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Euthanasia and Brain Death: Ethical and Legal Considerations

Dennis J. Horan

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I.

For many years the problem of defining death was basically one of a simple medical judgment, a diagnosis made by a physician at the deathbed in a home or in a hospital.[1] The criteria for determining when death occurred were medical criteria easily applied by physicians and seldom, if ever, questioned by the public. There existed no statutory definitions of death, and the common law considered the issue only in relation to the distribution of property or in determining whether a person who had been the victim of an assault died within a year and a day.[2] The common law defined death as a moment when life had ceased, "defined by physicians as a total stoppage of the circulation of the blood and a cessation of the animal and vital functions consequent therein, such as respiration, pulsation, etc."[3] Any more was not necessary, and so no more was undertaken.

Then two advancing areas of medicine converged on the deathbed to create one of our current problems. The first of these was the increasing ability of medicine to resuscitate dying patients and to maintain those patients on sophisticated machinery. The second was the ability of medicine to transplant organs from one person to another. Both of these advances depended upon a myriad of factors too complicated to discuss here, but were related to the tremendous growth in medical technology of recent years.

In response to the problems of resuscitation and the modern use of respirators, several states passed new laws redefining death in two ways.[4] One definition was used when the death occurred in the hospital where resuscitative methods were being used. This definition brought in the relatively recent requirement of "brain death." The

other definition of death was applicable when resuscitative means were not involved. This definition continued to rely on the traditional grounds of cessation of heartbeat and respiration.

My concern here today is the ethical and legal considerations for society in adopting brain death as a basis for a diagnosis of death. I did not say *the* basis for such a diagnosis since I presume that no one intends but that brain death should be an additional way — albeit, the "sole" way — of determining death in a given case.[5] That is to say, where mechanical support is not in use or transplantation is not an issue, we would not have the problem since the diagnosis would be a matter of clinical judgment by the attending physician. Obviously, brain death is also a matter of clinical judgment, but is only too seldom discussed in those terms. We are not *per se* discussing a statutory definition of death but rather two other questions: one, a broad philosophical, moral, ethical and legal question; and the other, a narrow technical medical problem. These questions are:

1) Is a person who is brain dead really dead? If the answer is yes, then
2) What means of proof that brain death has occurred is acceptable to society?

Many of the sections of this conference are concerned with the second question. Even though I have labeled that a technical medical question, there indeed can be ethical-legal problems associated with that question also, but those problems are not my purpose. My concern is with the first question: Is a person who is brain dead really dead? This is similar to the question we ask when we ask whether brain death may be a statutory criterion for defining death. However, to say we are defining death is really incorrect. What we mean to say is, "What are the criteria on which the medical diagnosis of death may be made?" We cannot really define death since it is the absence of life which we can only describe.

II.

If the determination of death is a diagnosis made by a physician and a person is dead when his brain is dead, then why can't a physician make such a diagnosis and declare the brain dead person to be dead? Why does he need a statute? In short, what are we doing here? Why are statutes being created to give a physician a "right" (to declare a brain dead person dead) he presumptively has?

In my opinion, the answer to those questions is two-fold: 1) the public and public policy-makers lag behind the physician in understanding these concepts, and 2) some persons, indeed some physicians, have used the concept of brain death in a socially unacceptable way.

The first answer means that more and better ways of reaching the public and informing public opinion on these issues must be found. The second we must discuss further to illustrate my point.

I do not wish to set up a straw man, but in order to clearly delineate the nature of the legal-ethical problem I am about to discuss, I wish to choose as an example a medical article published in the *Baylor Law Review* entitled "Medical Death."[6] In that article Sheff D. Olinger, M.D., director of the Department of Neurology and director of the Stroke Unit and EEG Department of the Baylor University Medical School in Dallas, took great care to make a distinction in the issue of brain death, which distinction, in my opinion, is at the heart of the problem as to why some public policy-makers have refused (and rightly so) to accept brain death as an alternative means of defining death. In that paper, Dr. Olinger stated:

