

DRAFT (2005)

Death for Doctors

William Ruddick

Philosophers have simplified brain death issues by drawing two distinctions--that between dead persons and dead bodies or organisms, and that between the concept of definition of death and the criteria for determining when and that death has occurred. The result has been protracted debates as to whether the death of patients is the death of persons or the death of organisms, and whether physicians should use cardio-respiratory criteria, whole brain criteria, or higher brain criteria. Advocates of the death of persons prefer higher brain criteria; advocates of the death of organisms prefer cardiovascular criteria; but both will compromise, for different reasons, on the whole brain criteria that most legislators have come to accept. Advocates of person-death regard whole brain criteria as unnecessarily demanding and woefully wasteful of transplantable organs and nursing care. Nonetheless, they accept current whole-brain based legislation as a first neurological step away from traditional cardio-respiratory.

Whatever their philosophic merits, neither concept suits medical practice. To reduce the death of patients to the death of organisms is as clinically inapt as to reduce the birth of babies to the expulsion of uterine contents. On the other hand, many patients before death do not meet the usual criteria of personhood; hence their deaths cannot be construed as the death of persons. Clearly, clinicians need some third concept of death.

I wish to suggest some features of such a concept, most importantly, its social features. Generally, death is a "bio-social" concept, and in modern societies, more specifically, a "bio-clinical" concept defined and applied largely by physicians. Even when people die alone or at home, it is physicians who have the last word about the time and cause of their death--two of the defining features of any event. But significantly, in exercising their authority and discretion in death matters, physicians are in practice constrained not only by biological facts, but by proper professional concerns for a patient's family and for other patients and colleagues. These social constraints reflect a fact often ignored in current Anglophone philosophy, namely, that death's clearest and most significant losses fall on survivors, not on the decedent.

The concept of patient death I will sketch accommodates these morally important matters, and will help free up brain death and persistent vegetative states (PVS) from their current

philosophic ruts. (It may, more modestly, rescue New Jersey brain death legislation from jokes about resurrecting dead Village patients by trucking them across the Hudson to Hoboken.)

In brain death debates, philosophers, lawyers, and neurologists tend to focus on the criteria of death, hoping to avoid the concept of death for the sake of clarity, consensus, and avoidance of metaphysical issues. The concept of patient death I sketch is not clear or precise, but it is I think metaphysically uncontentious. Its stress on social matters, including loss, neither favors nor excludes any views about personal post-mortem existence or annihilation. And though social, it neither favors nor dismisses particular cultural attitudes or practices regarding death or death rites, so far as I can tell. These are clear virtues for physicians whose patients greatly vary culturally and religiously both from themselves and one another.

Now for the details.

Death of patient-organisms

Organ systems are at the center of medical studies and the definitions of medical specializations (cardiology, ophthalmology, endocrinology). Mammals and other lower organisms are the basic subjects of medical experimentation. To define human death as the death of organisms would reflect these features, and, moreover promise precise biological criteria for important clinical and conceptual details of death, such as times and causes.

The two current criterial debates (neurological vs. cardio-respiratory; whole brain vs. higher brain) show, however, that precision is elusive. Witness the difficulty of answering such questions as, What counts as a vital function?

Has an organism lost a vital function if the relevant organ is assisted or has been replaced by a mechanical device?

Has the organism “permanently ceased functioning as a whole”¹ if most of its functions and their coordination are performed machines and attendants?

¹ --Bernat’s widely noted definition of death. James L. Bernat *et al.*, “On the Definition and Criterion of Death,” *Annals of Internal Medicine* 94 (1981):389-94. Bernat has recently revised the definition to “the permanent cessation of the critical functions of the organism as a whole” in “Refinements in the Definition and Criterion of death,” *Defining Death in a Technological Age*, ed. Stuart J. Younger *et al.* (Baltimore, Md: Johns Hopkins University Press 1998) and “A Defense of the Whole-Brain Concept of Death,” *Hastings Center Report* 28.2 (1998) 14-23. A “critical function” is a function of the organism as a whole which is necessary for “the maintenance of life, health, and unity of the organism,” such as autonomic control of circulation, neuroendocrine feedback loops, and consciousness necessary for meeting needs for hydration, nutrition, protection, and other needs, by contrast with hypothalamic neurosecretion of antidiuretic hormone, a function that continues in many brain dead patients. Since the definition of

