Brain death symposium: Commentary 1

Wanting it both ways

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Author’s abstract

In this commentary on the recommendations of the Danish Council of Ethics (DCE) concerning criteria for death it is argued that whilst the DCE is correct in stressing the cultural aspects of death, its adoption of cardiac-oriented criteria raises several problems. There are problems with its notion of a ‘death process’, which purportedly begins with brain death and ends with cessation of cardiac function, and there are serious problems regarding its commitment to a cardiac-oriented definition whilst permitting transplantation when the heart is still beating.

The recommendations of the Danish Council of Ethics (hereafter DCE) as reported by Dr Bo Andreassen Rix, deserve serious consideration. They assert that ‘any change in the criterion of death is an event of such significance that it should not be permitted without a major public debate on the ethical questions involved’. In this respect the DCE acknowledges that proposed definitions of death involve judgements which are legal, political, theological and philosophical, involving lay as well as medical opinion. For this reason the DCE drew upon the expertise of a cross-section of specialists with interests in health care. Nevertheless, between them they appear to have produced a set of proposals marred by considerable confusion. With the exception of four members, who favoured a brain-oriented definition of death, the DCE endorsed criteria for death based on cessation of cardiac activity which, if implemented, would make Denmark unique in Europe where criteria for brain death are widely accepted.

In most of the recent literature on brain death it has become clear that there is more to the ‘meaning of death’ than the acquisition of skills concerning medical tests, and that these tests themselves are only meaningful when derived from a philosophically grounded concept of death. In addition to its biological aspects death is also a cultural phenomenon, and it is in the context of their cultural background that criteria and tests are applied by physicians. In this respect the resurrection of a cardiac-oriented definition by the DCE would be non-controversial, if it merely indicated that Denmark had certain unique cultural features which are deemed essential in the context of determining the boundary between life and death. Controversy must arise, however, when the DCE addresses the concept and criteria for brain death (which they interpret as ‘the beginning of the death process’) whilst at the same time seeking to define criteria for cardiac transplantation.

The DCE is correct to seek precision in the determination of death and their attempt to ground this in ‘everyday experience’ is also methodologically appropriate – although problems are encountered in this area. For example, references to the ‘everyday life experience’ of death of ‘oneself or others’ and the experience of one’s own death ‘as the concrete process of dying’, raise intriguing images. Whilst it is possible to observe (and hence experience) the death of another, our own death as Wittgenstein so forcefully put it, is not an experience but rather the cessation of experience (1). Perhaps this is a minor quibble, but there seems to be little value in basing criteria for death on a subject’s alleged experience of death if the subject is not thereafter available to report on events.

A better formulation, in keeping with the DCE’s respect for public sensitivity, might be based on the need to maintain a morally significant boundary between duties owed to a dying patient and those which are appropriate to a corpse. In this sense the primary reason for a definition of death would be to mark an ethically important distinction between behaviour in the presence of the living and behaviour in the presence of the dead. This would require a conceptual formulation which is incompatible with the DCE’s notion of a ‘death process’.

According to the DCE’s notion of the ‘everyday experience of death’ efforts to ‘prolong the death process’ are inappropriate, death only occurring with the final cessation of respiration and heartbeat. This view as to when death occurs is contestable and would land its proponents in insuperable difficulties in their advocacy of criteria for cardiac transplantation. The DCE’s view is compatible, however, with the ethical requirement not to persist with therapy when it is of no
use to those beyond its reach. It should be stressed, in this context, that relatives also have an interest in a clear boundary between life and death which is why references in the media to 'brain dead' patients 'kept alive on life-support machines' engender confusion and needless anxiety.

Most of the problems seem to occur when the interest in defining death moves from a patient-centred concern towards other concerns such as the procurement of transplantable organs. This seriously undermines the DCE's proposals. For despite an explicit rejection of brain death the DCE nevertheless assumes that a different death awaits organ donors. Recognising the need for 'organs transplanted from donors whose hearts are still beating' the DCE uses brain death as a moment in the 'death process' when viable hearts can be removed, subject to prior consent. This is the Achilles heel of their whole argument. Having opted for a single concept of death (the cessation of cardio-respiratory function) they therefore avoid some of the pitfalls according to which a patient could be diagnosed dead by either loss of cardiac or brain function. The DCE does not even appear to advocate cardiac transplantation prior to death. Instead it offers a curious notion of a 'death process' which begins with the death and ends with cessation of cardio-respiratory function, in the middle of which cardiac transplantation is permissible.

Attempts to harmonise criteria for death based on the patient's interest with an interest in organ procurement have long bedevilled discussions on the criteria for death. It is important that criteria for death are based exclusively on the state of the patient, not on any extraneous factors such as the cost of therapy or the need for transplantable organs. Resistance to brain-oriented definitions has been bound up with alarmist reports (such as the notorious 1981 BBC Panorama programme) that the concept of brain death is merely a convenient strategy for procuring organs from donors who are not really dead. Defenders of brain-oriented definitions have not served their case well by baiting their arguments with the prospect of lives saved through brain-dead donors. The case for brain death should stand or fall on its own clinical and theoretical merits. Even without organ transplantation sophisticated ICU technology had rendered it necessary to think in terms of brain-oriented criteria. In the 1950's, long before cardiac transplantation, and at a time when renal transplantation was highly experimental and performed only as a last resort, there were profound ethical discussions concerning the value of ventilating to asystole when treatment for patients in irreversible apnoeic coma was obviously hopeless and increasingly gruesome.

Even more confusion has been generated out of proposals to alleviate fear of premature harvesting of donor organs. In several countries guidelines have been suggested according to which criteria for diagnosing death should be more stringent for organ donors, thus perpetuating an absurd belief in a special kind of death for organ donors (2). The DCE compounds this confusion in its attempt to harmonise criteria for death with guidelines for cadaveric organ procurement while maintaining a cardio-respiratory concept of death. This confusion is highlighted in the proposals listed in the penultimate paragraph of the DCE report. In relation to these proposals it should be noted that tests for brainstem death (surely necessary to determine cessation of 'all brain function') presuppose that the patient is already in an apnoeic coma and on a ventilator. Having met criteria for brainstem death, respiratory and cardiac functions are only maintained by the appropriate equipment. Yet the diagnosis of death at this point is unacceptable to the DCE as it considers it incompatible with its notion of the 'everyday experience of death'. The DCE sees the ventilated brain-dead patient as merely having entered the 'death process', which is only complete with the cessation of cardio-respiratory function. The DCE does not, however, recommend ventilation to asystole: 'all treatment should cease' after brain death has been established. But disconnection from the ventilator, following the final test for brainstem death, would within minutes result in loss of cardiac function, and the proposed distinction between the beginning and the end of the death process would lose all significance.

The problem with the DCE's proposals stems from the attempt to reconcile two incompatible positions: demands that death be based on 'cessation of respiratory and cardiac activity' and the requirement for 'organs transplanted from donors whose hearts are still beating'. If death means loss of cardio-respiratory function then removal of a beating heart could very well involve an act of homicide. A heart-oriented concept of death may be upheld, providing that major conceptual allowances are made for cardiac resuscitation and mechanical replacements. But the concept cannot co-exist with endorsement of cardiac transplantation. The DCE recognises this when it says, rather ambiguously, that 'the transplant procedure will end the death process but will not constitute the cause of the donor's death'. This can surely only mean that the donor was dead when the cessation of brain function was determined.

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References