> I would like to distinguish the term cerebral death from brain death. The brain is composed of several parts, including the medulla, cerebellum, midbrain, and cerebrum. We are concerned here with the cerebrum. The other portions of the brain may function to produce spontaneous circulation and respiration in the absence of the cerebrum without consciousness or awareness. When all the brain has lost its function, there is no spontaneous respiration, and usually no effective circulation. I would emphasize again that cerebral death and brain death are different things and that the term cerebral death expresses the medical concept which is equated with death of the individual person.[7]

After discussing the Harvard criterion and criticizing it because it is highly technical and incapable of lay understanding and, more importantly, because the Harvard criteria "do not recognize the cerebral quality of human life, [since] the cerebrum might be totally destroyed without hope of recovery, although circulation and respiration could persist or be supported indefinitely,"[8] Dr. Olinger then proceeds to put his finger on the heart of the matter.

> Having defined medical or scientific death as death of the cerebrum, it must be pointed out that this definition is not usually used in ascertainment of death by physicians.[9]

Dr. Olinger's last statement presents two problems, the discussion of which is important for us today. 1) Is that definition (death of the cerebrum) not used because there is a lag in the knowledge necessary to make a determination of death based on brain death, or 2) is it not used because the concept of brain death as cerebral death is not (as I asked previously) really death?

Death of the cerebrum alone has not been accepted as real death in our society.[10] Those who push this definition of death, whether they realize it or not, are asking for a change in the current homicide laws and asking for the introduction of euthanasia, which creates for each of us substantial ethical problems as well.

Although the American Medical Association has not opted for any definition of death, a two-part article recently published in *The Jour-*

nal of the American Medical Association has reviewed the concept of brain death and has reported on the current status of these medical and ethical considerations. Throughout this two-part article continued reference is made to brain death as the *complete* destruction of brain function or the irreversible cessation of *all* brain function. The authors review the current ethical positions and conclude that only destruction of the *entire* brain constitutes an acceptable definition of death. Consistently throughout this article such language is used as this:

> Patients with irreversible total destruction of the brain fulfill this definition, even if heart action and circulation are artificially maintained.[12]

The American Bar Association in its Resolution voted and approved by the House of Delegates on 2/24/75 accepted as a definition of brain death the irreversible cessation of total brain function. However, it is important in considering that definition that the thrust of the entire Resolution be understood. The preamble to that Resolution recites that the concern of the medicine and law committee, which formulated the Resolution after extensive research and investigation, was the necessity to cease all artificial life supports when someone has died and to maintain the best cellular condition of a donor's organs. The Resolution in full reads as follows:

> WHEREAS, it is to the well being of the public to cease all artificial life supports, respiratory and circulatory, after a human body is dead; and
>
> WHEREAS, it is currently medically established that irreversible cessation of brain function is determinative of death; and
>
> WHEREAS, in the current technology of organ transplants it is vital that the donor's gift be in the best cellular condition,
>
> THEREFORE, be it resolved: that the American Bar Association offers a Current Definition of Death as follows:
>
> For all legal purposes, a human body with irreversible cessation of total brain function, according to usual and customary standards of medical practice, shall be considered dead.

The preamble is important to keep in mind because it limits and explains the applicability of the resolution. The ABA definition is intended for those occasions when artificial means of life support are in use or organ donation is contemplated. Even though the definition includes the words "for all legal purposes," the definition is not intended to supplant a physician's use of his clinical judgment when he declares a person dead. The intent of the resolution is to aid him in the specific area of artificial life supports where clinical judgment, it is said, has become tentative and confused.

Consequently the ABA definition does not mean that a person who has spontaneous respiration and circulation, but has a brain lesion which makes him comatose can be declared dead. So too, the hydranencephalic child cannot be declared brain dead under the ABA test because he probably has a thalmus and upper brain stem. The

anencephalic child is another question, but even this child — if it has voluntary respiration or circulation — is not brain dead under the ABA definition. In any event, anencephaly is incompatible with life and such a child will not live more than a few hours. However, even that child is a person under our law and is protected by the full panoply of legal and constitutional rights.

