Government Printing Office, 1981).
15. See M.Z. Solomon, D.E. Sellers, K.S. Heller, et al., “New and Lingering Controversies in Pediatric End-of-life Care,” *Pediatrics* 116 (2005): 872-83.
16. See T. Tomlinson, “Misunderstanding Death on a Respirator,” *Bioethics* 4 (1990): 253-64, pp. 257, 259.
17. See M. Lock, “Inventing a New Death and Making It Believable,” *Anthropology & Medicine* 9 (2002): 97-115, pp. 108, 109, 110.
18. See Note 6 above.
19. Quoted by D.A. Shewmon in his publication: “Mental Disconnect: ‘Physiological Decapitation’ as a Heuristic for Understanding ‘Brain Death,’” in Working Group on the Signs of Death 11-12 September 2006 edited by Msgr. H.E. Marcelo Sanchez Sorondo (Vatican City: Pontificia Academia Scientiarum, 2007), 292-333.
20. Quoted by A.R. Joffe in my publication: “Are Recent Defenses of the Brain Death Concept Adequate?” *Bioethics* (2009): In Press.
21. D.A. Shewmon. “Mental Disconnect: ‘Physiological Decapitation’ as a Heuristic for Understanding ‘Brain Death.’” In Working Group on the Signs of Death 11-12 September 2006 edited by Msgr. H.E. Marcelo Sanchez Sorondo (Vatican City: Pontificia Academia Scientiarum, 2007), 292-333.
22. See F.G. Miller, R.D. Truog, “Rethinking the Ethics of Vital Organ Donations,” *Hastings Center Report* 38 (2008): 38-46 and R.D. Truog’s entry in this volume.
23. See D.A. Shewmon, “Chronic ‘Brain Death’: Meta-analysis and Conceptual Consequences,” *Neurology* 51 (1998): 1538-45; and his entry in this volume.
24. See the entries by J. Lizza and D. Marquis in this volume.
25. *Ibid.*
26. See B. Gert, C.M. Culver, K.D. Clouser, “Death,” in *Bioethics: a Systematic Approach*, 2nd edition (Oxford University Press, 2006): 283-308; see also the entry by B. Gert in this volume.

27. President's Council of Bioethics. *Controversies in the Determination of Death* (Washington, D.C.: President's Council of Bioethics, 2008).
28. *Ibid.*
29. *Ibid.*

Mental Essentialism and the Definition of Death

Don Marquis Affiliation?

The irreversible loss of all functions of the entire brain produces irreversible unconsciousness. Many people believe that if they would lose consciousness irreversibly they would no longer exist. To go out of existence is to die. This argument, if sound, justifies the standard neurological definition of death. The key premise is the doctrine of mental essentialism. According to mental essentialism the capacity for mental activity is an essential property of us; that is, we cannot lack that property and still exist. What considerations support mental essentialism?

Jeff McMahan has offered two. In Brain Transplant you are invited to imagine that LeBron James has suffered a terrible accident, is brain dead, is on life support, and has not been injured below his chin. You want to be a great basketball player so you arrange to have your brain transplanted into LeBron's body.¹ Psychological continuity considerations, that is, considerations involving memories, beliefs, plans, and desires, show that you would continue to exist in LeBron's body. Thus, your brain, not your (former) body, is the basis for your continuing identity. Because you cannot be in two places at once, your former body, even if maintained on life support, is not evidence of the continued existence of you in that body. If you became brain dead, your body would not be different in any important respect from your former body after the transplant. Therefore, it is not evidence of the continued existence of you in that body either. Therefore, if you are brain dead, then you are dead. Brain Transplant renders transparent our conviction that we are essentially mental entities. Michael Green and Dan Wikler defended the neurological definition of death in 1980 on the basis of this sort of argument.²

Here is an objection to the Green-Wikler view. When you irreversibly lose the capacity for consciousness the biological organism that you are can remain alive (as Alan Shewmon³ and Bob Truog⁴ have correctly argued, and as the cases of Terri Schiavo, Nancy Cruzan, and Karen Anne Quinlan show). If the Green-Wikler view is correct, then if you are a biological organism, then you could be both alive and not alive. This is not possible.

Jeff McMahan has argued that these considerations show that you are not a biological organism. You are a brain. Your organism is an individual different from you. You are part of an organism. Your organism continuing to live does not imply your continuing to live. Here's an analogy. The horn of a car is a part of some car; but is not the same individual as that car. A part of a car can be rendered irreversibly nonfunctional (or removed) even though the car continues to be functional. In sum, the view about our nature revealed by Brain Transplant establishes mental essentialism. If mental essentialism is true, then dualism is true! You may (of course!) resist this conclusion, so here is another argument for it.

According to Leibniz (and all other rational persons), if a is identical with b, then all the properties of a are properties of b. According to the above argument the longevity of you (the

"persistence conditions" for you metaphysicians) may not be same as the longevity of your body. It follows that you and your body are not the same individuals. You are not a human being. Sorry about that.

Now consider Dicephaly.⁵ Abigail and Brittany Hensel are twins. The head of each emerges from the same body. Abigail and Brittany Hensel are different individuals. Because identity is transitive, they cannot be identical to the one biological organism they share. There is no other biological organism to which either can be identical. The truth of dualism follows.

Strictly speaking, according to McMahan, we are identical with our cerebra, not our entire brains. Nevertheless, the death of our entire brains is sufficient for the death of our cerebra and the death of our cerebra is sufficient for our death. It follows that if an individual is brain dead, then that individual is dead.

Notice mental essentialism does not render the Shewmon-Truog definition of death false. It renders it irrelevant. The Shewmon-Truog view concerns the death of that biological organism with which we are so intimately associated. McMahan is talking about our death. Our death is the death of something else (because dualism is true) and it is, after all, what concerns us. Therefore, when we define death, we should define it.

Are Brain Transplant and Dicephaly considerations that compel us to adopt mental essentialism? Consider first the Hensel twins. Are they two persons in one body? They are indubitably two persons. But do they share one body? There is some duplication of organs above their waist. Along with other duplications, they have two spinal cords and two vertebral columns above the waist. It seems apt to describe them as a case of incomplete twinning. What would we say in other cases of incomplete twinning?

Consider an amoeba in the process of fission. There will be times in that process at which whether there is one amoeba or two is indeterminate. The Hensel twin's body seems analogous. Accordingly, they are not clear counterexamples to the claim that we are biological organisms.

There is another problem with Dicephaly. Even if we neglect issues that concern their anatomies below their necks, the "twoness" of the Hensel twins involves much more than cerebra. They are, in addition, two heads and necks within which there are separate veins and arteries, separate boney structures, separate sets of cranial and cervical nerves and, for that matter, separate brain stems. These could be thought of as separate biological organisms with some common physiological support mechanisms. Accordingly, Dicephaly does not compel us to accept a dualism between the mental (as embodied in cerebra) and the physical.

The case that McMahan calls "Division" complicates analysis of Brain Transplant.⁶ In Division your cerebrum is divided and each hemisphere is transplanted into a different body. Psychological continuity obtains between you prior to the transplant and each transplanted hemisphere. On the one hand, Division seems to be a great deal for you. Suppose you are debating whether to pursue a career as a full-time basketball player or a full-time philosopher. You could go through Division and not have to choose! You could be both! On the other hand, if, after Division, each hemisphere were a later stage of you, then, since identity is transitive, both hemispheres would be identical to each other. That is not possible. Therefore, because there is nothing to choose between them, neither hemisphere would be identical to you. To undergo Division is to cease to exist. So much the worse for your two careers!

Here is the difficulty. According to mental essentialism, our psychological continuity is the basis of our continuing identity as individuals. If so, then we could undergo division and continue

to exist. We cannot. Therefore, mental essentialism is false. Can McMahan get around this difficulty?

McMahan's strategy is to say that, if I undergo Division, although I would not be the same individual as each of my hemispheres, I would have egoistic concern for each. However, this cannot be quite right. Egoistic concern is the concern I have for the future of my later self. After Division, my later self has gone out of existence. So McMahan stipulates that "egoistic concern" as he uses it means "special egoistic-like concern," concern that is "phenomenologically indistinguishable from concern for oneself" but need not be concern for oneself.⁷

Now suppose that the operation I am about to undergo is not Division, but merely just standard, run-of-the-mill, everyday brain transplant. (Suppose your local neurosurgeon is advertising a special.) Plainly I will have "special egoistic-like concern" for what seems to be my future self. But why should I suppose that what seems to be my future self actually will be me? McMahan's analysis of Division shows that I am not entitled to that inference. The trouble is that the inference to which I am not entitled is the basis for McMahan's conclusion in Brain Transplant. Apparent psychological unity is not a sufficient condition for our continuing identity.⁸

Is it a necessary condition? Recall that its support is the McMahan-Green-Wikler analysis of Brain Transplant plus the claim that if that analysis is correct, then if my body lacked a functioning brain, it could not be me. Since the mental essentialist analysis of Brain Transplant fails, we are no longer compelled to accept the mental essentialist conclusion concerning when we die.

I think that McMahan's great contributions to this discussion are to have shown that if mental essentialism is true, then dualism is true and also his dogged analysis of alternatives. However, I think that there are serious difficulties with the considerations he offers in favor of mental essentialism, and I think that his arguments for mental essentialism are the best there are.

It is worth adding in this connection that no considerations of personal identity are sufficient to establish mental essentialism. Personal identity is presumably concerned with the question of the conditions under which two stages of one or more persons (who, by definition, have a mental life) are stages of the same person. If that question is understood to be the same question as the question of the conditions under which we continue to be the same individual, then considerations of personal identity do not establish mental essentialism; they presuppose it. Such an understanding of our issue should be characterized, as Russell remarked in another context, as having all the virtues of theft over honest toil.

Endnotes

1. Jeff McMahan. *The Ethics of Killing: Problems at the Margins of Life* (Oxford: Oxford University Press, 2002), 31-35. The above version of Brain Transplant is mine.
2. Michael Green and Daniel Wikler. "Brain Death and Personal Identity." *Philosophy and Public Affairs* 9 (1980): 105-33
3. D.A. Shewmon. "The Brain and Somatic Integration: Insights into the Standard Biological Rationale for Equating 'Brain Death' with Death." *Journal of Medicine and Philosophy* 26 (2001): 457-78
4. R.D. Truog. "Is It Time to Abandon Brain Death?" *Hastings Center Report* 27 (1997): 29-37.
5. McMahan, *op. cit.*, 35-39.
6. McMahan, 39-43.
7. McMahan, 42.
8. This problem also emerges in teletransportation cases.

On Conscious Non-Organisms, Unconscious Persons, and Bisected Person-Organisms

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The debate surrounding the concept and criterion of human death is in some ways like the proverbial blind men and the elephant. Each position is based on some important insight, and irresolvable disputes arise when each claims to be the whole story. Here I shall briefly examine two contrasting positions represented in the session on "brain death" (BD) at the 2009 APA meeting—Bernard Gert's and John Lizza's—and try to reconstruct the part of the elephant between them.

Gert sees the importance of bodily integrative unity in human death; but he does not see that it is essentially an emergent phenomenon deriving from the mutual interaction among all the parts of the body, not a top-down micro-managing by some master integrator-organ (the brain). By contrast, Lizza sees that human (and other vertebrate) organisms without brain function can still be "organisms as a whole"; but he does not see that this has any relevance for human death. In explaining and defending their respective positions, both make heuristic use of thought experiments involving organism bisection.

Organism as a whole

Gert and colleagues have defined death as "the permanent cessation of all observable natural functioning of the organism as a whole and the permanent absence of consciousness in the organism as a whole and in any part of that organism" [1, p. 290]. At the conference, Gert expounded interpretations of "observable" and "natural" that represent further development of his thought since the publication of that definition. To me (and I believe to the other panelists as well), his present view diverges in important ways from how most people, including at least one of his earlier co-authors, James Bemat, understand the notion of organism as a whole in the context of modern intensive care units (ICUs).¹ In this paper, therefore, by the phrase "Gert et al.," I mean their published writings, with the terms of the definition understood how (I daresay) most of their readers, most advocates of the integrative-unity rationale, and the rest of the conference panelists understand them—not necessarily Gert's present view as outlined in endnote 1.

