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Human Death as Neocortical Death? The Ethical Context

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I have felt for some time that ethicists should be reluctant to get involved in discussions of the clinical definition of death. The question of whether death has occurred is one that demands medical, not ethical, expertise.

Recent suggestions that the patient be declared dead when the neocortex is dead (such as the proposal by Rizzo and Yonder)[1] are, however, much more than just discussions of how to tell when death has occurred. Such proposals are advocating a revision of our definition (social and ethical as well as clinical) of human death and, by immediate implication, of human life. What is at stake here concerns all of us.

Mr. Weber, an assistant professor of religious studies at Mercy College in Detroit, proposes three questions man must ask in order to arrive at a definition of death. His exploration examines the ethical context of the sanctity of personal life.

The following reflections revolve around three central questions about the proposed definition. Is such a definition of human death (and human life) philosophically satisfactory? What are the likely and/or possible contributions such a definition would make to the ethical values of our society? Might the hoped for benefits be accomplished in any other way?

The Sanctity of Personal Life

Right at the heart of many questions in medical ethics today is the question of what constitutes life that is really human. Rizzo and Yonder have posed a very important thesis for our consideration:

> With the death of the neocortex, human life is ended because the potentiality to reflect consciously is eradicated in the organism.[2]

> When the essential prerequisite for human consciousness no longer exists, that is, when the neocortex is dead, then heartbeat, breathing and reflexes should not be regarded as signs of human life but rather signs of biological life which has lost the organic wholeness that makes it human life and which is in the process of dying organ by organ.[3]

Do we want to accept the notion that human life can be truly ended even in the presence of spontaneous heartbeat and breathing? If we do, we ought to consider very carefully what we are doing.

To clarify the issues at stake in medical ethics, two conflicting approaches are sometimes compared, the "sanctity of life" ethic and the "quality of life" ethic. The sanctity of life ethic holds, in essence, that each and every human life is intrinsically good; that, therefore, all lives are of equal value; that it is always an improper attack upon human dignity to terminate the life of someone because of the condition of that life. The quality of life ethic, on the other hand, puts the emphasis upon the type of life being lived, not upon the fact of life. Some lives are of more value than others; some lives should not be lived. When a certain quality of life is no longer possible, the termination of that life is acceptable.

While such a distinction may often be useful, the question at hand indicates that the typology must be refined to include a third approach – one that might be called the "sanctity of personal life" ethic.

The sanctity of personal life position may very well be more common than either the quality or the sanctity of life approaches. In her study of physician's attitudes toward the treatment of the critically ill, Diana Crane found physicians much less inclined to treat patients with severe brain damage than other patients.[4] Yet there was no indication that these doctors accepted the quality of life ethic in the full sense discussed above.

The discussion surrounding the now famous case of the 43 severely deformed infants allowed to die in the special-care nursery also indicates something of the sanctity of personal life ethic. In the *New England Journal of Medicine*, the authors wrote:

> Regarding the infants, some contended that individuals should have a right to die in some circumstances such as anencephaly, hydroanencephaly, and some severely deforming and incapacitating conditions. Such very defective individuals were considered to have little or no hope of achieving meaningful "humanhood".[5]

The suggestion is clear that "humanhood" is not to be violated, but that such humanhood is also not to be equated with animal life of the human species.

Implicit in many abortion discussions also is the argument or the assumption that much more than the fact that the fetus is living is necessary before such life need be acknowledged to have the rights and the sanctity that are recognized to adhere to human life. The thinking, frequent in our society, that abortion is in many cases acceptable while infanticide is totally repugnant reflects, I think, the sanctity of personal life understanding in medical ethics.

The essential differences between the sanctity of life position and the sanctity of personal life position is in the understanding of what is human life. The sanctity of life ethic defends two propositions:

1. That human life is sacred by

very fact of its existence; value does not depend upon certain condition or perfection of that life.

2. That, therefore, all human lives are of equal value; some are not of more value than others.

The sanctity of personal life ethic accepts the second proposition but not the first. The quality of life ethic, on the other hand, rejects both.

This distinguishing of three approaches in medical ethics may provide for a useful context in which to consider the proposal that human death be viewed as neocortical death. It does little justice to proponents of such a definition to equate their views with those who, in the quality of life tradition, can defend such practices as direct euthanasia. On the other hand, it should be recognized that the proposal is not in complete agreement with the traditional sanctity of life position.

To the question, can humanhood ever be lacking in the presence of spontaneous heartbeat and breathing, the proponents of the sanctity of life and the proponents of the sanctity of personal life make different responses. Even though the Rizzo-Yonder proposal was careful to insist that human death has occurred only when the *physiological* prerequisite for human consciousness has irrevocably ceased to function, it differs from the traditional sanctity of life position by emphasizing the physiological basis for a particular *type* of life, not the biological life itself of the human species.