In addition to the preamble to that Resolution, which is frequently forgotten in discussing the nature of the ABA's position on brain death, the advantages of such a definition, as published in the American Bar Association's report when it accepted this definition, are the following reasons in support of or as "advantages of the definition":

1. permits judicial determination of the *ultimate* fact of death;
2. permits medical determination of the *evidentiary* fact of death;
3. avoids religious determination of *any* facts;
4. avoids *prescribing* the medical criteria;
5. enhances *changing* medical criteria;
6. enhances *local* medical practice tests;
7. covers the *three known tests* (brain, beat and breath deaths);
8. covers death as a *process* (medical preference);
9. covers death as a *point in time* (legal preference);
10. avoids *passive* euthanasia;
11. avoids *active* euthanasia;
12. covers current American and European *medical practices;*
13. covers both *civil* law and *criminal* law;
14. covers current American *judicial decisions;*
15. avoids *non-physical* sciences.

A fair reading of the articles concerning the medical, legal and ethical aspects of brain death which appeared in the October issue of *The Journal of the American Medical Association* clearly indicates support of the American Bar Association Resolution on brain death. The importance of that resolution for our discussion is its explicit rejection of the notion that cerebral or partial brain death are satisfactory definitions. As one author stated: "Thus, destruction of the entire brain or brain death, and only that is consonant with biblical pronouncements on what constitutes an acceptable definition of death . . . ."[13] The article concluded that total brain death is acceptable as a definition of death to most Jewish, Roman Catholic and Protestant scholars. I would agree.

So also, in a recent review of European practices concerning brain death it was said:

> The term 'cerebral death' is too ambiguous to be adequate for use in any serious discussion of death because linguistically and medically the term means the death of only the cerebrum and not of the entire brain, even though colloquially it encompasses both senses of the word. The author knows of no proof nor unanimous opinion that the total and irreversible cessation of function of only the cerebrum guarantees or proves total and

irreversible cessation of all perceptions. Therefore, proof of the death of the cerebrum does not prove that the person is dead (as person is defined in this article).[14]

This article states that there is no general agreement or proof that all levels and forms of psychic activity are produced exclusively by the cortex.[15] A number of German doctors state that brain stem activity may be able to produce primitive psychic activity. Consequently only the *total* and irreversible cessation of all brain function guarantees that all perception has totally and irreversibly ceased and that the person is medically and legally dead. This author then defines death thus:

. . . death of the person occurs exclusively if and when brain death occurs, that is when total and irreversible cessation of all neuronal function in all parts of the brain occurs.[16]

In my opinion, the irreversible cessation of total brain function is an ethically acceptable, as well as adequate legal and medical definition of death. However, death of only the cerebrum is not.

III.

What then are the legal and ethical implications of the distinction between cerebral brain death and total brain death? In discussing this question we should first indicate that we are not speaking about when it may be proper to cease treatment in a terminal case, even if that treatment is a Bennett respirator, such as was involved in the Quinlan case. My own position on that issue is that a physician is authorized under the standards of medical practice to discontinue a form of therapy which in his medical judgment is useless. He is not mandated by the law to render useless treatment, nor does the standard of medical care require useless treatment. Under those circumstances, if the treating physicians have determined that continued use of a respirator is useless, then they may decide to discontinue it without fear of civil or criminal liability. By useless is meant that the continued use of the therapy cannot and does not improve the prognosis for recovery. Even if the therapy is necessary to maintain stability, such therapy should not be mandatory where the ultimate prognosis is hopeless. This does not mean that ordinary means of life support, such as food and drink can be discontinued merely because the ultimate prognosis is hopeless. In addition, we will reserve for some other time the discussion of whether or not IVs may be discontinued even under those circumstances. My own position is that they may not. By hopeless is meant that the prognosis for life (not meaningful life) is very poor. The fact that someone may or may not return to "sapient or cognitive life" may or may not fulfill the requirement depending upon other medical factors, but of itself it does not.[17] The Supreme Court of West Germany put this idea very succinctly in its recent opinion on the abortion issue:

Where human life exists, human dignity is present to it; it is not decisive that the bearer of this dignity himself be conscious of it and knows personally how to preserve it.[18]

Nor are we discussing the equally difficult legal-ethical question of whether, and if so when, orders not to resuscitate may be given. Such orders, in my opinion, should be given only when based on good medical judgment that the ultimate prognosis for recovery is hopeless and when informed consents have been obtained from the patient and/or the patient's family (if the patient can't consent). The order should be in writing and signed by the attending physician. Some hospitals, as has been recently suggested, may want this done by a committee. Some physicians are willing to give such an order, but balk at writing it in the record. This attitude solves little, but perhaps as an accommodation to this problem the physician's order could be a separate record, such as a sterilization consent form that does not become a part of the patient's bedside record.

