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What sort of death matters?

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Michael Nair-Collins and Franklin G. Miller argue in an extended essay that the dominant view in medical ethics of patients who are brain dead but sustained on mechanical ventilation is false. According to this view, these unfortunate patients are biologically dead, yet appear to be alive as a result of the fact that mechanical ventilation ensures that their heart continues to beat, that their skin remains warm, that their wounds continue to heal, that their body does not decay, and (of course) that they continue to breathe. This view was defended by the U.S. President's Commission in 1981, and again by the President's Council in 2008. That brain-dead, mechanically ventilated patients are *biologically* dead—rather than dead merely in a social or legal sense—is seen by defenders of this view as important. The President's Council explicitly rejected the idea that death is anything other than a fact of biology. The significance of this move is explained by Nair-Collins and Miller as follows:

> Getting this biological conception right is critically important: responsible moral and policy deliberation begins with an unbiased assessment of relevant factual questions. One cannot address the difficult normative questions surrounding organ retrieval, just use of resources, withdrawal of mechanical support and so on, without first addressing the biological question: what is the vital status of this organism? (*see page 746*)

Essentially, working with a biological conception of death makes certain decisions much less ethically murky than they would be in the absence of such a conception. The 'dead donor rule', for example, prohibits causing death to a patient by removing their organs. If it is a fact of biology that brain-dead, mechanically ventilated patients are dead, then removing their organs for donation clearly does not fall foul of the dead donor rule. If, on the other hand, the status of these patients is determined by non-biological considerations, applying the dead donor rule is more complicated. In particular, if the question 'Is this patient dead?' ultimately depends on judgments about legal, social, or ethical matters, including 'Would it be ethical to remove this patient's organs?', then we need some other standard by which to judge under which circumstances it is ethical to remove a patient's organs.

Nair-Collins and Miller proceed by arguing that defenders of the view that brain-dead, mechanically ventilated patients are biologically dead—let's call this view the *biological view*—take an overly simplistic view of the relationship between the patient and the ventilator. Specifically, defenders of the biological view depend on the claim that mechanical ventilation is solely responsible for (in other words, a sufficient condition of) these patients' appearing to be alive. Nair-Collins and Miller argue that, in fact, mechanical ventilation is merely a necessary condition for producing signs of life in such patients, since there are many biological processes that must occur alongside ventilation if the patient is to continue to display signs of life such as warm skin, fighting infection, and so on. This removes the justification for the biological view.

With the justification for the biological view gone, it is hard to know what to say about the vital status of brain-dead, mechanically ventilated patients. This, in turn, makes it hard to know how we may treat them. If organ removal is ethical in these circumstances, then—as Nair-Collins and Miller remark—it 'must be on some other grounds'. They leave open what those other grounds might be.

There are parallels between, on the one hand, the problem discussed by Nair-Collins and Miller, and on the other hand, some of the thought experiments about personal identity described by the late philosopher, Derek Parfit. Parfit thought that, in some conceivable cases, there would be no satisfactory answer to the question 'Is that future person me?' If, for example, I faced the prospect of dividing like an amoeba to form two people who were physically and psychologically exactly similar to me, then there is no simple yes-or-no answer to the question whether I survive the division or not. This remains true even if we know all there is to know about the division; that is, even if we know all there is to know about the physical and psychological states of everyone involved. As a result, the question 'Do I survive the division?' is, Parfit tells us, an 'empty question'. Despite this, Parfit insists that dividing in this way would not be as bad as ordinary death. On the contrary, it would be about as good as ordinary survival. While it's not clear whether I would survive the division, then, it is clear that the division preserves what matters in my concern for my own survival. Parfit concludes from this that what matters in our concern for our own survival is not our own survival. Instead, it is a certain kind of psychological connectedness and continuity over time.