For present purposes, I am happy to accept a slightly modified version of the definition of death proposed by Gert and colleagues, with "observable" omitted, and "natural functioning of the organism as a whole" understood as not being invalidated if one or a few particular vital functions require artificial support. Advocates of the integrative-unity rationale assert that fulfillment of such a definition is guaranteed by the criterion of "total and permanent loss of functioning of the whole brain." Given that permanent loss of all brain function obviously entails permanent absence of consciousness, their justification for the neurological criterion critically hinges on whether, for post-embryonic vertebrates, brain function is necessary for being an "organism as a whole." They claim that it is, offering as the main (if not only) reason a sampling of bodily dysfunctions resulting from lack of brain regulation. In an earlier publication [2] I offered several counterarguments, two of which are, to my mind, conclusive, and I have yet to receive serious rejoinders to them.

First, rather than trying to conclude anything from comparing lists of somatic functions and dysfunctions, that entire line of argumentation can simply be bypassed and trumped by the following syllogism.

1. A functionally brain-disconnected patient on a ventilator in an ICU (e.g., from high spinal cord transection or extreme Guillain-Barre syndrome) is a severely disabled organism as a whole, not just a conscious head connected to an unintegrated collection of organs and tissues enclosed in a bag of skin.
2. The somatic effects of brain nonfunction are necessarily identical to those of brain disconnection.
3. Therefore, a patient without brain function is also a severely disabled organism as a whole (merely an unconscious one).

The major premise requires some elaboration and justification. For the sake of brevity, suffice it to say that the somatic physiological equivalence between total brain failure and high spinal cord transection can be made exact for purposes of the argument.² The somatic equivalence between brain disconnection and brain nonfunction is not merely theoretical; it can be confirmed by a clinical comparison of the two conditions [3 4].

A second fatal flaw in Gert's and colleagues' thesis is that there exists no measuring scale or methodology for "degree of integration" of a complex organism such as a vertebrate. And even if (hypothetically) "degree of integration" could be meaningfully measured, there would be no point along that continuum that could reasonably, non-arbitrarily constitute the dividing line between extremely sick, dying organisms and just-dead (non-)organisms. Gert and colleagues simply list a few integrative functions mediated by the brain, followed by "etc.," omit mention of any integrative functions not mediated by the brain, and perfunctorily declare that the set of lost functions lands squarely on the "disunified" side of the dividing line.

But even without a system for measuring "degree of integration," it can easily be shown with the following syllogism that many BD bodies lie on the "integrated whole" side of the dividing line:

1. Dying patients in ICUs, with multisystem dysfunction and a rapid downhill spiral, by virtue of being still alive, are (by Gert's definition) necessarily on the "whole" side of the hypothesized dividing line along the continuum of degrees of integration.
2. Many BD patients in ICUs are as stable as, and some are more stable than, such dying patients.
3. Therefore, such BD patients are also on the "whole" side of the dividing line.

Other arguments can also be made for the organism-as-a-whole status of many BD bodies, but to my mind these two are the strongest. The BD patient has the same ontological status as a permanent vegetative state patient who, for whatever reason, has lost the capacity to breathe. I am not alone in judging the integrative-unity rationale for a neurological criterion of death to be inadequate. Even the President's Council on Bioethics, in its recently released "white paper," has just lent its voice to the growing chorus of rejecters of this hitherto "mainstream" rationale [5].³

Gert and colleagues state that four criteria of death have been put forward: "permanent loss of natural functioning of (1) the cortex, (2) the brain stem, (3) the whole brain, and (4) heart and lungs," and that "Only the third criterion...is perfectly correlated both with loss of all observable natural functioning of the organism as a whole, and with total absence of consciousness" [1, p. 307]. In my opinion, they are right in rejecting #1, #2, and #4, wrong in accepting #3, and they overlook an important fifth criterion that has in fact also been put forward, namely: "irreversible cessation of circulation

and respiration" [2]. Ironically, this criterion was articulated long before me almost verbatim by the 1981 President's Commission, in the first arm of its Uniform Determination of Death Act [6] (which Gert et al. even quote [1, p. 304] but strangely do not include in their list of proposed criteria).⁴ A "circulatory-respiratory" criterion is not at all synonymous with a "cardio-pulmonary" one, which Gert and colleagues rightly reject. For reasons developed elsewhere [2], if not by sheer process of elimination, I believe this to be the criterion that best corresponds to the concept of "cessation of the organism as a whole." What is truly necessary for the anti-entropic integration of a higher organism is not the functioning of heart and lungs, but the circulation of oxygenated blood and exchange of gases at the cellular level throughout the organism.

Organism-bisection thought experiments

It is interesting that both Gert and Lizza (and many others, including my past self) make use of decapitation as a heuristic for understanding BD. Gert and colleagues felt obliged to amend their 1981 version of the death concept [7] by adding "and the permanent absence of consciousness in the organism as a whole and in any part of that organism," in order to accommodate both hypothetical and actual cases of decapitation and artificial maintenance of the living head (e.g., the gruesome experiments carried out on monkeys in the late 1960s by neurosurgeon Robert White [8 9]). Gert regards the isolated head as clearly alive, by virtue of being conscious, but not a living organism—only part of a former organism. The artificially maintained decapitated body, in Gert's view, is of course also not an organism; for him (and many others) the functional similarity with a BD body constitutes strong additional proof that the BD body cannot be a living organism either.

Whether the conscious head is a severely mutilated organism or a non-organism (which used to be part of a former organism) depends, of course, on the definition of "organism." Gert et al. offer no such definition, but simply assert that the maintained head is not an organism. Lizza seems implicitly to agree on this point when he argues, contra Gert, that the maintained headless body has more claim to organism status than the head [10]. As far as I am aware, there has not been much development of a "philosophy of organism" that would provide a reasonable, non-arbitrary dividing line between mutilated organism and non-organism along the continuum of imaginable mutilations. But what is relevant to the BD debate is not whether the conscious head is an organism, but whether the maintained headless body is.

To answer this question, one would need to examine the actual biological properties of an artificially maintained headless body and see if there are any emergent, holistic properties that must be attributed to a whole that is greater than the sum of its parts. One opportunity to examine such a body was with White's monkey experiments, but he was interested in the heads and did not maintain the headless bodies chronically or study their properties. There is one report of a pregnant sheep that was decapitated and artificially maintained for thirty minutes until Cesarean section delivery of a healthy lamb [11]. Evidently the experimenters had no interest in maintaining the mother sheep any longer than that to search for possible holistic properties in a chronic headless state. May no such experiments ever be carried out on humans, even by the most terrible future Nazi-style doctors (or ever again on our animal cousins)! The only way to know what the physiological properties of a technologically maintained headless human body might actually be is by inference from analogous "experiments of nature," i.e., actual BD bodies. Many of these, as demonstrated above, are rightly classified as living "organisms as a whole," albeit severely disabled ones. So, far from the hypothetical

headless body proving that a BD body is a non-organism (on the same ontological level as an amputated limb), actual BD bodies prove that the hypothetically maintained headless body would be a living organism!

Now, in the thought experiment we have on the one hand a conscious head (whether one wants to call it an “organism” or not), and on the other hand a distinct, unconscious (perhaps better stated, non-conscious) human organism. Actually, the head’s consciousness should not simply be taken for granted. In White’s monkey experiments, the heads reacted in grossly apian fashion to stimuli (mainly noxious ones), but that is hardly proof that a maintained human head would be subjectively conscious and would communicate its thoughts to us. But, assuming for the sake of argument that a maintained human head would exhibit conscious behaviors, there are several conceivable ways of interpreting the thought experiment philosophically. Let us call the pre-decapitation person “John.”

Regarding the maintained head:

1. The head is John’s; when it communicates with us, John is communicating with us.
2. The head is not John’s anymore. The behavior and communications of the head only resemble John’s former personality because of the retained neural circuitry, but they are coming from an automaton or “zombie” rather than from John.

Regarding the maintained headless body:

3. The headless body is, or is part of, John’s body. 3a: If # 1 above, then both head and headless body are part of John’s on-going body, and we would have to posit his person maintaining some sort of trans-spatial relationship with both. 3b: If # 2, the headless body is John’s body, equivalent to a BD John.
4. The headless body is a non-personal human organism. (This assumes a concept of “person” that accommodates actual dissociability between “human person” and “human organism.”)
5. The headless body is a new human person-organism, a kind of identical twin of John that came into existence not from embryo splitting but from a very special kind of adult splitting (one that does not occur spontaneously in nature). The new person (call him Fred) is unable to exercise cognitive functions due to lack of a brain—something like an anencephalic infant suddenly coming into existence except with an adult body. (This assumes a concept of “person” that is not reducible to mind or to brain activity, one for which “permanently unconscious person” is not an oxymoron.)

Even within the imaginary context of the thought experiment, no “thought-empirical” observation or test will help to distinguish # 1 from # 2. Nor is there a way to “thought-empirically” distinguish among # 3, # 4, and # 5. The difference between # 4 and # 5 depends entirely on the philosophy of personhood that one brings to the thought experiment; it is not decided by means of the thought experiment. Lizza would subscribe to the philosophy of personhood in # 4, whereas those who regard anencephalic infants and permanent vegetative state patients as persons would subscribe to that in # 3b and # 5. I’m not sure whether anyone subscribes to # 3a, but it is at least a logical possibility.

Entertaining as such mind-games maybe, they shed no light on the relationship between brain function and human death. Suppose the bisection were done in the midline sagittal plane rather than across the neck. The midline raw surfaces could be

covered over through plastic surgery, and the half with a missing heart could be sustained by a transplanted or artificial heart (with either the other unpaired vital organs replaced through transplantation or the thought experiment simply terminated by death from liver failure or whatever).⁵ This thought experiment can be understood as simply taking split-brain experiments to the extreme. From one person-organism (John), the bisection generates two (John and his identical twin Fred), one of whom can communicate with us verbally (at least through eye movements) and the other nonverbally. If the bisection were done in childhood, both could be verbal. Now, if we surgically reunite the two halves, including microanastomosis of every severed axon in the nervous system, resulting in one person-organism again (physically identical to before the bisection), is it John or Fred? By repairing the mutilation, have we killed someone? Some hard-core split-brain enthusiasts have gone so far as to maintain that in each of us there are actually two minds (one associated with each cerebral hemisphere), who think and act in parallel and are completely unaware of each other’s existence, with observational uncertainties vaguely analogous to quantum mechanics [12].

Similar thought experiments based on cases of dicephaly, Siamese twins, brain transplants, and so on can be devised ad infinitum. What do they really prove about persons, organisms, and BD? Nothing whatsoever. Why? Because they all are about questions of personal enumeration and personal identity in relation to two or more distinct pieces of living matter. But in actual clinical BD, there is only one piece of living matter and only one person at issue. The question is not whether the BD body is John’s or Fred’s but whether it is John’s or nobody’s. The question is really twofold: (a) whether it is a living human organism at all, and (b) whether human personhood is actually separable from human organismhood (not just logically distinct). The first question, I maintain, has already been convincingly answered in the affirmative. The second question goes to the very core of philosophical anthropology and has been debated intensely by philosophers for a very long time without any signs of rapprochement. Neither question is answered by thought experiments; rather, conversely, the interpretation of the thought experiments depends on the answers to these questions [13].