As is typical when discussing these emerging issues concerning death and dying, I've spent considerable time telling you what the issue is not. What then is the issue? In my perception of the problem of brain death the issue is that total brain death is an acceptable legal and medical manner of declaring persons dead. Cerebral death is not an acceptable legal, ethical, medical or moral manner of declaring persons dead. Cerebral death is akin to euthanasia, which is morally and legally unacceptable.

IV.

Percy Foreman has said that euthanasia is a "highfalutin' " word for murder.[19] Under our law euthanasia is a homicide.[20] Even though the one who commits euthanasia bears no ill will towards his victim and believes his act to be morally justified, he nonetheless acts with malice in the eyes of the law if he is able to comprehend that society prohibits this act regardless of his personal belief. The motive of the perpetrator of the euthanasia is rejected as an ameliorative fact in American law. If the facts establish that the killing was done willfully, that is with intent and as a result of premeditation and deliberation, our law calls it murder in the first degree regardless of what the defendant's motive may have been.[21]

Even if the homicide is committed at the request of the decedent it still constitutes a homicide since, as our courts have indicated, murder is no less murder because it is committed at the desire of the victim. "He who kills another upon the other's desire or command is in the judgment of the law as much a murderer as if he had done it merely from his own volition."[22]

All nations consider euthanasia the crime of homicide, although it is frequently indicated that Uruguay may be the one exception.[23] In a number of countries such as Germany, Norway, Switzerland, etc., a

compassionate motive or homicide on request will operate to reduce the penalty, but the crime remains the same — homicide. Homicide is no less homicide because the victim is aged, senile or near death.[24] The criminal law has as great a respect for the young and hearty as the old and aged. The law teaches that mankind has not supported euthanasia. It is considered a homicide by all nations and societies.

For the medical profession our discussion of euthanasia has particular importance. Already our society has legalized abortion and has made the killing of the unborn an option between the mother and her physician. It is significant that that decision to abort must be a matter of medical judgment as well as the mother's wish. At least it was such in the eyes of the U.S. Supreme Court but, as we have all seen, in the majority of cases, if not well in excess of 98% of the cases, no medical reasons exist to support the abortion.[25]

From the point of view of the physician who has been trained to preserve life, the legalization of homicide at the request of the actor is of very great significance primarily because the actor would be the physician. To understand euthanasia one must understand that we are focusing not on the conduct of the person dying, but on the conduct of the person who will participate in the act of killing that person, either voluntarily or involuntarily. Make no mistake about it, that person would be a physician.

Suicide is not considered a crime and assisting at suicide is a crime in only a small number of jurisdictions.[26] Although euthanasia is frequently equated with assisted suicide,[27] it is really something very different from the point of view of the physician.[28] The legalization of euthanasia is always sought on the basis that the physician would be the one who would assist in the killing. Under current arguments for legalization, it is the physician who is being asked to kill the person involved. In determining whether or not euthanasia should be legalized, society must focus on the act of the physician or the person administering the euthanasia to understand the nature of euthanasia under both our law and our medical-ethical concepts of what euthanasia is. Do we wish to legalize killing? In his famous article[29] Prof. Yale Kamisar answered that question "no," arguing from purely nonreligious grounds against mercy killing legislation that for the good of society there should be no exception to our universal societal expectations that we will not kill nor be killed. Any breach in that absolute he sees as the beginning of a slippery slope, the danger being that "legal machinery initially designed to kill those who are a nuisance to themselves may someday engulf those who are a nuisance to others."

Those who would legalize euthanasia want it to be legalized so that a physician can kill someone who is desirous of euthanasia. This fact should not be glossed over or eliminated from any discussion of this important issue, especially by physicians. The legalization of euthanasia will make death an option or a treatment of choice in some circum-

stances. Will the ideology of cost containment one day make it mandatory? Before answering these questions we must understand that there is a vital distinction between killing and letting die.[30]

All men will one day be hopeless in the face of death. Anything we say or do is not going to alter that fact. We shall all die. The vital distinction is whether we shall die as a result of being allowed to die, or whether we shall die as a result of ourselves or others.

