Debate

Death in Denmark

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Author's abstract

Does it matter that the hearts of 'brainstem dead' patients may persist in beating spontaneously? Hostile reactions, to the Danish inclusion of cardiac criteria in the determination of death, betray reductionist views of human life at the core of 'brainstem' conceptions of death. Such views (whether centred on neurological function or on abstractions concerning 'personhood') supplant the richness of human life and death with the poverty of essentialism: and mask the lethal nature of beating-heart organ retrieval. The affirmation of cardiac criteria for death is not an alternative form of essentialism as some critics suppose, but part of an understanding of human life and death which rejects essentialism altogether.

The spontaneously persistent heartbeat does not constitute human life, but most certainly counts for it.

Versions of brain-centred criteria for the declaration of death hold sway more or less everywhere in Europe, with the notable exception of Denmark. This year the Danish Council of Ethics (DCE) issued a report commending the adherence to a cardiac-centred conception of death, and the Council's Secretary, Dr B A Rix reported on their conclusions in the *journal* (1). The interesting symposium of commentary accompanying Rix's exposition was unremittingly hostile to the Danes; however in my view this hostility arises as much from these commentators' own positions on the matter, as from inherent deficiencies in the DCE's position (2). Drs Pallis and Lamb may be thought of respectively as the chief clinical and philosophical apostles of 'brainstem death' in the UK, while Dr Gillon's editorial hymns the sufficiency of 'brainstem death' criteria to both biological and biographical understandings of human death.

But there are other views on the appropriateness of brainstem and even whole-brain conceptions of death. One does not need to be Danish to insist on the significance of persistent spontaneous cardiac function and, following some of the insights of Hans Jonas, I have argued elsewhere the case for including reference

to cardiac function in the conception and determination of death (3,4). In what follows I shall use what I take to be deficiencies in the way that Gillon, Lamb and Pallis attack the DCE position, to illuminate the importance of a more cautious conception of death. Specifically, Pallis and (less transparently) Lamb are relying on an essentialist view of human life, both to yield their conception of human death and also to distort rival conceptions of death into a similarly essentialist mould, which they then (not surprisingly) find easy to demolish. Gillon attempts a related enterprise, extracting, from the DCE's proper concern with personal relationships, a notion of the person which is suitably amenable to the 'elementary' logic of punishment he metes out.

Perhaps the DCE deserve some of this treatment. Perhaps they do indeed attach an essentialist significance to the heart, in which case Pallis and Lamb know how to deal with them. Alternatively they may have a notion of personhood that relies on the continuing unity of body and consciousness, in which case Gillon has a lesson or two for them in simple logic. But notice that they can hardly be guilty of *both* of these errors: an essentialist view of the heart is incompatible with a view of the human person as embodied consciousness. It follows from this at least that either Gillon on the one hand, or Pallis (with Lamb) on the other, has misconstrued them.

Alternatively, perhaps the DCE deserve none of this: they may not have made either of the errors which these commentators have supposed them to make. They certainly *need* not, and should not: no more should we, and part of what is wrong with the brainstem conception of death is precisely that it commits, in my view, an essentialist mistake of the very kind that is imputed to the Danes. But of that more anon.

At least, however, let us concede the most important point made by Lamb and Pallis, the point about 'wanting it both ways'. Lamb and Pallis are surely right to point out the basic contradiction at the core of the DCE's ethical position. You simply cannot insist on a cardiac conception of death whilst simultaneously denying that cardiac explantation constitutes a proximal cause of death. If death is identified with the final loss of heartbeat, then denying an individual his

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heartbeat (by denying him his heart) is to bring about his death.

There is only one way to reconcile a cardiac conception of death with 'beating heart' transplantation: that is to acknowledge the removal of vital organs from those who are not dead but dying. A moral justification for this would need to rest on the explicit and fully-informed consent of the donor, given in full understanding of the meaning of his last act. Such a justification would have to overcome the obvious objections, concerning actively cutting short a human life, that are familiar from debates about euthanasia. Those who think that I may not be killed even when I believe it to be in my own declared interests, are unlikely to be persuaded by an argument based on the declared interests of others. Equally familiar objections concern the cheapening of human life, slippery slopes, dangerous precedents, the demoralisation of health carers, and the demeaning of health care.