Personhood

Regarding the concept of personhood, I join those who regard “human person” as essentially a biological-psychological hybrid being [14]. If either the biological or the psychological dimension is lost, but not both (e.g., conscious head or permanent vegetative state), we would say there is a severely disabled person. Permanent unconsciousness in a living human organism is understood as the extreme along the spectrum of mental disabilities. By contrast, Lizza joins many others in the camp that regards “human person” as essentially a human mind, in principle and sometimes in actuality separable from “human organism” or “human being” [15]. I do not pretend to offer any insight or explanation that will convince the latter camp to come over to the former or both to merge into some compromise position. They seem irreconcilable at the most fundamental level of philosophical worldview. Returning to the parable of the elephant, such disagreement over the nature of personhood does not stem from the blind men feeling different parts of the elephant, but from feeling the same part with different hand coverings: those with bare hands claim that the skin is firm and leathery, while those wearing wool mittens claim that the same area of skin is soft and woolly, and those wearing coats of mail claim that it is hard and metallic. Being blind, no one can see what he himself or the others are wearing, and everyone has been dressed that way for so long that they

know no other kind of hand-sensation. Each personhood-camp will claim that it is the bare-handed one in the parable, and that all the others are impeded from a true understanding by a wrong fundamental worldview cloaking their minds.

So I will not attempt to convince Lizza or anyone else of the philosophy of personhood that I subscribe to, but will instead pose a question for further philosophical study. For Lizza, human death is the permanent cessation of mental activity [10, 15, 16]. He also describes it as the “irreversible” cessation of mental activity, but with “irreversible” understood in the weakest sense, more or less synonymous with “permanent,” even if the permanence is not due to any intrinsic physical defect but to a mere decision on the part of someone in control. This contingent concept of personhood he applies at both the beginning and end of life (fetuses to be aborted and permanent vegetative state patients being equally non-persons despite being living human organisms) [10, 16, 17].

But if we understand “irreversible” in its usual (“strong”) sense of “impossible to be reversed by any natural means,” then the notion of “irreversible cessation” of consciousness approaches in meaning what other philosophers have called loss of the “radical capacity” (or “basic natural capacity” or “second-order capacity” or “active potency”) for consciousness [18, 19]. The “radical capacity for X” can be understood as the “capacity to acquire the capacity for X.” Thus, human embryos lack the (immediately exercisable) capacity to see or to think, but they have the radical capacity for these operations. There is a popular tendency to locate radical human capacities in the brain. But since they exist in the brainless embryo, it is clear that the brain is not their sole and necessary locus in an absolute sense. In the embryo, radical capacities are grounded in the combined genetic and epigenetic factors distributed throughout the organism. It is therefore reasonable to ask whether brain-based capacities are really “radical” enough to serve as the basis for personhood even in mature organisms.

Adult stem cells can now be induced to develop into various functioning tissues and even parts of organs, a feat imaginable only as science fiction just ten years ago. Moreover, the capacity to regrow an amputated limb (previously thought to be possessed only by salamanders) seems to be latently present even in higher animals, including humans. Actualization of this potential requires not even stem cells, but merely release of its epigenetic suppression in the cells involved in normal wound healing. One research team has speculated that by “tapping into and activating developmental programs necessary for regeneration” (present in the human genome but inactive post-embryonically), “we may be only a decade or two away from a day when we can regenerate human body parts” [20, p. 63].

So we should not be too hasty to assume that the radical capacity for regenerating body parts, present in human embryos, is absent in mature human bodies. Of course, regenerating a brain is a far cry from regenerating a limb. But a radical capacity is something intrinsic to an organism; how long it takes medical technology to become sophisticated enough to remove the impediment to its actualization is ontologically irrelevant. Moreover, for purposes of minimal sentience, a regenerated brain would not have to be normal or very large. Even hydranencephalic children, with only a brainstem and diencephalon, can be sentient and have rudimentary consciousness [21].

Lizza, following Feinberg [22], has objected that such a notion of capacity (or potentiality) is so “promiscuous” as to be virtually useless [16]. I am not convinced, however, that this is so. What is proposed is not a notion of potentiality by which virtually anything can “potentially” become anything else. The question is whether a damaged organism has the radical

capacity (potential) to repair itself. Although not discussed by May [18] or Lee [19], the notion of “capacity to develop the capacity for X” should be understood in a not overly restrictive sense. “To develop” should be understood not as necessarily entirely spontaneous, but as also accommodating instances where external elimination of some impediment is required for the development to proceed. So long as the assistance is truly the removal of an impediment and not a frank replacement, such a “capacity to develop the capacity” should be ontologically relevant. One can distinguish potential for X without assistance, potential for X with assistance, and performance of X by an external agent. The first is too restrictive a concept, and the third is not a potential of the organism at all. The second sense is the appropriate one for the question at issue.

For example, we should not adopt an interpretation of radical capacity so strict that the facts that the healing of large wounds requires sutures, the healing of compound fractures requires plates and screws, and recovery from serious infections requires antibiotics, would negate the body’s radical capacity for self-healing in these scenarios. Similarly, the radical potential for sight should be understood as present in someone with dense cataracts, even though ophthalmologic surgery is necessary to actualize that potential. The hidden regenerative potentials of mammals, including humans, that are actualizable through epigenetic de-suppression are now beginning to come to light. If a certain kind of self-repair requires assistance to become actualized, that should not negate the existence of a radical capacity for self-repair; any more than requiring external assistance to survive negates being alive.

So perhaps the ultimate radical capacity for human consciousness might lie not in the brain after all, but in the genetic and epigenetic information throughout the living human body. If centuries from now a new brain could be grown from spinal-cord primordia in a BD body, would there be a new person or the same person merely with a new personality and set of memories? This depends on which theory of personal identity is correct and whether persons use their brains as an instrument of mental functioning or, rather, brains generate their persons.⁶ In any case, one could at least say that there was all along some human person by virtue of the continuity of the human organism, which ipso facto possesses the radical, if not always actualizable, capacity for consciousness. I am not here going on record as endorsing such a proposal, and would retract it immediately if it could be proven that such futuristic reconstitution of a functioning brain were impossible (even a poorly functioning one would suffice for the argument). But I merely offer this proposal for serious consideration as a possible connection between two parts of the human-death “elephant”: on the one hand recognizing the essential importance of both consciousness and the bodily organism for human personhood, while on the other hand accommodating both permanently unconscious human persons and human “organisms as a whole” without brain function.

Endnotes

1. At the conference, Gert clarified that by “observable” he means “observable by the clinician at the bedside.” I think that the tests for death must be observable in that sense, but the very definition of death should have to do purely with the properties of the organism in question, independent of epistemic considerations of a clinician.

By “natural” functioning Gert means “not dependent on a sustaining cause,” i.e., an assistance without which asystole will occur “immediately” or “almost immediately” upon its discontinuation. I find this notion very problematic. A mechanical ventilator is not the only example of such a “sustaining cause” in contemporary medicine. Pressor medications for patients in shock and pacemakers for certain

kinds of cardiac conduction defects would also qualify—to name just two other examples. (Let’s even set aside the ambiguity of “almost immediately,” the lack of a clear reason why the time latency to asystole should matter at all, and why such an interpretation is not to confuse a tendency to near-future death with present death.) As Gert stated at the conference, a patient with permanent unconsciousness plus dependency on a “sustaining cause” fulfills the definition and is dead. I don’t see how dependency on a ventilator or pressors or a pacemaker, added to unconsciousness, constitute “the permanent cessation of all observable natural functioning of the organism as a whole.” Why isn’t it simply the permanent cessation of diaphragmatic function, or vascular tone, or cardiac conduction, while the organism as a whole continues to function, with every other aspect of its functioning (apart from consciousness) being quite “natural”? In such examples, it is simply not the case that all natural functioning of the organism as a whole has ceased; only one function has ceased, and that is even a function of a specific part of the organism, not of the organism as a whole.

2. In a nutshell, the complete equivalence can be secured by: (1) limiting the comparison to that subset of spinal cord victims lacking vagus nerve function (sometimes the vagus is pharmacologically ablated for therapeutic reasons), and (2) either (a) comparing high cord transection with the subset of BD cases without diabetes insipidus or (b) supposing that the spinal victim was on hormonal replacement therapy pre-accident for diabetes insipidus and comparing with the subset of BD cases with diabetes insipidus. See references 3 and 4 for further details.
3. For my own reaction to the Council’s white paper, see Shewmon DA, Brain Death: Can It Be Resuscitated? *Hastings Center Report* 39:2 (2009): 18-24
4. The Uniform Determination of Death Act uses the phrase “circulatory and respiratory functions,” but I prefer the more straightforward “circulation and respiration.”
5. Each hemi-body would be paralyzed and numb due to severing of the decussating fiber tracts across the spinal cord and brain-stem midline.
6. This latter view, which is widespread today, is epitomized in the very title of a recent book: J. Knoll, *The Brain and Its Self: A Neurochemical Concept of the Innate and Acquired Drives* (New York: Springer, 2005).

References

1. Gert B, Culver CM, Clouser KD. 2006 *Bioethics: A Systematic Approach*, 2nd ed. Chapter 11, “Death,” 283-308. Oxford University Press.
2. Shewmon DA. 2001. The brain and somatic integration: insights into the standard biological rationale for equating “brain death” with death. *Journal of Medicine and Philosophy* 26(5): 457-78
3. Shewmon DA. 1999. Spinal shock and ‘brain death’: somatic pathophysiological equivalence and implications for the integrative-unity rationale. *Spinal Cord* 37(5): 313-24
4. Shewmon DA. 2004. The “critical organ” for the organism as a whole: Lessons from the lowly spinal cord. In *Brain Death and Disorders of Consciousness*. *Advances in Experimental Medicine and Biology*, Vol. 550, edited by Machado C and Shewmon DA. 23-41. New York: Kluwer Academic/Plenum Publishers.
5. President’s Council on Bioethics. 2008. *Controversies in the Determination of Death* (Washington, D.C.: President’s Council on Bioethics). <http://www.bioethics.gov/reports/death/index.html>.
6. President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. 1981. *Defining Death: Medical, Legal, and Ethical Issues in the Determination of Death*. 73. Washington, D.C.: U.S. Government Printing Office.
7. Bemat JL, Culver CM, Gert B. 1981. On the definition and criterion of death. *Annals of Internal Medicine* 94: 389-94

8. White RJ, Albin MS, Verdura J. 1964. Preservation of viability in the isolated monkey brain utilizing a mechanical extracorporeal circulation. *Nature* 202: 1082-83
9. White RJ, Wolin LR, Massopust LC, Taslitz N, Verdura J. 1971. Cephalic exchange transplantation in the monkey. *Surgery* 70: 135-39
10. Lizza JP. On the definition of death. In *Defining the Beginning and End of Life; Readings on Personal Identity and Bioethics*. Baltimore: Johns Hopkins University Press, forthcoming 2009
11. Steinberg A, Hersch M. 1995. Decapitation of a pregnant sheep: a contribution to the brain death controversy. *Transplantation Proceedings* 27: 1886-87.
12. Bogen GM. 1986. Mental duality in the intact brain. *Bulletin of Clinical Neurosciences* 51: 3-29
13. Shewmon DA. 2007. Mental disconnect: ‘Physiological decapitation’ as a heuristic for understanding ‘brain death.’ In *The Signs of Death*, edited by Sanchez Sorondo M. The Proceedings of the Working Group 11-12 September 2006 292-333. Vatican City: Pontificia Academia Scientiarum.
14. Lee P, George RP. 2008. *Body-Self Dualism in Contemporary Ethics and Politics*. Cambridge: Cambridge University Press.
15. Lizza JP. 2006. *Persons, Humanity, and the Definition of Death*. Baltimore: Johns Hopkins University Press.
16. Lizza JP. 2005. Potentiality, irreversibility, and death. *Journal of Medicine and Philosophy* 30(1): 45-64
17. Lizza JP. 2007. Potentiality and human embryos. *Bioethics* 21(7): 379-85
18. May WE. 2008. *Catholic Bioethics and the Gift of Human Life*, 2nd ed. 352-53. Huntington, IN: Our Sunday Visitor, Inc.
19. Lee P. Substantial Identity, Rational Nature, and the Right to Life. (in press)
20. Muneoka K, Han M, Gardiner DM. 2008. Regrowing human limbs. *Scientific American* 298: 56-63
21. Shewmon DA, Holmes GL, Byrne PA. 1999. Consciousness in congenitally decorticate children: “developmental vegetative state” as self-fulfilling prophecy. *Developmental Medicine and Child Neurology* 41(6): 364-74
22. Feinberg J. 1974. The paradoxes of potentiality. An appendix to *The Rights of Animals and Unborn Generations*. In *Philosophy and Environmental Crisis*, edited by Blackstone WT. 43-68. Athens: University of Georgia Press.