Where there is no obligation to treat because treatment is not beneficial and is therefore useless, treatment may be ceased and the patient may be allowed to die. Whether or not such a state has been reached by the patient is a medical judgment to be made by the attending physician. Direct intervention to end life is never licit. It is neither legal nor ethical. The use of drugs to alleviate pain and suffering in terminal patients is not only licit, but is a desired medical intervention to avoid unnecessary suffering. The distinction, however, between the positive act of killing and allowing a patient to die as a result of the natural disease which is killing him is of vital importance and should be understood by all.

The distinction is really no different in the law than in moral or ethical matters. Where there is no duty to act there is no mandate to act and the physician and health personnel are excused from acting under those circumstances. The law only requires that a physician or nurse possess and exercise the skill and judgment of an ordinarily well-qualified physician or nurse in the same locale and under similar circumstances. Neither the means nor the ability are required to be extraordinary or heroic. It is not necessary that all available means be used to prolong life to its ultimate. Good medical judgment can be the basis for termination of treatment when that treatment is no longer beneficial to the patient.

So, too, the patient may reject medical treatment.[31] The cessation of medical treatment because it is useless or the rejection of medical treatment by a competent adult has never been considered to be suicide or assisted suicide, either medically, legally or ethically.[32]

Those who would opt for the legalization of euthanasia are very prone to confuse these necessary ethical and legal distinctions. For example, Joseph Fletcher is fond of saying that the omission of extraordinary or heroic means is just as much a decision to kill as is the positive act of euthanasia.[33] True, the distinction between killing and letting die may be fine "but so are many other lines that men must draw in their fallible perception and limited wisdom."[34] The kinds of distinction and judgment that a physician makes when he determines that heroic means are no longer proper and necessary are the same kinds of distinctions and judgments that he makes daily during the course of his medical practice. The fact that he is making these decisions with regard to a terminal patient should not deter him from making such judgments. There is nothing mysterious or extraordinary

happening in his practice when handling a terminal patient than when handling any other type of patient. Obviously this distinction between extraordinary and ordinary means of medical practice is difficult to ascertain and changes from day to day. In my opinion, a physician is better guided by determining whether or not the treatment will be beneficial to life, rather than trying to determine whether it is heroic or extraordinary. The importance of the heroic or extraordinary aspect is that consideration of the problem in those terms allows consideration of familial difficulties, such as inability to pay for the proffered treatment.

If cerebral brain death is not really death, then the use of cerebral brain death as a criterion for letting die would be legally unjustified. There are few cases to guide us in this area. In the California case of *People v. Lyons*[35] the jury was confronted with determining whether the bullet from a defendant's gun caused the death of the victim, or whether the death occurred as a result of the removal of organs from the deceased's body by the physicians. This case was not appealed and consequently there is no opinion of precedential value. However, the trial court used the following instruction to the jury:

> Death is the cessation of life. A person may be pronounced dead if, based on the usual and customary standards of medical practice, it has been determined that the person has suffered an irreversible cessation of brain function . . . and since the deceased, Samuel Moore, was dead before the removal of his heart there was no issue of fact as to the cause of death.[36]

The trial court relied on the medical testimony of two physicians of the California Medical Transplant Center. I am unable to determine whether or not the words "brain function" as understood by the physicians and the court meant only cerebral function or total brain function. In another *nisi prius* case, *Tucker v. Lower*,[37] similar issues were involved and the court instructed the jury on both the traditional definition of death as contained in Black's *Law Dictionary* and as an alternative "the loss of brain function test." The Tucker case was not appealed and consequently no written opinion of precedential value exists.

There is an issue concerning medical judgment which must be faced. If the physicians agree that total brain death is equivalent with being really dead, then society will eventually come to that position also. However, the concept of cerebral brain death is objectionable because traditionally it has not been accepted, either medically, ethically or legally. In addition, it cannot properly be applied to otherwise comatose people who have spontaneous respiration and circulation, but who are in some stage of deep coma. Ceasing to treat these people because the treatment is extraordinary does not resolve the question as to whether or not they are alive or dead. I think that no one disagrees that those people are alive as we understand it. They are neither dead nor brain dead.