I cannot anticipate how such objections would fare were the proposal of 'explantation from the dying' to be put squarely to the public. However those who believe, as I do, that a conception of human death ought properly to make crucial reference to the significance of the spontaneously persistent heartbeat, are obliged to consider *existing transplantation practice* in the light of such objections. It is not a comfortable reflection. But in my view the alternative, that of persisting with transplantation on the basis of a conception of human death which I take to be logically and morally untenable, is less comfortable still (5).

This brings us to the difficulties with the objections put forward by Gillon, Lamb and Pallis. Gillon argues that the DCE's 'diffuse' discussion of the ordinary concept of death reveals a concern for the ceasing to be of a *person* and that, contrary to what the DCE suppose, the best way of acknowledging the death of a person is in terms of brain death:

'...whatever one's concept of a person is, one feature widely acknowledged as *necessary* for being a person is a capacity – or at least the potential for a capacity – for consciousness. It follows that when a person has permanently lost the capacity for consciousness – as occurs in brain death – the person no longer exists; the person is dead' (6).

I do not know how widely it is acknowledged that to be a person you must have the potential for the capacity for consciousness. The question does not ordinarily arise. Take Jones, for instance. No doubt Jones had the potential for the capacity for consciousness when he was alive. He was certainly conscious: for instance, I had a good many arguments with him over the circumstances of the sinking of the *Hood*. However it is not in this that I took him to be a person: indeed I did not 'take' him to be a person at all, but simply knew and argued with *him*. I needed no reference to any list of characteristics of personhood in order to be

confident of his credentials. When he died, I do not doubt that he lost the potential for the capacity for consciousness. However, it is not in this that I took him to be dead (though I would obviously have been astonished had it been claimed that he died without losing this potential). I took him to be dead in that *he* simply ceased to be. And, no doubt in conformity with my culture, I saw that he was dead when respiration and heartbeat stopped, and he became cold and grey. It was not the death of 'Jones the person' which I mourned, but the death of Jones.

Thus, even if Gillon has given us a plausible account of the death of a person (and there can be dispute even over this), he has given us an incomplete account of the death of Jones. Notoriously, Jones may lose even the potential for the capacity for consciousness, yet linger on in profound coma for years. (Brainstem enthusiasts cannot claim that the brainstem has a monopoly on this 'potential', for the potential is as surely lost in massive cortical destruction as it is in the loss of upper brainstem function, if by 'potential' we mean here the possibility of future consciousness.) Of course, had Jones been in irreversible and profound coma then my relationship with him would catastrophically have changed, but this would not mean that he was dead, and whilst he breathed and was warm, pink and perfused I could not sanction that we bury or cremate him.

Although the DCE may indeed have miscast the distinction between 'ordinary' and 'scientific' conceptions of death as Gillon charges, their notion of interpersonal relationship is richer than that entailed by the attenuated notion of 'personhood' in Gillon's account of the death of a person. Rix puts it like this:

'One's relation to the death of others is determined by one's relation to the dying person ... Moreover, the relatives may continue to experience the dead person, not only as a dead body but also as the being that has died.

'It is this relationship, which continues through and beyond the process of death, that implies the need for an ethical approach to the criterion of death; an approach, that is, defined by interpersonal relationship' (1).

Of course some have argued that such an attitude is mere superstition, and that only squeamishness prevents our following the rational course of burying the comatose (7). And indeed this is the logical consequence of any essentialist interpretation of personhood. Gillon quotes the DCE's view of personhood as a 'unity of consciousness and body', and of course such unity seems as threatened by the loss of consciousness as it does by the loss of the body. But this seems only to confirm the logical and moral peril of reducing those whom we know and love to abstractions such as the 'unity of consciousness and body'. This reduction, at odds with the Danes' apparent enterprise, clearly does their position no service.

A parallel reduction is at the heart of Pallis's portrayal of the DCE's cardiac criteria as 'a slipshod formulation, from which absurd conclusions can be drawn'. Pallis invites us to consider the specific absurdity of patient B who, though long since interred in the local graveyard, *lives on* via his heart – which has been transplanted into patient A, who lost his own life with the removal of his own diseased heart (but whose death fortunately has not prevented his happily walking around).