This difficulty should not be surprising, for crucial terms like organism, vital function, and life are themselves not biologically well-defined. This is partly because biologists have little need to define them, since they play little role in biological theory or research. They tend to appear, if at all, in meta-biological essays about the relation between biology and thermodynamics or other branches of physics.²

Suppose, however, that for medical purposes these terms could be given precise definition. Would that be sufficient reason for physicians to embrace the definition of patient death as the death of an organism? I think not. Admittedly, to regard patients as organisms preserves the evolutionary connection and rationale for medical research on cats and mice. But to regard patients' deaths as animal-death or organism-death physicians must be willing (and able) to ignore obvious differences between animal and human dying. Human patients fear or welcome death, resist or insist on further treatment, and lament the burdens that dying or prolonging their lives may impose on them and their intimates,. For humans a good death involves more than being pain-free. Arguably, even unconscious patients may suffer a bad death if their prior wishes or values are ignored or subverted. There are few if any animal analogues to such beliefs and emotions.

To dismiss such death-differences would be to dismiss the therapeutic ideal of always "treating the whole patient." It would be akin to thinking of women in labor as "expelling a fetus from the uterus." But women often have "maternalist" thoughts early in pregnancy, regarding even first-trimester abortions as "losing a baby." An obstetrician who reduces such "maternalist" thoughts to anatomical language about uterine contents would surely be an incompetent birth-attendant. Likewise, physicians who adopt the organism view of patient death are incompetent death-attendants.

"critical function' mentions maintenance of life it tends to threaten the definition of death with implicit circularity, but the more serious failing of both the original and revised versions is Bernat's claims that "death fundamentally is a biological phenomenon," that "beliefs, customs, and practices surrounding death..can be viewed as a rich and colorful tapestry" reflected in metaphorical uses of 'death' and 'die' but not their literal meaning." *Ibid.*, p.15. This may be a defensible view for purposes of neurology but not for appropriate clinical care of dying patients and their families, as I explain in the following paragraphs.

² Most notably in Erwin Schrödinger, What is Life? (1944)

Death of person-patients

In current Bioethics literature the main alternative to death of patients as organisms is death of patients as persons, understood as having a certain level of consciousness of self and others. (Theories of personhood vary somewhat on the requisite level.) Although this view would seem to foster the ideal of always treating “the whole patient,” it nevertheless has its own clinical shortcomings. First, if the end of personhood meant the end of (justifiable) patienthood, many physicians and even more families would resist. Even those family members who have eventually gone to court to remove life-support from relatives in PVS have been slow to do so, often waiting years until the patient’s body and appearance have been greatly deformed. Moreover, there is a continuing conflict in the clinic as to whether a patient’s movements are signs of minimally conscious responsiveness or, rather, are misleading reflex reactions to unexperienced stimuli. And even when movements are not taken to be signs of consciousness, they often inspire the hope among daily caretakers that the patient could recover some consciousness, however low grade. Accordingly, they demand that physicians continue to treat, even if in violation of the patient’s explicit advance directive to the contrary, and physicians usually comply. In practice, patienthood is clearly understood to outstrip and outlast personhood.

There is conceptual backing for keeping them distinct. Both personhood and patienthood may both be regarded as a matter of recognized or conferred social status, but on very different grounds and with very different consequences. To be regarded as a person is to be seen as deserving equal respect, in virtue of having souls, minds, or moral or rational capacities. To be regarded as a patient, by contrast, is to be seen as in want of specific medical attention, in virtue of recognized medical physical or psychological needs. Clearly, non-persons can be regarded as in want of medical attention.

Arguably, there is a further conceptual disparity between persons and patients: Patients die, while persons, strictly speaking, do not die but rather cease to exist. It may be argued that in ceasing to exist, a person is no longer alive, for non-existent beings can have no vital properties. Indeed, they can have no properties whatsoever, including the property of being dead—a property shared by all dead bodies. Likewise, one cannot infer from the fact that a non-existent person is no longer alive that the person is dead: The terms ‘alive’ and ‘dead’ are not contradictories, since many things are neither alive nor dead. Nor are they contraries, for some things are “more dead

than alive” and therefore are both dead and alive to varying degrees. It may be, admittedly, that although being dead and not being alive are conceptually distinct, they may be regarded nonetheless as clinically equivalent. I’ll take up this suggestion below under the topic of the “near death” of brain dead patients.