V.

Ethically our understanding of this problem must be based upon our understanding of respect for persons. Each person is a unique entity not only in the eyes of God, but in the eyes of the United States Constitution and the criminal law of all our states. A dying person is no less a person in the eyes of the law. Ethically he not only continues to be a person of infinite moral worth and humanity, he now has a greater claim on us and on our humanity because he is ill and helpless. Even more so, he has his claim upon the practitioner of the healing arts raised to a higher level because of his illness. Indeed, some courts have found the relationship between a physician and his patient to be of the highest legal relationship — that of a fiduciary.

Each one of us deserves from each other the respect we all feel is due ourselves. That respect for a person means that we should be treated as an end in ourselves and never as a means towards an end. In addition, as each of us exists in this society we depend upon the covenant that each of us has with one another, that certain rules of the game — certain unspoken promises we have made to one another — will be followed by all of us. One of those rules or promises is that we will not kill one another.

Such a burden rests even more heavily on the shoulders of the physician who, in addition to his moral role as an individual in this convenantial society, has opted to be the healer of those who need a practitioner of the healing arts. He, therefore, has a double duty to respect the individuality of the persons he is treating and to see in those persons the same degree of respect he would wish for himself were he in a similar circumstance. He must, in short, see persons as an end in themselves and never as a means towards an end. Acting thus he will do no harm.

Arthur Dyck, Saltenstall Professor of Population Ethics at Harvard, has coined a new word to try to clarify the ethical debate about euthanasia.[38] Those who opt for euthanasia in our society such as Marvin Kohl,[39] use terminology such as beneficent euthanasia. Dyck, in order to distinguish a true death with dignity from mercy killing, uses the term *benemortasia.* Confining the words mercy killing and euthanasia as referring only to the deliberate inducement of a quick painless death, Dyck coins the word *benemortasia* to signify an ethic which rests on certain presuppositions about human dignity. Those who support mercy killing justify it when it is done out of a sense of kindness in order to obtain relief of suffering.[40] They wish to uphold the general prohibition against killing and limit its use only to relieve suffering in instances where suffering serves no useful purpose. Dyck argues that the desire and obligation to be merciful or kind do not commit us to a policy of euthanasia and that, indeed, such a policy has widespread effects which are not intended, but are foreseeable.

Although there are deep philosophical and religious differences which divide people on this issue, the injunction not to kill and the promise we have made one to the other that we will not kill, does not invite that type of division. For doctors that sense of divisiveness between themselves and their patients should be a crucial factor in determining whether or not they would opt for mercy killing as an alternative treatment of choice. In my opinion, that option undermines the relationship between physician and patient and will create a sense of distrust which will undermine not only the patient's sense of rapport with his physician, but the physician's own sense of rapport with his professionalism and his profession.

Dyck argues compellingly that the point of the wedge argument is very simple when applied to the euthanasia debate. Killing is generally wrong and should be kept to as narrow a range of exceptions as possible. But beneficent euthanasia or mercy killing applies logically to a wide range of cases depending upon who is making the application and, in particular, upon the ideology of the cost containment over ever-escalating health costs which loom on the horizon. In my opinion, there is no way to limit the application of beneficent euthanasia or mercy killing to a narrow range of cases definitely circumscribed and carefully controlled. As in the case of abortion, to open the door and legalize mercy killing in one case is to legalize it in a full range of cases that are never contemplated by the progenitors of the policy. For these reasons even what appears as a small inroad into the creation of this policy, namely cerebral brain death, must be opposed. However, if the irreversible cessation of total brain function is really death, which it appears to me and to most observers to be, then such a concept can be supported without creating the dangers of which I have spoken.

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36. Friloux, *op. cit.*

37. See *San Diego Law Review*, Vol. 12, No. 2, March, 1975, pp. 424-435.

38. Dyck, "Beneficent Euthanasia and Benemortasia: Alternative Views of Mercy," *Death, Dying and Euthanasia, op. cit.*, pp. 348-361.

39. Kohl, Marvin, ed., *Beneficent Euthanasia* (Buffalo, N.Y.: Prometheus Books, 1975).

40. Kohl, *idem.*