Of course it is indeed instructive to consider the absurdity of this, and properly to locate the absurdity where it belongs – in Pallis's attempt to cast cardiac criteria for death into this grossly essentialist mould. Certainly anyone who thought that the essence of human life was constituted by the heartbeat would be vulnerable to such objections; but such a reduction has even less to do with respecting the significance of the persistent heartbeat than had the reductive notion of personhood to do with interpersonal relations. The importance of a persistent heartbeat is partly contextual: it makes a difference, for instance, that we are talking about patients in the intensive care unit and not freshly procured victims of the guillotine, which so intrigue Pallis (8). More crucially, the persistent and spontaneous heartbeat has a moral importance: our attitude, as Wittgenstein might have put it, to the warm, pink and perfused individual is profoundly different from our attitude to one who is cold, clammy and grey, regardless of their loss of spontaneous respiration. I cannot put it better than Hans Jonas: the beating heart counts for the life of its owner! Pallis's *reductios* are best answered in kind: let him supervise, for instance, the cremation of the 'brainstem dead' prior to asystole.

The increasingly cautious Lamb echoes this reductionist view of cardiac criteria when he notes their admissibility as being subject to 'major conceptual allowances ... for cardiac resuscitation and mechanical replacements' (9). But such 'allowances' are necessary only if we take human life to reside *essentially* in cardiac function, such that the loss of cardiac function were a sufficient condition of death. By contrast, the importance of cardiac function is that its final loss is a *necessary though not sufficient* condition for death, an altogether different view from the facile essentialism with which supporters of cardiac criteria are charged, explicitly by Pallis and implicitly by Lamb.

Whence springs this charge of essentialism? In Pallis's case, at least, I think the answer is clear: he is himself the victim of an essentialist reduction of human life to the capacities for breathing and for consciousness, and assumes that his opponents must view the organ of their choice – generally, the heart – in precisely the way that he views the brainstem. He takes his own essentialism to be a modern refinement of the Judaeo-Christian view of the significance of the 'departure of the soul from the body' and of 'the loss of the breath of life'. The essentialism is manifest in his assumption that when the capacities for respiration and

for consciousness are lost, the individual is dead *regardless* of what remains. By contrast, those who insist (as I do), on the necessity of the final loss of cardio-vascular function for a diagnosis of death, cannot and should refuse to locate the significance of human life in any given function, or indeed in any given shortlist of functions. Indeed, Rix put it very well:

'The concept of death is multifarious, and to specify what death means might seem a hopeless task ... Thus we must take as our guide in establishing a concept of death the everyday experience of death common to the individuals of a particular culture' (10).

This is also of course the approach favoured in Wittgenstein's understanding of moral attitudes and practices. The way we do and see things *expresses* our moral convictions, which stand independent of rational account or explanation. The way we react to the 'beating heart cadaver' may include a certain repugnance on being given certain scientific information, but our attitude to the warmth, the colour and the perfusion consequent upon a persistent heartbeat is generally beyond the reach of science to dispel. I see that Jones is alive; or alternatively, when his heart also has stopped, I come to see that he has died. In its way, of course, this attitude is equally a metaphysical view of the significance of human life, and as such must compete with the reductionist or essentialist view of human life or of persons. But I claim for it a longer pedigree, and greater conviction.

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References

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- (3) Jonas H. Against the stream: comments on the definition and redefinition of death. In: Beauchamp TL, Walters L, eds. *Contemporary Issues in Bioethics*. Belmont, California: Wadsworth, 1982.
- (4) Evans M. A plea for the heart. *Bioethics* 1990 Jul 4; 3: 227–231.
- (5) I develop the argument in reference (4) above. The crucial *moral* point concerns what we are prepared to do to the 'beating heart cadaver'. If we seriously believe such an individual to be dead, then we cannot rationally flinch from cremating or burying it as it lies, beating heart and all. Most would flinch: morality is more than rationality, as Wittgenstein showed. Fundamentally, to explant such an individual's vital organs differs from cremating him only in its utility to others.

The *logical* point concerns the 'criticality' of the brainstem, and requires greater elaboration than is possible here.

(6) See reference (2): Gillon: 4.

(7) For instance, the rationalist position put forward by Gervaise in Gervaise K G. *Redefining death*. New Haven: Yale University Press, 1988.

(8) This analogy is prominent in Pallis C: *ABC of brainstem death*. London: BMA Publications, 1983.

(9) See reference (2). Lamb D: 9. He took a tougher approach to cardiac criteria in his *Death, brain death and ethics*. London: Croom Helm, 1985.

(10) See reference (1): 6.