Given such clinical shortcomings of both organism-death and person-“death”, let us look for some third concept of patient death more clinically propre. One possible source are the actual clinical death practices, specifically, the ways in which doctors determine the time and cause of death. We distinguish one event from another by their differing times and causes—a conceptually relevant fact on most theories of events generally.³ So, we might expect these clinical determinations to shed conceptual light on death, or at least death in the clinic, regarded as an event.

Physician discretion in death matters

Let us first note the discretion physicians enjoy with regard to the timing of death. For example, when CPR is attempted and fails, the time of death is not the time at which the heart stopped beating, or the somewhat later time of irreversible anoxic cardiac damage. Rather, it is set at the time when the CPR team stops its efforts at resuscitation. This may or may not be the time at which they all agree that further efforts would be futile. Sometimes CPR continues well beyond that point of medical consensus in order, for example, to allow family members to arrive at the hospital before death is declared, or to be able to prove that the staff “did everything humanly possible” to save the patient.⁴ Alternatively, the team may stop before there is consensus about futility if, for example, they are paged for a newly arrested patient with a far better chance of rescue. .

³ I draw here on a long held tenet that criteria for individuating one thing from a highly similar thing, or criteria for identifying one thing as the same thing in an earlier or different context, are conceptually central and illuminating (Accounts of personal identity are the familiar locus of this assumption.) This tenet would seem to be a legacy of Logical Positivists who took the meaning of a term or sentence to be the method of its application or verification. Whether this tenet can be defended without the Positivist backing I’m not sure.

⁴ Michael Fetters reports that Japanese teams may continue CPR for several hours “to provide the family time to come to the hospital, to observe cessation of CPR, and to be at the patient’s bedside at the time death is pronounced, a practice known as shini me ni au (Looking in the eyes of death).” “Cardiopulmonary resuscitation and care of deceased patients: Japanese and US perspectives.” Abstracts, Global Bioethics: East and West, South and North, IAB4 World Congress of Bioethics, p.90.

This temporal discretion, however, has biologically determined limits: Physicians cannot set the time of death later than the onset of rigor mortis nor earlier than cardiac arrest, but that arrest need not be permanent. In heart transplant protocols, a heart may be removed well before that point. The “dead donor rule” is taken to require a delay of five to six minutes after arrest, but the Pittsburgh protocol allows removal after only two minutes. In neither case is the heart itself dead, that is, permanently non-functional. Indeed, the whole point is to get a heart that will readily restart, with or without electroshock, in the recipient’s chest. But, it is objected, with only a two-minute delay, a heart could spontaneously resume beating before fully removed. Hence, surgeons could be seen as taking the heart of a still-living donor and thereby be the cause of death and arguably guilty of homicide.⁵ Waiting a few more minutes after arrest eliminates the risk of premature restarting and hence the risk of a charge of homicide.

This worry, I think, ignores the causal discretion that physicians have in deciding what causal factor counts as the cause of death in particular cases. From Aristotle on, philosophers have pointed to the complexity of causal diagnoses. There is rarely only one correct answer to the question, What is the cause of such-and-such? Which of the many causal factors we select as the cause may be influenced by a variety of features of the case, some of them epistemic or practical. A factor may be elevated to the status of “the cause” because it is novel, or unexpected, or close in time to the effect, or explains the effect best, or can be most easily manipulated—or most easily identifies someone to hold responsible for damages in case of a compensable harm.⁶

Physicians have just such discretion as to what counts as “the cause” of a patient’s death. Cardiac arrest may be the closest temporal neighbor to many deaths, but doctors may choose a more obvious, earlier factor (stab wound, drug overdose, asphyxiation), or a more long-standing, pervasive causal factor (pancreatic or renal insufficiency), and so forth. Understandably, in exercising this causal discretion physicians are inclined to exempt their own actions from the list of candidates, unless there have been egregious deviations from standard medical practice. In

⁵ Alan J. Weisbard, “A Polemic on Principles: Reflections on the Pittsburgh Protocol,” *Ibid.* 217-239.