Brain Death and the Dead-Donor Rule: A Critique and Alternatives

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In their seminal early work on brain death, Gert and his colleagues helpfully distinguished between definitions, criteria, and tests.¹ While acknowledging the central importance of these distinctions, and the logic of reasoning from the “top down” (i.e., from definitions to tests), the historical development of this topic has actually been in the other direction, starting with articulation of the tests, and secondarily coming up with criteria and definitions that were compatible and supportive. My intention here will be to trace some essential features of this debate in the historical direction.

The Uniform Determination of Death Act (UDDA) defines brain death as the “irreversible cessation of all functions of the entire brain, including the brain stem.” Breaking this down, it requires showing that all functions of the brain have ceased, and that this cessation cannot be reversed. In looking at functions, we differentiate between those based in the higher brain, or cerebrum, versus those in the lower brain, or brainstem. For

the cerebrum, we need to show that the person is comatose, unresponsive, and unresponsive. Our testing for this is actually quite crude—typically no more sophisticated than seeing if the patient can respond to our questions or efforts to produce responses to painful stimulation.

Our documentation of the loss of brainstem function is more technical, but quite selective, examining only those brainstem functions that can be easily tested by bedside exam, including, for example, whether the pupils constrict to light and whether the centers that drive respiration are intact and effective in stimulating diaphragmatic effort.

Finally, our testing seeks to show that the loss of these functions is irreversible, by ruling out confounding factors like drug overdose, low body temperature, and low blood pressure.

Looking back over forty years of the literature, multiple attempts have been made to explain why these clinical findings should be equated with the death of the patient. I will mention a few of the better known approaches:

1) Patients with this constellation of clinical findings literally have the complete absence of all brain functions, as required by the UDDA.

This one can be quickly dismissed, as virtually no one believes it anymore, despite the fact that this is what is legally required, literally speaking. Even defenders of the approach, like James Bernat, acknowledge that our current testing is no more than an “approximation,” and there is no doubt that many patients diagnosed as brain dead maintain critical integrative brain functions, such as temperature control and the regulated secretion of hormones like vasopressin.²

2) Patients with this constellation of clinical findings are dead because they always have a cardiac arrest in a short period of time.

This justification prefigured the more sophisticated formulation developed by Gert and colleagues: that brain death is death because it represents the loss of the functioning of the organism as a whole. This justification fails for two reasons: first, and most fundamentally, it confuses a prognosis with a diagnosis. Even if it were true that the diagnosis of brain death predicted imminent cardiac arrest, this would only prove that the patient is irreversibly dying, not that the patient is already dead. Second, it is factually false—as Dr. Shewmon has so famously demonstrated, patients who meet all criteria for brain death can be kept alive for many years.³

3) Patients with this constellation of clinical findings are dead because they are permanently unconscious.

It is true that these patients are permanently unconscious. But, as many philosophers have argued in detail, this line of reasoning leads us to a consciousness-based definition of death, not a defense of whole-brain death.⁴⁵

4) Patients with this constellation of clinical findings are dead because they are permanently unconscious and apneic (incapable of spontaneous breathing).

This is an attempt to retain the consciousness-based definition but exclude patients who are in a permanent vegetative state. In addition to appearing ad hoc (why prioritize breathing above other equally essential physiological functions, such as digestion, excretion of waste, wound healing, etc.?), it relies on a distinction between functions that are spontaneous or “natural” versus those that are supplied artificially. Countless patients who are clearly alive depend upon artificially provided life-sustaining functions, such as diabetics who require insulin, patients who cannot eat for whatever reason and who require tube feedings, patients with endocrine problems whose lives depend upon administration of vasopressin, thyroid

hormone, or growth hormone, those without kidney function who need dialysis, and those who cannot breathe but need a ventilator. Certainly no one would regard patients with cervical quadriplegia as any less than fully alive just because they need a ventilator to breathe. So the ad hoc addition of apnea to the requirement of unconsciousness seems to be just that—an ad hoc way to reconcile the methods of diagnosis with an attempt at a philosophical justification.

My conclusion, at this point, is that our current approach to diagnosing brain death does not correspond to any conceptually or theoretically coherent understanding of death. Rather, the constellation of tests that we use have been chosen for two very practical reasons, neither of which is related to the concept of death:

- 1) The diagnosis can generally be made clinically, at the bedside, without the need for sophisticated technology, and
- 2) Patients with this constellation of findings have a very poor neurological prognosis, such that it is ethically acceptable to regard them as being “as good as dead.”

These are reasons, I suggest, that brain death has become the standard for determining when patients are eligible to make a “lethal” donation of vital organs.

Since it is often a lot easier to critique the status quo than to offer useful alternatives, I will sketch out a different way of looking at the issues.

First, it is helpful to ask, “Why do we need a concept of brain death?” Remember that when the concept was developed in the late 1960s, removing a living patient from a ventilator was considered homicide, and physicians were therefore looking for criteria that would allow them to declare neurologically devastated patients “dead” before acceding to family requests for withdrawal of life support. But, in 2009, this is no longer the case. This change began with the Quinlan case, and has been further developed and refined in a long series of legal cases over the succeeding decades. Today the majority of ICU deaths occur following the withdrawal of mechanical ventilation before the death of the patient. Although it is still correct to say that the “death-causing act” in these cases is ventilator withdrawal, we no longer speak of this as homicide, but rather (misleadingly) as merely allowing the patient to die.

In fact, in 2009 the concept of brain death is used almost exclusively to define a cohort of patients from whom organs may be removed for transplantation while their organs are still being perfused by a beating heart. In this way, the concept of brain death has paved the way for the development of the life-saving organ transplantation enterprise, while apparently respecting the dead-donor rule—the implicit rule that vital organs may not be removed from patients before death. (A much more rare application of brain death is as a societally sanctioned definition of futility, such that even in the absence of organ donation, physicians may legally remove life support from these patients, even against the objections of the family.)

As Frank Miller and I have written recently in the *New England Journal of Medicine* and the *Hastings Center Report*, the risk here is that the public will “see through” the inadequate justifications that have been developed in support of brain death, and will cynically see that this construct has been developed almost entirely to enable the availability of transplantable organs.⁶⁷ This is both unwise and unnecessary, since we believe that the flawed concept of brain death is not necessary, and that alternative approaches are both ethically defensible and avoid the need to defend this unsupportable concept. We see this as a particularly important time to call attention to these

problems, since the error of gerrymandering the definition of death is now being compounded by the emergence of yet another approach to organ procurement, known as “donation after cardiac death,” or DCD. This approach has resulted in other similarly implausible definitions of death, which I do not have space to explore further here, but which Bernie Gert critically but accurately described in his comments as “death by decision.”

Briefly, the alternative that Miller and I propose is that we replace the central ethical requirement of organ transplantation—that the patient must be dead—with two necessary and sufficient ethical requirements: 1) obtaining consent for withdrawing life-sustaining treatment and organ procurement, either from the patient directly or through an advance directive or surrogate, and 2) determining that the ratio of harm to benefit must be acceptable, first from the patient’s perspective but also from the perspective of societal norms.

Under our formulation, paradigmatic candidates for organ donation would include those about to have life-sustaining treatment removed, such that their death is imminent. Rather than using flawed criteria to declare them dead before taking them to the operating room for organ removal, their organs would be removed, under anesthesia, as part of the dying process.

This approach is entirely symmetrical and consistent with the ethical approach we take to living organ donations, such as when a person chooses to give an organ (such as a kidney or a lobe of the liver) to a relative. In these cases, the same principles apply. In addition to consent, we also require a favorable balance of the harms to the benefits, both from the perspective of the donor, but also with respect to societal norms. So, for example, if physicians believe that the risks to the potential donor are excessive, then the clinicians will not move forward with the procedure, even if the potential donor insists. Similarly, our proposal is limited only to patients in whom there has been a decision to withdraw life-sustaining therapy, as a way to avoid the ethical complexities of self-sacrificing vital organ donation by healthy individuals as well as to ensure that public sensibilities are not offended by the process.

This is only a brief sketch of some of the problems with the concept of brain death, as well as an overview of possible alternatives. A more detailed exploration of these issues can be found in our published work on this topic.

Endnotes

1. J.L. Bernat, C.M. Culver; B. Gert. “On the Definition and Criterion of Death.” *Ann Intern Med* 94 (1981): 389-94
2. J.L. Bernat. “How Much of the Brain Must Die in Brain Death?” *J Clin Ethics* 3 (1992): 21-26
3. D.A. Shewmon. “Chronic ‘Brain Death’ - Meta-analysis and Conceptual Consequences.” *Neurology* 51(1998): 1538-45
4. R.M. Veatch. “The Whole-brain-oriented Concept of Death. An Outmoded Philosophical Formulation.” *Journal of Thanatology* 3 (1975): 13-30
5. M.B. Green, D. Wikler. “Brain death and Personal Identity.” *Philosophy and Public Affairs* 9 (1980): 105-33
6. F.G. Miller; R.D. Truog. “Rethinking the Ethics of Vital Organ Donation.” *Hastings Cent Rep* 38 (2008): 38-46
7. R.D. Truog, F.G. Miller. “The Dead Donor Rule and Organ Transplantation.” *N Engl J Med* 359 (2008): 674-75

Is “Brain Death” Death?: Commentary on Papers Presented by Bernard Gert, D. Alan Shewmon, Robert Truog, Ari Joffe, and Donald Marquis at the Special Session Arranged by the APA Committee on Philosophy and Medicine at the APA Pacific Division Meeting, April 10, 2009.

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Donald Marquis is right that, if true, mental essentialism, i.e., the claim that we cannot lack the property of mind and still exist, would justify acceptance of the standard neurological criterion for death. However, he argues against mental essentialism by challenging Jeff McMahan’s and Green and Wikler’s arguments for the claim that psychological continuity is sufficient for our continuing identity as individuals. Marquis argues that since McMahan’s own analysis of division in brain transplantation shows that the egoistic concern that one might have for each transplanted cerebral hemisphere cannot be concern for oneself, since one cannot be in two places at once, the same egoistic concern that we have in the simple (non-divided) case is insufficient to establish that psychological continuity is sufficient for our continuing identity. Marquis notes that a similar problem arises in teleportation cases.

Suppose Marquis is right that psychological continuity is insufficient for personal identity and actually presupposes it. While this may pose a difficulty for the way McMahan, Green, and Wikler have argued for a consciousness-related neurological formulation of death, it does not pose a challenge for an argument based on a more modest form of mental essentialism, i.e., one that holds that a minimal necessary condition for something to be a human being is that it must have the potential for consciousness or mind. Such a view may be non-committal about whether this potential is sufficient to be a human being. One does not need intuitions or grounds for what would be sufficient in order to have intuitions or grounds for what is necessary for one to exist. For example, one might not know the sufficient neurological conditions for a mental state to exist, but one may have good reason for thinking that some neurological matter is necessary.