We might say something similar about brain-dead, mechanically ventilated patients. We can know all there is to know about such patients in terms of their physical and psychological states, yet still have difficulty giving a simple yes-or-no answer to the question, 'Is this person dead?' Like 'Do I survive the division?' in Parfit's thought experiment, this may be an 'empty question'. Rather than focus on exactly which properties a patient must possess in order to count as unambiguously dead, we might instead—following Parfit—focus on what matters in our concern about the difference between life and death. The reason it is important to know whether brain-dead, mechanically ventilated patients are alive or dead is to answer certain ethically and legally relevant practical questions, such as: Is it permissible to stop treating this patient? Is it permissible to remove this patient's organs? Is it permissible to dispose of this patient's possessions in accordance with the wishes they expressed in their will? and so on. Currently, at least in the sorts of cases with which Nair-Collins and Miller are concerned, the answer to these questions is 'Yes' if and only if the patient in question is dead. But that is not the only way to answer those questions. We could, instead, work out what factors other than the patient's vital status are relevant. Perhaps it is the case that the answer to these questions is 'Yes' if and only if the patient has 'severe, irreversible and nearly total brain dysfunction, and hence irreversible unconsciousness' (*see page 746*), without any need to make a definitive judgement about whether or not the patient is dead.

In reality, however, this reductionist approach to death is certain to be unpopular. Parfit's view that personal identity is

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not what matters is controversial, even though—unlike the cases that Nair-Collins and Miller focus on—his problem scenarios are ones that are highly unlikely ever to arise. Too much hangs on our views about personal identity for Parfit's view to be very appealing. And too much hangs on our views about life and death for the reductionist view described above to be appealing.

There is a lesson that we can take from comparing the view that biological death is not what matters to the view that personal identity is not what matters, however. Parfit's view that personal identity is not what matters tends to be unpopular because it is so counterintuitive and unappealing: *of course* what matters when I care about my own future is that *I* survive. Analogously, we might reject the reductionist view about death that I have just described on the ground that *of course* what matters in decisions like whether a patient's organs may be removed and whether we may dispose of the body is that the patient is *dead*. Death is important, just as personal identity is important.

There is an important difference between these two cases, however. The sort of personal identity that Parfit talks about in his thought experiments is exactly the sort of personal identity that underpins our everyday hopes that we should survive and prosper. On the other hand, it is less obvious that the conception of death on which Nair-Collins and Miller's opponents focus is exactly the sort of death that underpins our everyday patterns of mourning, our views about the moral status of the patient, and so on. Nair-Collins and Miller attack the biological view, proponents of which focus on a biological conception of death. However, it is far from clear that biological death is what matters in our familiar attitudes to death. Long before the contemporary, secular, science-based conception of life and death were conceptions—shaped by religion and other folk views—that took death to be the point at which the soul left the body. The latter such views remain popular even today, and plausibly it is views like these, rather than the biology-led views pervasive in medicine, that shape our normative beliefs relating to death. These views are often linked, of course; for example, one might believe that the moment the patient's soul leaves the body is the moment that she biologically dies. But this is not always the case, nor has anyone (to my knowledge, based on some searching online) examined the relationship between death as biologically conceived and other influential conceptions of death. The view that our decisions about how we ought to treat people should be shaped by whether or not those people are *biologically* dead may be convenient for legal and ethical box-checking, but the status of 'biological death' as the default successor in our intuitions to older and traditional conceptions of death is worth examining.

Nair-Collins and Miller's article is accompanied by a commentary from Melissa Moschella, whose views they critique in their article and who responds to those criticisms here.

Elsewhere in this issue, Alexander Masters and Dominic Nutt propose a way of increasing the number of new medicines that are made available to the public: allow rich donors, who may benefit from the development of a certain medicine, to finance its development in return for their participation in a clinical trial. Effy Vayena responds to this provocative suggestion in a commentary. Other issues addressed in this issue include an examination, by Joseph Tam and colleagues, of the ethics of betel nut consumption—an examination that requires the authors to balance serious health risks against cultural considerations—and two papers exploring ethical issues surrounding live kidney donation.

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