⁶ H.L.A. Hart and A.M. Honoré, *Causation in the Law*, chs.1-2. These policy influences are an example of the wider role of anthropocentric factors in causal explanation in engineering, laboratory science, historical explanation, and other practical realms, as noted by J.S. Mill (*A System of Logic*, Vol.1, Bk.3), R.G. Collingwood (*An Essay on Metaphysics*, Part 3-c), and Douglas Gasking (“Causation and Recipes,” *Mind* 64 (1955)479-87).

such cases of “iatrogenic” deaths, physicians’ causal contributions cannot be kept in the causal background. For some critics, withholding or withdrawing life-support counts as iatrogenic death, for the patient would not have died at that time but for the physicians’ actions. Defenders of so-called “passive euthanasia” argue that the physicians are at patients’ or parents’ request giving up their fight against the disease, thereby allowing an incurable disease to proceed to its natural outcome. So, it is the disease, not they who cause death—unlike the case of “active euthanasia” in which the physician’s action is the cause of death and the “underlying” disease, not the cause, but rather the reason for his “mercy killing” of the patient. By using causal discretion to suppress doctors’ role in passive euthanasia, the AMA is able to protect physicians’ image as life-savers, not life-takers.

It should be noted that causal discretion is not used only for professional self-protection. Physicians often protect their patients’ interests in their choice of “the cause of death.” For example, before AIDS reporting became legally mandatory, physicians would list pneumocystis pneumonia as the cause of death. Likewise, suicides might be reported as dying from “tracheal obstruction” in order to protect the dead patient and/or the family from stigma or untoward legal or religious consequences.

As with time of death, however, there are limits to physicians’ discretion in the choice of cause of death. In a widely noted case, a physician listed leukemia as the cause of death for a patient who had taken barbiturates he had prescribed so that she might avoid terminal debilitation, if she so chose.⁷ In so doing, he fulfilled his promise to her to spare her family the delay and distress of mandatory autopsy and legal inquiries that suicides trigger. In his defense, could he have met the charge of lying by invoking the model of passive euthanasia reasoning? That is, could he have made her action transparent in the way that doctors’ withdrawing life-support is made transparent, thereby allowing the blame to fall on the underlying disease. I think not. The case is more like that of active euthanasia: the leukemia was the reason for the fatal action, not the cause of death. In both cases, drug intake is too salient to be left as merely one among many causal factors.

To set biological boundaries for physicians’ causal discretions, we might try to define a “perifatal” period by analogy with the “perinatal” period surrounding birth. Obstetricians .

⁷ Timothy Quill, “Death and Dignity: A Case of Individualized Decision Making,” New England Journal of Medicine 324: 691-694 (March 7, 1991).

have some leeway as to which event in the birth process to count as the moment of “live birth” (crowning, emergence of the whole head or whole body from the birth canal, severance of the umbilical cord, the first inspiration or first cry)-- the time of each somewhat under their control. But some events in the birth process would clearly be too early (breaking of the amniotic sac) or too late (opening of eyes).

Brain death poses a problem for defining a “perifatal” span, namely, does brain death come too early to be counted as death, or, alternatively, do brain dead patients fall within a physician’s discretion as to whether to declare them dead or not? Let us consider current practices, in particular, the two sets of required diagnostic tests. Initially, the two sets had to be at least 24 hours apart, but now only six. Otherwise, when to test is up to physicians’ discretion, and so, too; the time at which after the second set is completed, death is declared. Routinely, physicians delay the first or second test to allow family members to arrive at the hospital, absorb the shocking news that their relative will not recover, and begin to consider organ donation. If family agrees to donation, then the declaration of death may be postponed until a recipient is identified and surgically ready. Even though a traumatic event or stroke may be counted as cause of death, neither is regarded as determining the time of death. As with CPR, it is clinical convenience that determines the time of death.

In those jurisdictions in which brain dead patients may be declared dead, physicians have yet another discretion, that is a choice of which death criteria to use. Thanks to legislation or court rulings, they may now use neurological criteria in order to secure viable organs for transplantation, or merely to end physiological support (sometimes confusingly called “life support”).