What reasons might there be for thinking that the potential for consciousness and some mental function is necessary for one’s continuing existence? Perhaps the simplest argument is to consider the case of an artificially sustained decapitated human body. Or let’s make it more personal: consider yourself decapitated and your body artificially sustained. Although this is a hypothetical case, it is not such a wild one. (I imagine that if given the green light, the folks at the Cleveland Clinic could figure out how to do it right now.) Would one identify oneself with such an artificially sustained body? Or would one say that one had died and that the body was one’s remains, but not oneself? I think that most people would say that they would have died and that what remains is just that: their remains. Here, I agree with Bernard Gert and disagree with the other panelists.

Besides the absence of a head, is there much of a difference between the organic integration that would be present in this case and what is present in the cases of artificially sustained whole-brain dead individuals? When Alan Shewmon presented his case in Cuba in 2004 of T.K., the whole-brain dead individual artificially sustained for over twenty years, the neurologist Calixto

Machado described it as a case of “physiological decapitation.” The point is that all or most of the organic integration that Shewmon and others point to as evidence that death has not occurred in cases such as T.K. could also be present in the case of the artificially sustained decapitated body.¹ I think that most of us, including some very conservative Orthodox Jews who view decapitation as death, would say that the person had died. We would not identify ourselves with such a body.²

If one believes, as Alan Shewmon does, that the potential for intellect and will is essential for something to be a human being, then the only way to maintain that the artificially sustained whole-brain dead body is still a living human being would be to hold that the artificially sustained whole-brain dead body retains such potential. Indeed, this is Shewmon’s view. However, while I think that he is consistent in bringing his view about the nature of the soul in line with his position on the criteria for determining death, I do not agree with his ascription of the potentiality for intellect and will to such an individual. Indeed, I think that he relies on an unrealistic view of potentiality—one that fails to consider physical realities that restrict potentialities.³

While I accept the conclusion of Shewmon, Joffe, Truog and others that an artificially sustained whole-brain dead body may be an integrated organism of some sort and, therefore, is not “dead” in the sense of having irreversibly lost its organic integration, it is not the body of a human being, but the live remains of one. Moreover, in this brave new world of technological intervention in the natural world, we had better get used to such challenges to our notions of life and death.

It is worth noting that in addition to relying on the concept of death as the “irreversible loss of the integration of the organism as a whole,” the 1981 President’s Commission used the concept of “the collapse of psycho-physical integrity” to characterize death as determined by the whole-brain neurological criterion.⁴ This concept may be closer to many people’s understanding of death than the concept of loss of organic integration of the organism. After all, the separation of the soul from the body has been part of the traditional understanding of death, and such separation could be understood as the collapse of the psycho-physical integrity of the human being. However, “psycho” in this conceptual formulation need not refer to a spiritual soul. It may refer to the mind, and it is compatible with various views of the mind, e.g., Cartesian dualism, non-reductive materialism, functionalism, mind-brain identity, etc. Whatever mind may ontologically be, the view simply holds that having a mind integrated with or dependent in some way on the brain is necessary to count among the living “we.” Moreover, it may be neutral on the issue of whether the “psycho,” however that reality is cashed out, would be sufficient for the existence of a person or human being.

In his consideration of the gruesome experiments in which the heads of dogs and monkeys were artificially sustained, Bernard Gert takes the presence of consciousness in the head as evidence that a death has not occurred.⁵ He now includes the clause about the absence of consciousness in the definition of death, because “the importance of consciousness to a conscious organism has no counterpart in nonconscious animals or plants.”⁶ He holds that the artificially supported head which manifests consciousness counts as a living “person” and asks for a new term to describe the headless body that might be artificially sustained, since in his view it is clearly not a human being. In earlier work, I have suggested that we use the term “humanoid” for the artificially sustained headless body, as well as the artificially sustained whole-brain dead. Like Gert, I am also inclined to call the artificially sustained conscious head a living person.

However, I believe that this is problematic for Gert, if he also wishes to maintain that “all and only living organisms can die” and that persons do not literally die. Since he holds that the artificially sustained head is not an organism and only organisms can die, it is unclear what he would say happens when that artificially sustained head, i.e., the living person, irreversibly loses consciousness. It cannot literally “die” in his view, since only organisms can die. But this seems mistaken. Is it not precisely because “the importance of consciousness to a conscious organism has no counterpart in nonconscious animals or plants” that we would say that persons can literally die in ways that non-conscious animals and plants cannot? If persons can literally live in ways that other non-conscious beings cannot, then it seems reasonable to think that they can also die in ways that non-conscious beings cannot. Indeed, I believe that this is the reason all along for why so many of us have been willing to accept brain death as death.

When it comes to us, our nature is different from that of other kinds of beings. While we do have a biological nature, that biological nature can be sustained in unprecedented ways. As an artificially sustained severed head, it would be the continuation of our consciousness as a kind of cyborg, rather than a natural human organism, along with the fact that we would continue to recognize, relate to, and value the individual as the same person, that ground our belief that death has not occurred. Absent the identification of this being as a locus of value in a network of conscious, social relations, there would be no reason to consider the person to still be alive. In this hypothetical case, the biological considerations of the internal integration of an organism as a whole would play little, if any, role in our understanding of what it means for us to continue to be alive. While the artificially sustained severed head would retain some type of psychophysical integration or integrity, it would not be the type of natural psycho-physical integration or internal “integration of the organism as a whole” found in ordinary forms of life. Thus, the death of the person could be understood as the loss of “psycho-physical integration,” but there would now be new ways in which the integration could be maintained. Accordingly, there would be new ways in which the psycho-physical integration could irreversibly cease. My claim is that total brain failure is an actual case in which our psycho-physical integration irreversibly ceases. Insofar as these possibilities represent new ways for people to live and die, the life and death of persons are distinct from the life and death of other organisms.

Gert and his colleagues, James Bernat, Charles Culver, and K. Danner Clouser, would likely protest at this point that to reject the biological paradigm of death and accept the irreversible loss of conscious as a criterion for death would be to radically change the ordinary meaning of death. However, I believe the opposite. Because human death has always signified a transformation from our being a person or human being into the remains of one, to ignore how our psychological, moral, and cultural nature defines the kind of being that we are and to focus exclusively on our biological nature to define our coming into being and passing away distorts our nature and the ordinary meaning of human life and death.

Technology has intervened in the natural life-history of human beings in unprecedented ways and presents us with the challenge of how we ought to project the terms “life” and “death.” Some of the assumptions about the meaning of death that may have governed our use of the term in the past may thus need to be given up in light of the new cases. It may be more important to preserve other assumptions about the psychological, moral, and cultural meaning of human life and death at the expense of giving up what may have been some of

the biological assumptions about the meaning of these terms. What is clear, however, is that this issue of how we ought to project “life” and “death” to the new cases is not one that can be settled by consideration of the meaning of terms, as if meaning were something timelessly fixed. While words cannot mean just anything, the debate about how to project the terms must be understood within a framework of interests, values, and history of use within which words have their meaning.

In his Cruzan dissent, Justice Stevens wrote: “for patients... who have no consciousness and no chance of recovery, there is a serious question as to whether the mere persistence of their bodies is ‘life’ as that word is commonly understood, or as it is used both in the Constitution and the Declaration of Independence.”⁷ Stevens was asking about the meaning of life and death within the context of the U.S. Constitution and the framework of the moral and legal rights of living persons recognized in that constitution. His question was not framed in strictly biological terms. When we ask for a definition and criterion for death that can be used in practical cases, it would be a mistake to frame this issue in strictly biological terms, since it is not in terms of persons or human beings as strictly biological beings that we are interested in an answer to the question. We are interested in the life and death of persons understood as psychological, moral, and cultural, as well as biological, beings. Indeed, if we frame the question in strictly biological terms, we rule out the psychological, moral, and cultural dimension of persons from the start and thereby distort the purpose of why we seek to answer the question in the first place. Moreover, as I have argued above, pushing a strictly biological account of life and death leads to strongly counterintuitive results when it comes to what we say about various actual and hypothetical cases. Most of us would not wish to identify ourselves with artificially sustained, brainless integrated human organisms, even though the strictly biological account of life and death leads to that absurd conclusion. If we resist this conclusion, then we are resisting it because we think of our nature as something more than biological.

In closing I agree with Robert Truog’s criticism of Prof. Gert’s reliance on “a distinction between functions that are spontaneous or “natural” versus those that are artificially sustained.”⁸ Since many patients dependent on artificial support are clearly alive, Truog claims that “the ad hoc addition of apnea to the requirement of unconsciousness seems to be just that—an ad hoc way to reconcile the methods of diagnosis with an attempt at a philosophical justification.”⁹ To spell this out in more detail, Professor Gert claims to have proposed a definition of death that captures what “death” means in ordinary language. “Its correctness,” Gert, Culver, and Clouser write, “is determined by seeing if there is any clear case where use of this definition is in conflict with the ordinary use of the term “death.”¹⁰ In Gert’s view, the justification for accepting a definition of death is thus not so much philosophically grounded as grounded in the ordinary use of the term. However, given Gert’s own test for the adequacy of his definition, there are two problems with its correctness. First, as Alan Shewmon pointed out in his testimony before the President’s Council on Bioethics, no biologist would consider the artificially sustained whole-brain dead bodies to be dead organisms.¹¹ Moreover, the artificially sustained whole-brain dead do not appear to be dead to many ordinary people, as they are warm to the touch and their hearts continue to play a crucial role in circulation and respiration. Thus, it is not clear how well Gert’s definition captures how biologists and ordinary folk use the term “dead.” Second, the clinical situations involving artificially sustained whole-brain dead bodies or individuals in permanent vegetative state are not “ordinary” situations and, therefore, it is far from straightforward how to extend the ordinary use of the term

“dead” in these clinical situations. At this point, Gert appears to privilege the use of the term “dead” as reflected in the current practice of using neurological criteria to determine death over other uses of the term, for example, by those practitioners and lay people who do not regard individuals with total brain failure as “dead” or those who would use the term to describe a loved one in permanent vegetative state.¹² Indeed, because the use of the term “dead” in these new contexts varies, more than linguistic research on the past use of the term is needed. We need to identify not only the interests, values, and other background beliefs behind the past use of the term but also to decide how we wish to extend those interests, values, and other beliefs in the new situations. This latter task requires ethical and ontological argument.

Endnotes

1. See D. Alan Shewmon’s article in this volume for agreement and confirmation of this point.
2. I take this to be a strong *reductio ad absurdum* argument, more generally, against animalism.
3. See John P. Lizza, “Potentiality, Irreversibility, and Death,” *Journal of Medicine and Philosophy* 30: 45-64 and John P. Lizza, *Persons, Humanity and the Definition of Death* (Baltimore: Johns Hopkins University Press, 2006), 99-110.
4. President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. *Defining Death* (Washington, D.C.: U.S. Government Printing Office, 1981), 58.
5. See Bernard Gert’s article in this volume, Chapter 11 of Bernard Gert, Charles M. Culver, and K. Danner Clouser, *Bioethics: A Systematic Approach* (Oxford: Oxford University Press, 2006), and Bernard Gert, “A Complete Definition of Death,” in *Brain Death*, edited by Calixto Machado (Amsterdam: Elsevier, 1995), 28.
6. Bernard Gert. “A Complete Definition of Death.” In *Brain Death*, edited by Calixto Machado (Amsterdam: Elsevier, 1995), 28.
7. Nancy Beth Cruzan, by her Parents and Co-Guardians, *Lester L. Cruzan et ux. v. Director, Missouri Department of Health et al.*, 497 US 261, 1990.
8. See Robert Truog’s article in this volume.
9. *Ibid.*
10. Bernard Gert, Charles M. Culver, and K. Danner Clouser. *Bioethics: A Systematic Approach* (Oxford: Oxford University Press, 2006), 290.
11. President’s Council on Bioethics, Session 5: Response to the Council’s White Paper, “Controversies in the Determination of Death,” by D. Alan Shewmon, MD., November 9, 2007, <http://www.bioethics.gov/transcripts/nov07/session5.html>.
12. For data regarding the understanding of the meaning of “death” by groups of health professionals, see Ari Joffe, Natalie Anton, and Vivek Mehta, “A Survey to Determine the Understanding of the Conceptual Basis and Diagnostic Tests Used for Brain Death by Neurosurgeons in Canada,” *Neurosurgery* 61:5 (2007): 1039-45; Ari Joffe, and Natalie Anton, “Brain Death: Understanding the Conceptual Basis by Pediatric Intensivists in Canada,” *Archives of Pediatrics and Adolescent Medicine* 160 (2006): 747-52; and Stuart Youngner et al., “‘Brain Death’ and Organ Retrieval: A Cross Sectional Survey of Knowledge and Concepts among Health Professionals,” *Journal of the American Medical Association* 261 (1989): 2205-10. Family members may often use expressions like the person is “gone” or “no longer here” to describe relatives in a permanent vegetative state. Indeed, Nancy Cruzan’s tombstone says that she “died” on the night of the accident and was put to final rest when she was buried many years later. Consider also Justice Steven’s remarks cited earlier about the meaning of “life” and “death” in the U.S. Constitution.

Light

Felicia Nimue Ackerman
Brown University

My sweet-sixteen dress was yellow as the daffodils
In the seamstress's cramped but spotless living room,
Yellow as the lemon bars she made each Christmas
For the neighborhood children.
Mrs. Mueller lived at the end of our block
In a little stone cottage near a field of flowers,
Like a grandmother in a fairy tale.
She was old and poor and crippled
But always tidy, always smiling,
Even as the marshals took her away
After it came to light that, once upon a time,
She was a guard at Auschwitz.

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Suffering, Identity, and Progressive Dementia¹

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This paper addresses five questions regarding suffering:

- (1) What is suffering (and how does it relate to pain and distress)?
- (2) Who—what kinds of beings—can suffer?
- (3) What is the relationship between suffering and identity?
- (4) Can the loss of identity due to progressive dementia, or the anticipation of such loss, constitute unbearable and hopeless suffering (as required for active euthanasia in Dutch law)?
- (5) More generally, can any medical or social fact about an individual (e.g., irreversible coma, extreme dependence upon others) entail unbearable and hopeless, or any, suffering?

1. What is Suffering?²

Casual usage sometimes suggests that suffering is the same as pain, but surely the pain caused by an ordinary pinch on the arm is too mild to count as suffering. Moreover, insofar as pain is a sensory experience, it has a bodily location whereas suffering does not. Might pain cause suffering, then? It might or might not. Returning to our example, a typical pinch on the arm will not cause suffering (in anything like ordinary circumstances).

While pain and suffering differ, it is possible to overstate their differences. Consider two models of the nature of pain. According to the sensation model, pain is simply a kind of sensation, which varies in intensity, duration, location, and features that permit classifying it as a particular kind of pain such as an ache or twinge. On this model, pain need not be at all unpleasant: we may or may not suffer even when in great pain, since pain itself does not involve an affective (emotional) dimension. On the attitude model, by contrast, pain is any sensation the subject dislikes for its own felt qualities, suggesting less conceptual distance between pain and suffering. Each

model of pain faces theoretical challenges. Suffice it to say that pain is typically (whether or not intrinsically) unpleasant, in which case at least most painful experiences involve some degree of negative affect—a feature shared with suffering.

Suffering also bears a close relationship to distress without their being identical. The mild distress of a workshop organizer who is running late need not involve suffering, though someone having an anxiety attack—a kind of distress—clearly suffers. Distress may be understood as a typically unpleasant emotional response to the perception of environmental challenges or to equilibrium-disrupting internal stimuli. Distress can be caused by such diverse phenomena as charging elephants, the prospect of failure, and diarrhea; and it can take the form of various more specific mental states such as fear, anxiety, and discomfort.

While any precise analysis of “suffering” will prove controversial, suffering may be understood, roughly, as a highly unpleasant emotional state associated with significant pain or distress.³ The words “associated with” bypass the issue of whether significant pain or distress causes suffering or is a form of suffering. Perhaps terror is a form of suffering, not a mere cause. Perhaps excruciating pain in its affective (as opposed to its sensory) dimension, if pain has an affective dimension, is a form of suffering. One’s judgments here will depend on one’s specific analyses of these mental states.

Any adequate account of suffering must acknowledge that whether and how much one suffers can vary in accordance with attitudes or expectations about the associated pain or distress and the context in which it occurs. Even the mild pain of a common headache can lead to great distress and suffering if the pain endures with no end in sight, or if the subject believes the headache to be a sign of impending physical collapse. On the other hand, soldiers have sometimes received major injuries yet apparently suffered little due to the relief of expecting removal from battle, or to positive attitudes about the heroic context of the injury. Long-distance runners who experience pain and discomfort in a race may or may not suffer, or may suffer more or less, depending on such psychological factors as how they evaluate their efforts, and whether they are confident or fearful regarding the remainder of the race. Thus, any meaning one attaches to one’s situation, as well as one’s expectations for the future, are important factors in whether and how much one suffers.

2. Who Can Suffer?

The issue of what sorts of beings can suffer should be settled by an understanding of the nature of suffering, what it requires mentally of a subject, and what sorts of beings can meet those requirements as determined by empirical evidence. Presumably, it should not be settled by a definition. In this light, the following definition of suffering, offered by Eric Cassell, appears highly question-begging: “Suffering is a specific state of severe distress induced by the loss of integrity, intactness, cohesiveness, or wholeness of the person, or by a threat that the person believes will result in the dissolution of his or her integrity.”⁴ On the same page, Cassell writes straightforwardly, “Only persons suffer.”

Although Cassell’s characterization of suffering differs significantly from mine in its specific formulation, it suggests a point established earlier: that meaning and expectations for the future are important factors in human suffering. Starting with this observation, one who assumes that nonhuman animals are incapable of assigning meaning and anticipating the future will infer that only humans—or perhaps, with Cassell, only persons—can suffer. But this inference would be hasty.

First, to say that meaning and expectations for the future are important factors in human suffering is not to say that either is a

necessary condition of suffering. It strikes me as highly plausible that pouring scalding water on a normal human infant would cause her to suffer even if she could assign no more meaning to the event than my dog could. Moreover, even if expectations for the future are necessary for suffering, the thesis that only humans can suffer would depend on the premise that animals have no sense of the future. But this premise is indefensible in light of available evidence, which suggests that many animals have memories (suggesting an awareness of the past) as well as anticipations of the future.

Rather than considering evidence for that modest claim, let us note a stronger thesis—which entails the more modest one—and then briefly consider the evidence for the stronger thesis. The latter, which brings us somewhat closer to Cassell's idea that only persons can suffer, is the idea that in order to suffer a being must have some sense of itself persisting through time. In other words, only beings with some degree of temporal self-awareness can suffer. Is that true? It would imply that a being in the most extreme pain could not suffer if that being had no awareness of itself as persisting over time. Maybe that is true.⁵ But, because there is abundantly good reason to believe that many animals have temporal self-awareness, requiring such a mental capacity for suffering will not impede the judgment that many animals can suffer.

Why should we believe that any nonhuman animals have temporal self-awareness? Surely, one might think, only humans—or, more accurately, some humans, namely persons (in the relevant sense)—are self-aware. To be sure, this unempirical article of faith has been propounded by many philosophers, theologians, and even scientists for centuries. Yet it tends to rest, in part, on the assumption that self-awareness is a single phenomenon. In fact, there are various kinds of self-awareness. (Contrast, for example, bodily self-awareness, social self-awareness, and introspective awareness.) More decisively, the article of faith is at odds with common sense and cannot face the tribunal of empirical evidence.

Consider, first, the point—which few will deny—that (many) animals experience fear, one of the most primitive emotions. Fear is impossible unless the subject has some awareness of persisting into the future. After all, one fears something that might happen to one—in the (possibly very near) future. Consider, second, the fact that cognitive ethology, the field that examines animal behavior in the context of evolutionary biology, generally supports the attribution of beliefs, desires, and intentional actions to many animals.⁶ The central claim is that the best explanation of these animals' behavior, given everything we know about them, requires these attributions. But if Buddy the dog wants (desires) to go outside to bury a bone, and intentionally does so, this suggests that Buddy has some awareness of himself as persisting over time. Desires typically concern states of affairs involving oneself in the future, and intentions are carried out over time. Third, there is considerable independent evidence that many animals have memories as well as expectations for the future. It has been rigorously demonstrated, for example, that many birds have extensive recall of where they have hidden food. Now if, as seems likely, some of an animal's memories or anticipations include representations of the animal herself, as in a memory of being hurt, that would entail a degree of temporal self-awareness. In sum, while suffering—along with certain other emotional states, such as fear—may require some temporal self-awareness, there is a strong case that many animals have such self-awareness.⁷

What about personhood? Is there any reason to believe that suffering requires one to be a person? I do not think that birds, rats, and dogs are persons (their temporal self-awareness

notwithstanding). Let us assume for the sake of argumentative simplicity that no nonhuman animals are persons.⁸ Persons, let's say, are fairly endowed with such properties as temporal self-awareness, the capacity to reason and plan, linguistic competence, moral agency, and the like; one must have enough of these characteristics, even if not all of them, to qualify. (Personhood is, of course, a somewhat vague concept, a concept with blurred boundaries.⁹) On this view, normal human adults, adolescents, and even young children are paradigm cases of persons. But human infants and nonhuman animals are not. If suffering requires one to be a person, then the infant on whom scalding water is poured does not suffer. Neither does a dog who is left unanesthetized during hours-long surgery or who is slowly tortured by a sadist. Many, like me, will find these implications very hard to believe. In view of these counterintuitive implications, along with the distinction between temporal self-awareness and personhood (the former being insufficient for the latter), the thesis that only persons can suffer would seem in need of substantial theoretical motivation to remain at all plausible. I am not aware of any good theoretical, or for that matter empirical, reason for maintaining that only persons can suffer.

A more plausible thesis is that any sentient being capable of highly aversive emotional states (which may in turn require temporal self-awareness) can suffer. Whether the assignment of meaning is necessary for suffering we may leave open. For those beings who do assign meaning to their circumstances, this factor plays a significant role in whether and to what extent they suffer. But maybe the assignment of meaning is not necessary for suffering. Then again, beings with temporal self-awareness are fairly strong candidates for beings who can assign meaning—assuming we don't over-intellectualize the latter. Consider a fox caught in a leg-hold trap who slowly chews off her leg to escape. This creature almost certainly suffers and suffers mightily. What meaning, if any, is she capable of assigning to her predicament? Perhaps something like this: "Gotta get this thing (the trap) off me or I'm fucked!"

3. What is the Relationship between Suffering and Identity?

It is often thought that suffering can pose a threat to an individual's identity. To determine whether this is true, we need to be tolerably clear on what the claim means. Achieving such clarity requires elucidating the relevant sense of "identity."

Usually, when philosophers in a tradition stemming from Locke through contemporary analytical philosophy employ the term "identity," whether applied to persons, human beings, or anything else, they have in mind numerical identity. This is the basic metaphysical (or conceptual) relation that a thing has to itself over time: being one and the same X over time, despite change. For example, a ship can undergo certain changes, such as the replacement of old planks, while continuing to exist. But a ship cannot survive complete destruction. A person, meanwhile, can grow, gain experience, and even modify values without going out of existence. But some changes would be so substantial that a person could not survive them. What changes are compatible with a person's continued existence is a debatable matter, different answers being implied by distinct accounts of personal identity (in this numerical sense) and of the essence, or essential properties, of human persons.

On my account, we human persons are essentially human animals, and only contingently and temporarily persons, so we go out of existence when organismic life ceases—at the time of biological death.¹⁰ On another broad approach—which encompasses various specific views and probably represents the majority of contemporary philosophers—we are essentially

psychological beings (e.g., persons, minds). Accordingly, on this approach, we may go out of existence prior to biological death if our essential psychological features are irretrievably lost.