Some jurisdictions, however, constrain physicians’ criterial discretion: New Jersey allows some religious objections to the legislated equivalence of brain death with death; and Japan gives families a veto, on whatever grounds, even over testing for brain death. All of these restraints on physician discretion serve to reduce doctor-family conflict and to make a patient’s death more bearable by allowing more time for grieving and death rites.

Whether subject to family or physician discretion, the time, cause, and criteria of death clearly reflect social as well as biological matters. But that is not to say that the exercise of discretion in these death matters is arbitrary or idiosyncratic. Even if there is no simple

“fact of the matter” in these death matters, there are, as we have seen biological parameters and practice-relevant factors (organ donation and family bereavement) that constrain the choices physician and family are allowed.

Let us look more carefully at the clinical import of the biological or pathological and medical practice parameters.

Near-death

What I called the “perifatal” period is a time at which patients are considered near death, even if not yet declared dead. Although near-death judgments are not well defined, clinicians can often agree among themselves that “a patient has gone sour,” should be placed on the “critical list,” or moved to an ICU. These near-death judgments do not carry precise predictions of the time of death, or even of the certainty of death. Some patients may unexpectedly linger near death for days, or even improve and return to an earlier, less dire condition. Nonetheless, the judgment of near-death usefully prepares a patient, family, or staff for the patient’s death.

Brain dead patients are clearly near death. Without continuous monitoring and various interventions, brain dead patients suffer cardio-respiratory collapse within a few days, and even if that can be delayed for weeks (or months in the case of some pregnant women), the ICU staff must wage a continuous fight against potentially fatal infections, fevers, or changes in blood pressure and other vital signs.⁸

There are reports that early hypothermic treatment may lead to longer survival without such continuous intervention, or even to partial recovery.⁹ Such patients embarrass an initial argument for the equivalence of brain death and death, namely, that the temporal difference between death by neurological criteria and cardio-respiratory treatment is at most a few days of total unconsciousness and unresponsiveness. These reports do not, however, prevent us from

⁸ See, for example, David R. Field et al., “Maternal Brain Death during Pregnancy, *JAMA* 260 (1988) 816-22.

⁹ Dr. Nariyuki Hayashi, Nihon University, reported such results at IAB4.

thinking of brain death as near death, since near death patients can improve or even, on occasion, recover, as I just noted.

In addition to being near dead in this clinical sense, brain dead patients are near dead in a related, but distinct biological sense. Having lost most of their vital functions and the capacity to coordinate them, brain dead patients are barely living organisms. It may be argued that the brain dead have not lost their vital functions or the capacity to coordinate them long as there are devices that perform them: “What counts is not how the job gets done but that it is done.”¹⁰ But what is it that is doing the job? Is it the body, a machine, or some combination?

These questions do not arise when, as with pacemakers, the device is incorporated in the body or is merely supplementing the feeble efforts of some barely functioning organ. But when, as with brain dead patients, almost all vital functions need external monitors, supplementary devices, or clinical interventions, it is less clear what it is that is performing the function. Seeing patients lying passively and unresponsively among a network of active machines and medical attendants surely favors the view that the brain dead are, as journalists say, like cyborgs or perfused corpses whose functions are performed not by them, but almost entirely for them. Alternatively, we might regard them as viruses who perform their single vital function of reproduction by invading and converting to its use a more complex host’s cells (in this case, the various part of the ICU system.)

The analogy with viruses suggests a possible resolution of whether the brain dead are still alive. The long-standing debate about viral life can be avoided by regarding viruses as alive or not, depending on context and purpose. In immunology, they can be regarded as alive (or killed) when it is necessary to distinguish active (“living”) from passive (“killed”) antigens. But in crystallography where structure, not activity is under study, we may regard viruses simply as inanimate molecules. Apart from any specific context, they are biologically indeterminate, straddling the living/non-living border. Without context, it may not matter whether one says or implies that that they are living, non-living, or both. Likewise, brain dead patients may be thought of as counting as living in some contexts, as no longer living in others, and as either or both when the question arises out of context.