Crucially for our purposes, numerical identity as applied to human persons is not the sense of identity at issue when it is asserted that suffering poses a threat to one's identity. For suffering could not possibly terminate one's numerical identity—that is, put one out of existence—on any remotely plausible view of our numerical identity.

It would appear, therefore, that the sense of identity at issue in discussions of suffering's threat to identity is narrative identity. One's narrative identity is one's self-conception or sense of oneself, the story one implicitly tells oneself about oneself in living a life. It is a psychological phenomenon, one that implicates an individual's sense of certain experiences, people, and values as especially salient, as especially definitive of "who she is." Insofar as human beings are social creatures, one's narrative identity will necessarily make reference to other individuals who play leading roles in the drama of one's life.¹¹ How best to characterize narrative identity in detail, and in particular how best to characterize the precise way in which narrative identity involves other individuals, is a controversial matter on which I will not attempt to adjudicate here.¹²

Narrative identity can be threatened by suffering. Indeed, intense suffering can lead to an identity crisis, a metaphorical collapse of the self that occurs when a person is no longer sure "who she is" or whether she can carry on. Consider, for example, a soldier who is captured and tortured for months, with no end in sight, and who as a result begins to abandon certain commitments to his army and nation, yielding information valuable to the enemy and the like. Or consider the protagonist in Orwell's 1984 who relinquishes his respect for truth, allowing that $2 + 2$ may well equal 5, and who even betrays his lover when he is tormented with rats. In the face of suffering and the absence of hope, such individuals may feel their integrity, their very selves, torn apart. Now consider someone who is transformed by an automobile accident from a swaggering athlete into a quadriplegic: even if the physical pain and discomfort are bearable, the sense of loss and consequent suffering may be unbearable as well as hopeless. He may be unable to bear losing the life he knew and loved, and his suffering may darken everything else he used to regard as valuable, driving him to thoughts of suicide.

In cases such as these, a person's sense of herself, her sense of wholeness and solidity, is threatened if not destroyed. What is threatened, then, is one's narrative identity, for the story of one's life becomes incomprehensible or at least insufferable (pun intended) to one. Employing somewhat different language from mine, Eric Cassell has written eloquently about this phenomenon.¹³

4. Can Loss of Identity Due to Progressive Dementia Constitute Unbearable and Hopeless Suffering?

Suffering can threaten identity (in the narrative sense). Can loss of identity due to progressive dementia constitute suffering? Might the mere prospect of this loss constitute suffering? If so, and if the suffering in question is unbearable and hopeless, this result would be very significant in the Netherlands insofar as Dutch euthanasia law permits active euthanasia in cases of unbearable and hopeless suffering (assuming certain other conditions are also met). As a preliminary to addressing these questions, let us consider more closely the relationship between progressive dementia and identity.

Much has been written on this relationship but quite a bit of this literature is conceptually unclear, muddled, or both. In general, the threat to identity posed by dementia has

been exaggerated.¹⁴ Many authors have stated or implied that progressive dementia often terminates numerical identity, literally creating a new individual in the old individual's spatiotemporal wake. This, I submit, is preposterous. If I am right that we are essentially human animals, so that our criteria of (numerical) identity are biological, the thesis that dementia eventually creates someone who is literally a distinct being from the first individual is a nonstarter: one and the same human animal lives through the stages of dementia. If I am wrong about our numerical identity and essence, then the most plausible view, I suggest, is that we are essentially "minded" beings, beings who have the capacity (not mere potential) for consciousness—in other words, sentient beings. On this view, we go out of existence upon entering a PVS or a permanent coma, but the cases of progressive dementia that interest us, the cases that have led to the claims I am calling exaggerated, are ones in which there remains a sentient subject. In such cases, if we are essentially minded beings, then we survive dementia so long as we are sentient as opposed to irreversibly unconscious.

One might invoke another theory, however, according to which we are essentially persons (in the sense sketched in section 2), and argue accordingly that one of us goes out of existence when dementia has so diminished his mental capacities that he is no longer a person (in this sense). But this view is unpromising. If we are essentially persons, then we literally came into existence after what is regarded as our birth, because newborn infants clearly lack the psychological capacities that comprise personhood. I take the implication that none of us was born—that none of us existed at what is commonly regarded as his or her birth—as a *reductio ad absurdum* of the thesis that implies it: that we are essentially persons. This leaves standing my judgment that in the sorts of cases that interest us, in which progressive dementia has stripped away someone's personhood but has left a sentient being, we cannot plausibly claim that the individual who became demented literally went out of existence.

So progressive dementia short of irreversible unconsciousness poses no threat to numerical identity. But, in an important respect, it threatens narrative identity. For, at some point in the typical cognitive decline, an individual is so bereft of memory and the ability to plan and recognize others—in short, so bereft of a sense of his own life-story—that we may say, meaningfully and realistically, that his self-narrative has ended. (Others may continue his narrative from a third-person standpoint, but this is not sufficient for narrative identity as I understand it.) At some stage in progressive dementia, an individual may lose herself as a self-narrator.¹⁵

Our question now is what this has to do with suffering. Well, for starters, many or most people in the course of progressive dementia suffer terribly. They are frustrated at declining abilities and all the practical hardship these entail; confusion intrudes increasingly; they become more paranoid and volatile. As the dementia becomes deeper, some patients enter a state of relative contentment, almost a blissful ignorance, but some do not. Whether and how much a demented patient suffers depend on the individual's particular characteristics and circumstances.

Might the losses entailed by advanced dementia, or perhaps the anticipation of such losses, constitute suffering or, more relevantly to Dutch euthanasia law, unbearable and hopeless suffering? Absolutely not. The medical condition of Alzheimer's disease or any other form of dementia does not constitute suffering. Rather, in some cases it contributes to or causes suffering. The medical condition *per se* is compatible with one's suffering and it is compatible with one's not suffering

or at least not suffering unbearably and hopelessly. Suffering is an emotional state whose occurrence and depth vary, as we have seen, with individuals' idiosyncratic mental lives, their perceptions of context and meaning, as well as their objective circumstances. No medical condition *per se*—except perhaps depression—can constitute suffering (and even depression is often bearable and not hopeless). *A fortiori*, the mere anticipation of some medical condition such as Alzheimer's disease cannot constitute suffering though it certainly occasions suffering in some individuals.

Do the judgments just advanced, and the conception of suffering on which they rest, imply that an individual has unchallengeable authority regarding whether and how much she suffers? One might think so insofar as I have emphasized the subjectivity of suffering. But "subjectivity" has various meanings. Suffering is obviously subjective in a way in which all mental states are subjective: ontologically. Suffering, in other words, is mind-dependent. (A world with no minds could include no suffering.) It is somewhat less obvious, yet sufficiently clear upon reflection, that suffering is subjective in another sense: that a particular aversive stimulus may lead to suffering in A but not in B because A and B attach different meanings to the stimulus. This type of subjectivity is important because it means that a particular medical condition, such as moderate dementia, or a particular circumstance, such as the anticipation of becoming demented, may occasion suffering in one person but not in another. Now, while suffering is subjective in these two senses, it is objective in a different respect: there is ordinarily a fact of the matter as to whether or not a particular individual is suffering.¹⁶

One might infer from there being a fact of the matter about whether someone suffers, plus the mind-dependence of suffering, that only the putative sufferer herself knows whether and how much she suffers. This inference would be a non sequitur, though, for more than one reason.

First, we often do know a great deal about other individuals' mental states on the basis of their behavior, circumstances, and neurophysiological similarity to us. It would not be admirably careful, but instead culpably obtuse, to doubt the suffering of a young child who spontaneously sobs upon learning that his parents are breaking up. (In my opinion, only very bad philosophizing could seem to support such obtuseness.¹⁷)

Second, there are some mental states whose self-ascription is fallible and requires interpretation. Perhaps I cannot doubt whether I am in pain. And perhaps I cannot wonder whether I am upset in cases in which it is introspectively obvious that I am. But in other cases I might not realize I am upset; a friend might point out the evidence to me. Certainly I might not know whether I am in love, for there are cases in which my feelings, dispositions, and commitments might add up only to infatuation or non-loving obsessiveness or friendly feeling plus protectiveness. What about suffering? In ordinary cases, a person knows whether she is suffering. But what about nonpersons? I'm pretty sure my dog can suffer—can be miserable—but I doubt he can know that he is in this state. And some human beings may be sentient nonpersons who, like my dog, have little or no introspective awareness. It seems possible, then, that a deeply demented individual might suffer without knowing that he suffers. Moreover, perhaps even a normal person can suffer without having absolute authority on how much she suffers—and, in particular, on whether her suffering is unbearable and hopeless.

If these reflections are correct, the attribution of suffering can be tricky even in the first-person case. But this complexity must not serve as a justification for attributing suffering to (1) individuals who retain introspective awareness and deny

suffering (while presenting no signs of dissembling) or (2) individuals who lack introspective awareness, or the ability to communicate it, for whom there isn't strong evidence that they are suffering.

5. Can Any Medical or Social Fact about an Individual Entail Unbearable and Hopeless Suffering?

Our reflections make it easy to answer our final question. No medical condition—not Alzheimer's, not PVS, irreversible coma, or any other—constitutes or entails unbearable and hopeless suffering. Indeed, the thought that PVS or irreversible coma might constitute suffering is especially nonsensical insofar as patients in these conditions are entirely unconscious. One must be capable of conscious states¹⁸ to feel anything; one must have the capacity to experience emotions to experience an emotional state such as suffering. Even less plausible is that one's social condition *per se* might constitute suffering. That one is poor, or bereft of friends, or radically dependent on others' assistance are conditions that will certainly cause suffering in some. But these conditions obviously cannot constitute or entail suffering.

In light of these reflections, there is no credible argument for conceptualizing dementia, irreversible unconsciousness, or radical dependency on others *per se* as forms of suffering. Whether someone suffers, and therefore whether she suffers unbearably and hopelessly, is determined by her psychological life, not by a medical or social condition *per se*. If there is any justification for permitting active euthanasia on the basis of such conditions, the justification cannot appeal to unbearable and hopeless suffering. But, cut off from this humane basis, any justification would seem rather unpromising—unless the patient remains competent and provides voluntary, informed consent or perhaps if the patient had previously, and competently, provided prospective authorization in an advance directive for active euthanasia, authorization that clearly applies in the present circumstances.¹⁹

Endnotes

1. This paper was prepared for a workshop—sponsored by the University of Amsterdam and the University of Erasmus—on the unbearable suffering criterion in Dutch euthanasia law, at the Royal Dutch Science Academy in Amsterdam on December 14, 2007. The questions with which the paper begins were the questions I was asked to address. My thanks to the workshop participants for their comments.
2. This section draws significantly from my "Suffering" in *Routledge Encyclopedia of Philosophy*, edited by Edward Craig (London: Routledge, 1998), 213-14.
3. A common objection to this definition is that even minimal pain can lead to, or cause, suffering as when mild pain is chronic and slowly drives someone into despair. Fair enough, but in such cases the subject experiences significant distress (consistent with my analysis).
4. "Pain and Suffering" in *The Encyclopedia of Bioethics*, 2nd edition, edited by Warren Reich (New York: Macmillan, 1996), 1963. My criticism of Cassell's analysis is advanced with great respect for the insight contained in his work on this topic.
5. My conceptual intuitions are unclear here. Part of the difficulty may be trying to imagine what it would be like to be such a being.
6. It is crucial here not to conflate intentional action, which requires appropriately related beliefs and desires, and autonomous action, which requires a higher degree of abstraction and self-control.
7. For an extended discussion of animal self-awareness, including citations to relevant empirical studies, see my *Taking Animals Seriously: Mental Life and Moral Status* (Cambridge: Cambridge University Press, 1996), 166-83; for background, see chaps. 5 ("Feelings") and 6 ("Desires

and Beliefs”). For a more up-to-date discussion, see “Self-Awareness in Animals,” in *The Philosophy of Animal Minds*, edited by Robert Lurz (Cambridge University Press, forthcoming 2009).

- 8 Actually, I believe matters are a bit more complicated (see my “On the Question of Personhood Beyond Homo Sapiens,” in *In Defense of Animals*, 2nd ed., edited by Peter Singer (Oxford: Blackwell, 2006), 40–53). On the other hand, I hold that very few nonhuman animals—just a small number of language-trained apes and dolphins—clearly qualify as persons.
- 9 See *ibid.*
- 10 I develop this account in *Human Identity and Bioethics* (Cambridge: Cambridge University Press, 2005), chap. 2.
- 11 Even an abandoned child raised entirely by wolves would have important relationships with certain other individuals—namely, certain wolves. A child raised by no one would simply die.
- 12 I make a preliminary attempt in *Human Identity and Bioethics*, chap. 3.
- 13 See, e.g., Cassell, *The Nature of Suffering and the Goals of Medicine* (New York: Oxford University Press, 1991).
- 14 I develop this thesis in *Human Identity and Bioethics*, chap. 5.
- 15 The point I stress here is that progressive dementia may eventually end what I have elsewhere called strong narrative identity, which requires a persisting self-narrator. On the other hand, as the institution of advance directives and the concept of precedent autonomy suggest, a person may project her self-narrative into a future in which she exists but no longer has narrative capacity. In such cases, we may say that weak narrative identity is maintained despite personhood-destroying dementia (so long as the subject lives). I discuss these issues *ibid.*
- 16 I say “ordinarily” because there may be borderline cases in which an individual’s mental state is indeterminate with respect to suffering due to the vague boundaries of the concept. There is no sharp answer to the question of how unpleasant one’s emotional state must be to count as suffering.
- 17 For an antidote to such bad philosophy, which grows out of an error promoted by modern philosophy—namely, that we know our own states of mind better than, and independently of, anything else—see Ludwig Wittgenstein, *Philosophical Investigations* (New York: Macmillan, 1953).
- 18 I use the term broadly to include dreaming states. On this broad construal, then, conscious states are those in which one has subjective experience. Mainstream medical opinion, as I understand it, holds that in PVS and irreversible coma cerebral damage is too extensive to permit subjective experience.
- 19 Cases involving patients who have never been competent should be decided on the basis of the patients’ best interests. Though I cannot defend this recommendation here, I would recommend permitting only passive euthanasia (allowing to die) on the basis of best interests, never active euthanasia. For doubts that advance directives are ever an appropriate basis for active euthanasia, see J.J.M. van Delden, “The Unfeasibility of Requests for Euthanasia in Advance Directives,” *Journal of Medical Ethics* 30 (2004): 447–52.

Reply to Micah Hester on Common Morality

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It is somewhat daunting to realize how much influence Beauchamp and Childress’s book, *Principles of Biomedical Ethics* has. In our ongoing discussions with them they have

continued to describe my moral theory as an impartial rule theory, and we have continued to protest that this is not a correct description of the theory at all. Nonetheless, Micah Hester seems to have accepted Beauchamp and Childress’s claim that we offered moral rules as the corrective for the four too abstract principles of “principlism.” He describes my theory as a “careful development of a rules-based system of reflection.” But our attack on principlism was not that their principles were too abstract, but that they were free-standing principles, not embedded in any system at all, and, hence, they provided no guidance at all when, as happens in any case about which there is any controversy, the principles conflicted with each other. I do not say, “We need to focus on the rules of action.” I say we need to understand the moral system of which the moral rules are only one part, but which also contains the moral ideals and the two-step procedure for determining if violations of the rules are strongly justified, weakly justified, or unjustified. Further, this procedure includes a way of identifying the morally relevant features so that we are not forced to use the worthless phrase *ceteris paribus*.

Common morality is a system, and Micah is correct that I claim to be describing this system. As I said in response to Glen Graber’s comments, I do not claim to be describing how people make moral judgments, I claim only that I am describing the system that if you explicitly follow it, you will make the same moral decisions and judgments that you would make no matter what way you actually make those decisions and judgments, at least you will make the same decisions and judgments after carefully reflecting on them. Micah asks the very interesting question, How can I be describing common morality if I hold that the moral system is justified by a normative account of rationality? But common morality is a normative system, so describing it must be have a normative foundation, and that foundation is a description of the normative concept of rationality.

I do not know why Micah says, “According to Prof. Gert moral agents are belief holders who can be rational, but the implication of Prof. Gert’s theory is that moral agents are only ‘truly’ rational when they use rationally acquired beliefs.” I do not recall saying anything that supports this interpretation. I certainly never say that “impartiality” [is] constitutive of all rationally held beliefs. I do not even know what it means for rationally held beliefs, which are factual beliefs, e.g., that all human beings are vulnerable and fallible, to be impartial. Indeed, I explicitly claim that it is rational (rationally allowed) not to be impartial and not to act morally. Nor do I claim, “the only way to “judge” rationality hinges on a “significant group of otherwise rational persons” agreeing that it is so.” All that is determined by “significant group of otherwise rational persons” is whether a reason counts as adequate for an action that would otherwise be irrational, which is a much narrower claim.

Further, I cannot understand why Micah says, “Prof. Gert believes an action is moral only if it is rational—or, to put it negatively, any irrational action is necessarily immoral.” It is true that I hold that all moral actions have to be rational (rationally allowed), but I clearly do not hold that “any irrational action is necessarily immoral,” for immoral actions must affect other people and a person can act irrationally all by himself on a desert island.

Other claims that Micah makes about my view are mistaken in slightly more complex ways. He says, “Morality is justified:

1. Only when rational beliefs are used (beliefs shared by all rational persons—“putting on the blindfold of justice”)

AND

2. When all rational persons would agree.

What I actually say is that morality can be justified, that is, all rational persons would endorse morality, only when they limit themselves to beliefs shared by all rational persons—“putting on the blindfold of justice” and seek agreement with all other rational persons.

He quotes my remarks from page 97 of *Common Morality*, “In the objective sense of ‘irrational’, no moral agent would ever advocate to any person...that he act irrationally,” but puts in “...” where I have “for whom she is concerned.” My complete sentence is, “In the objective sense of ‘irrational’, no moral agent would ever advocate to any person for whom she is concerned that he act irrationally.” I do not say that you would not advocate to a person for whom you are not concerned, that you dislike, that he not act irrationally. Impartiality is not involved at all in the definition of an objectively irrational act. Indeed, harm to self plays an important part in my definition of an irrational action.

Micah talks about my being involved in a circle, but that maybe because he does not appreciate that the only function of talking about a “significant group of otherwise rational persons” is in determining whether a reason counts as adequate for an action that would otherwise be irrational. But this significant group of otherwise rational persons” does not determine what counts as a reason; that is an objective matter. Reasons for doing an action are facts or beliefs that the action will avoid or prevent some harm (death, pain, disability, loss of freedom, or loss of pleasure) or will promote some benefit (consciousness, ability, freedom, or pleasure) for yourself or anyone else. Rationally required beliefs are also explicitly listed, e.g., people are vulnerable and fallible. Perhaps, like many philosophers, he does not accept that a basic concept like rationality can be defined by a list and so tries to invent some formula that I must be using to define the concept.

Micah claims, quite correctly, that my theory borrows much from previous theories. Rawls was a teacher of mine and my theory has been described as Kant with consequences, Mill with publicity, and Ross with a theory. There is a point to all of these descriptions. But I must object to his claim that I have “a purely formal theory.” I continually attack purely formal theories as inadequate and claim that only a theory of rationality with content captures the fundamental normative concept of rationality. So I do not understand his problem with (Prof. Gert’s) [my] formal definition of “rationality/impartiality”; I have no formal definition of rationality. I do have a formal definition of impartiality, but it is quite different from that offered by Rawls or any other philosopher. My account of impartiality does not depend in any way on anything like “Rawls’s “original position” and “veil of ignorance.” I use my analog to these, “the blindfold of justice,” only when I am talking about the justification of morality, not to explicate the concept of impartiality.

Micah’s claim, “there is no such thing as an impartial observer—we are all partisans, shot-through with our own interests and values,” rests upon the standard mistaken account of impartiality. He seems to be holding that a basketball referee cannot be impartial if he has a view about how the game should be played. But that is clearly false, if he makes the same calls, no matter which player or team is involved, he is refereeing impartially, and it is irrelevant what values he has. It is being unduly cynical to claim that no referee, umpire, or judge is ever impartial. Bad philosophy leads to bad attitudes. His criticism of my account of rationality as too “limiting, championing unemotive logic over affective sensibilities,” also seems based on a mistaken interpretation of my account of rationality. My account of rationality includes concern about the harms suffered by others. On my account of rationality it is rational to

sacrifice your own interest to act so as to prevent or relieve the evils suffered by others.

It is true that, like Kant and Mill, I think it most important that people not unjustifiably violate the moral rules. But for most people, especially good people, there is not often a significant temptation to unjustifiably violate the moral rules. The moral rules only set the limits on what we can do, they do not provide a positive guide to life; that is the function of the moral ideals. I explicitly claim that following the moral ideals can justify violating moral rules, a claim that seems to be ignored by those who hold that the moral rules completely dominate the moral system. I explicitly put forward as the goal of morality lessening the amount of harm suffered by those protected by morality. This “vision of the larger picture” is what does determine how we should follow the rules. Nothing I say indicates anything contrary to this.

Micah’s example of two people on a Sunday afternoon deciding what to do is a wonderful example of moral sensitivity. Far better than any example of real life decision making than anything I have ever provided. He is also completely right in saying that the “second scenario yielded a better result than the first.” He is also right when he says, “(Prof. Gert) [I] will rightly say that his system does not preclude such judgment, but neither does it champion them as central to morality.” Not only does my system not preclude such judgment, it actually supports it. Although I do not think that this example is central to morality, it is an example of someone sensitively following a moral ideal, being careful not to put someone in an awkward situation that may make her feel uncomfortable. But taking this example as central to morality presupposes the kind of life that only a very few people are privileged to live.

Most Important Healthcare Reform Resources, spring/summer 2009

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- (1) Arnold Relman, “The Health Reform We Need and Are Not Getting” *New York Review*, 2 July 09, pp. 38-40 (which is also in part a review of Ezekiel Emanuel, *Healthcare, Guaranteed*, Public Affairs Press, 2009).
- (2) Paul Menzel, “Justice and Fairness: Mandating Universal Participation.” In *Connecting American Values with Health Reform* (The Hastings Center, June 2009), pp. 4-6
- (3) Uwe Reinhardt, testimony before the U.S. House Committee on Ways and Means, 22 April 2009. (esp. on mandating coverage) <http://waysandmeans.house.gov/hearings.asp?formode=printfriendly&id=7672>
- (4) Alan Garber and Sean Tunis, “Does Comparative-Effectiveness Research Threaten Personalized Medicine?” *New England Journal of Medicine* 360: 19 (7 May 2009): (esp. re the “Public Option” and comparative-effectiveness research, which is absolutely crucial to efficiency and cost control)
- (5) David Brooks, “Something for Nothing” *New York Times*, 23 June 2009, p. A23 (esp. re the 1925-1931 tax exemption on employer-provided health benefits, important for financing reform and cost control)
- (6) David Brooks, “Fiscal Suicide Ahead,” *New York Times*, 15 May 2009, p. A23 (re cost control)
- (7) David Leonhardt, “Limits In a System That’s Sick,” *New York Times*, 17 June 2009, pp. B1, 9

(8) David Leonhardt, "In Health Reform, a Cancer Offers an Acid Test," *New York Times*, 8 July 2009, pp. A1, 14

(9) Rationing: Peter Singer, "Why We Must Ration Health Care," *New York Times* on-line, 15 July 2009. http://www.nytimes.com/2009/07/19/magazine/19healthcare-t.html?_r=1&emc=eta1. Also in *New York Times Magazine*, 19 July 2009

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