¹⁰ Daniel Wikler,

We might combine the notions of near death and context-determinacy to make the following point. In certain contexts defined by certain purposes, the difference between death and near death is insignificant: for legal and moral purposes they are ruled equivalent. This may explain why physicians and nurses involved in transplants shift back and forth between saying or implying that brain dead patients are alive and dead, and why they easily forget to declare a patient dead before removing organs and when reminded do so in a perfunctory way.¹¹

Of course, for a brain dead patient's family, the difference between brain death and declared death may be very significant. So long as their relative is not yet dead they may still hold out hope, however irrational by physicians' lights. Or, they may at least try to comfort the dying patient, or perform pre-death rites which will make their immanent loss more bearable. For Roman Catholics, there will still be time for "last rights;" for Buddhists, a chance to "look into the eyes of death,"¹² and hold the body as it cools.

Some critics joke that in New Jersey a brain dead patient is dead unless she is an Orthodox Jew or a Native American (the two established religions that oppose brain death legislation and organ donation). Likewise, there are jokes about being dead on one side of the Hudson, but not the other—hence the possibility of being legally revived by an ambulance ride through the Holland tunnel. To have bite, these jokes must presuppose that there is a "fact of the matter" about whether someone is dead or not, but that is what is at issue. I have been suggesting that physicians' discretion show that in the case of brain death that is not so, even if for the condition of near death it is.

Degraded life

By contrast with the brain dead, PVS patients retain too many vital functions and require too little machinery to be placed on the animate/inanimate border--but it understandable that they may be thought to straddle the human/subhuman border. On Aristotle's analysis in De Anima, all living things have bodies so organized as to render them capable of nutrition and growth, including reproduction. Since, on his view, souls are not separable entities, but rather are the

¹¹ Stuart Youngner and colleagues explain this as confusion and ambivalence, but indifference could equally well explain their findings. "Brain Death" and Organ Retrieval: A Cross-sectional Survey of Knowledge and Concepts among Health Professionals, JAMA 261:15 (1989: 2205-10).

¹² Again, from Michael Fetter's informative IAB IV talk.

form of a material body, we may say that living bodies with these capacities are “ensouled” in a vegetative way. Animal bodies are further organized in ways that give them additional capacities for sensation and motion. Human bodies have even more complex organization to give them the capacity for deliberative thought and action. In short, they alone are ensouled in a rational way.

In these terms, we might think of some brain-damaged patients as having lost their rational soul, that is, the bodily organization necessary for rational deliberation. They are still capable, however, of perception, purposive movement, and pleasure and pain. Accordingly, they resemble animals. By contrast, PVS patients have lost even those capacities and retain only capacities for nutrition and growth. Whatever motion of the eyes or limbs, they are not purposive or expressive of pleasure, pain, or perception by any clinical standards. Accordingly, they are appropriately said to be in a vegetative state.

Unlike brain dead patients in a viral condition, they are clearly still alive but are they still human? They are clearly not human beings if that is taken to be roughly synonymous with persons in the philosophical sense previous mentioned above. Nor are they subhuman plants, but rather they are literally de-graded humans in a pitiable plant-like condition. Were they subhuman plants, there would be no cause for pity since plants are not pitiable--except perhaps when sick or dying, and PVS patients are neither.

Another way of making these points is to say that PVS patients, although alive, are no longer living a human life. Some philosophers have found it helpful to draw a distinction between biographical and biological life, a distinction found in the ancient Greek terms bios and zoe.¹³ Biographical lives are defined by particular projects, emotions of pride and shame, sense of self with past and future, and psychological and social characteristics that lend lives some features of narratives (and many of the properties defining personhood). PVS patients are clearly no longer leading such lives, but there are ways that their lives may be extended to a limited extent by others.

¹³ See James Rachels & William Ruddick, “Lives and Liberty” in John Christman, Ed. The Inner Citadel: Essays on Individual Autonomy (Oxford UP 1989), as well as William Ruddick, “‘Biographical Lives’ Revisited and Expanded,” Journal of Ethics (forthcoming, March 2005).

In many cultures, the dead though no longer visible are thought to be hovering, disembodied, watchful and wrathful spirits to be consulted, pleased, and placated. Without such beliefs, we may nonetheless keep the influence of the dead active through retrospection, commemorative projects, and imagined conversations. Visiting and talking to PVS patients may have something of the same “life-extending” aspect and would need to be included in any biography of such patients as Karen Ann Quinlan and Nancy Cruzan.

There are, however, psychological limits of memory and devotion to such continuations, as reflected in legal provisions for declaring “civil death.” In many jurisdictions someone who has disappeared and been absent for seven years may be declared civilly dead, thereby allowing relatives to inherit, remarry, and in other ways regard their loss as permanent, as indeed it is. In most cases, were the civilly dead to return later, they could not resume the life they had lived with those from whom they had been so longed departed. They would be almost as strange as would someone who returned to a village after everyone who once knew him had died or departed.¹⁴

We might draw on civil death provisions to set a time after which a patient in PVS need no longer be regarded as the person people once loved. Joseph Cruzan argued (after seven years) that continuing care of his daughter’s body made it impossible for him to grieve properly for the daughter who had left him along time ago. His only legal recourse was to find “clear and convincing evidence” that she had years ago previously expressed clear opposition to being kept alive in such a condition. Families cannot often meet this evidentiary standard, nor is it clear why they should be made to so. To cling legally to autonomy is both conceptually and morally insensitive. It is oxymoronic to regard long and permanently unconscious patients as autonomous, and it is morally obtuse to make the relief of present family suffering turn on what someone once thought about being in an improbable and interminable amented condition in the distant future. It is the sort of ruling that gives high Western individualism the air of uncritical ideology.

Extension of the legal notion of civil death to PVS would avoid these conceptual and moral problems, as well as those of the higher brain death criteria proposals. It fully recognizes their

¹⁴ In certain tribal societies, post-mortem spirits cease to be personal presences once the last person who knew him or her dies or moves out of the village.

claim that PVS patients have lost “all that makes human life worth having,”¹⁵ but it does not address that loss by extending physicians’ criterial discretion to regard such patients as dead (or as good as dead for certain purposes). Rather, the civil death proposal would make it a matter of family discretion as to whether PVS patients are as “good as gone,” a condition that may be worse for the family than were the patient regarded as good as dead. Indeed, were PVS patients as good as dead in the ways that brain dead patients are, family suffering and relief would be far less acute: passively dependent on a network of machines, brain dead patients are not physically contorted or distorted, and they do not live long even with monumental clinical effort.

Death and loss

Brain death and PVS are not clinical or moral problems in countries which do not have the medical resources for, or the moral commitment to such life-prolonging projects. Nonetheless, I would hope that the biosocial concept and family context into which I have tried to place these special conditions would be recognizable and congenial beyond the wealthy West and North. What I take to be near universal is the loss that death inflicts on survivors, whatever their metaphysical and cultural beliefs. The losses we all suffer from the death of those we care for are subject to none of the philosophical doubts or metaphysical comforts about which people differ. Whether our own deaths are inconceivable or not, whether we are irrational to fear our deaths, or whether in dying we suffer any losses are complex and debatable issues, since they turn in part on whether the metaphysical issue of whether death is personal annihilation or rather a transition to another form of life. But what is not in doubt are the losses through death that we can all too easily vividly imagine, rightly and intensely fear, and acutely suffer, namely, losses that befall us through the death of others. Even as children and young adults we share a sense of mortality, not necessarily of our own individual mortality but the mortality and vulnerability of those we care for. Metaphysical beliefs about the lingering presence of the dead, or eventual reunion with the dead, may somewhat reduce or transform these losses, but rarely do they eliminate them. (And, of course, they may sharpen our losses if we believe, for example, that the dead suffer from being separated from the living, or that we may not be reunited after our deaths.)

How can physicians take these losses into account? In some ways, they already do so. They frequently refer to the death of a patient as “losing a patient,” and we have seen how adept

¹⁵ as Robert Veatch has often argued.

sensitive physicians are in taking family losses into account in exercising their professional temporal and causal discretions with regard to patient death.

Fortunately, some bioethicists—especially feminist bioethicists¹⁶—have begun to shift discussion from patients, viewed as unrelated individuals, to patients embedded in family and other relationships that do not lend themselves to talk of competing individual interests, autonomy, and paternalistic intervention. My suggestions for a biosocial conception of patient death, distinct from organism-death and person-death, are meant to contribute to this effort.

¹⁶ For example, Hilde Lindemann, James Nelson, Alisa Carse, Margaret Little, and Susan Sherwin.