The increasingly common tendency among ethicists to accept the personal in their understanding of man may border on a dualistic view of man's nature. There is no doubt that man is a personal being and that when his ability to live as a personal being is diminished his ability to be fully human is diminished. But to suggest, as is often done, that when personal life is absent or nearly absent, we are talking about "mere biological life"[6] that has no human significance is to say that it is only the personal dimension (in traditional language, the soul of man) that really counts. To distinguish "the higher human functions"[7] from the "vegetative functions shared by other animals"[8] and argue that it is only the former that adheres to the essence of man appears to express a dualistic view of man at the very time that much of Christian theology is priding itself in overcoming the "Greek dualism" of medieval Christianity. It would be even more ironic for medicine, which has always ministered to the needs of the body, to adopt a view that seems very close to denying that the animal nature of man has any value.

Without denying that there is much that is attractive and to be supported in the personal emphasis in contemporary thought, questions should be raised about the tendency to define man in such a way that his animal nature is nearly excluded. Paul Ramsey wrote:

> Man is an embodied person in such a way that he *is* in important respects his body. He is the body of his soul no less that he is the soul (mind, will) of his body. There are more ways to violate a human being, or to engage in self-violation, than to coerce man's free will or his rational consent. An individual's body . . . belongs to him, to his *humanum*, his personhood and self-identity, in such a way that the bodily life cannot be reduced to the class of the animals over which Adam was given unlimited dominion. To suppose so is bound to prove anti-human—sooner than later.[9]

It may be a mistake to define something in terms of its specific difference alone. While man differs from other animals in his ability to reflect consciously, he also has very much in common with them. The human animal is an animal and, when animal life continues to be present, it would seem that human life would also be present in some sense.

This is not to deny that certain capacities are more fully human than others. It is to say, rather, that even when the fullness of humanhood is absent, human life is still present. James Nelson makes an important distinction between human life and personal life:

> Human life, understood developmentally, can exist in *pre-personal* forms (as in the fetus), in *personal* forms (as in the individual with the capacity for consciousness, etc.), and in *post-personal* forms (as in the permanently comatose patient). In all of these stages it is human life and as such it deserves our profound respect and concern. Nevertheless, there are occasions in which the competition of values between lives makes choices about life's quality imperative.[10]

To say that human life exists and should be respected even when personal life is not present is not to solve all the ethical problems of modern medicine and of contemporary society. It is, though, to refuse to evade the ethical issues by denying that human life exists. One of the biggest reasons why we should go slow in accepting the definition of neocortical death as human death is that it may be trying to solve a problem in an oblique way, through redefining. Obviously, it makes no sense to go on treating a patient with cerebral incapacity if such a person is declared dead. I wonder if it would not be better to directly attack the question of when to treat and when not to treat the dying patient.

The Impact on Medical Ethics

On the more practical level, there are also a number of reasons for being reluctant to endorse such a definition of death. It may have an important and, perhaps, highly undesirable impact upon the attitudes of many in our society in regard to important ethical dilemmas. This can be seen if we consider briefly the questions of euthanasia, abortion, and the treatment of the mentally retarded.

I am using the term euthanasia here to refer to the active intervention of the human agent to bring about death, not to the cessation of attempts to prolong life. Perhaps the most characteristic defense of mercy killing as ethically acceptable is the argument that a system of ethics must be "humanistic or personalistic, i.e., . . . a value system that puts humanness and personal integrity above biological life and function".[11] In other words, the

argument in favor of euthanasia suggests that it may at times be necessary to inflict damage upon the physical dimension of man in order to show respect for his personality. The personal and physical are separable and violation of the human person consists primarily of violation of the personal. "Biological life and function" are of only secondary importance; they are not inviolable.

It would seem that any definition of death that sees death in the presence of spontaneous breathing and heartbeat cannot help but contribute to the denial of the inviolability of the body, to the I-can-do-what-I-want-with-my-body mentality. The very fact that one can talk about human death while bodily life can be observed (I am not talking, of course, about "life" provided by the respirator) suggests that bodily life is not sacred or essential to the understanding of what is human. While the support for neocortical death is in no way the equivalent of support for direct euthanasia, it may very well be that in the larger context of social attitudes, the movement toward such a definition will give support to the euthanasia movement.

While most of the ethical arguments in defense of euthanasia and most of the proposals for legalizing euthanasia have been restricted to voluntary euthanasia, there is an undercurrent of support for involuntary euthanasia as well. At this level, the argument goes something like this: the capacity for personal existence may be so diminished (as in the case of severely retarded infants) that certain "persons" should not be considered human and, as, their lives should be mercifully ended.[12] The possible contribution of a neocortical definition of death to this understanding of man has already been discussed.

An ethical argument that is used to defend both voluntary and involuntary euthanasia is that there is no significant ethical difference between allowing someone to die and intervening to bring about that death. Although it is a little more difficult to see the connection in the proposed new definition of death may support this argument also. An ethical approach that denies that there is any difference in the means used in the achieving of a timely death is an approach that puts the primary emphasis on motivation and on intended results and not on the more "objective" factors like the actions taken. It may very well be that an understanding of death that emphasizes the capacity for personal subjective life will, in the development of attitudes, give support to a primarily subjective approach to ethics; what counts is the subjective dimension.

It is not difficult to see how the emphasis on personal life as human life is much more congenial to the proponents than to the opponents of abortion. Much of the abortion debate revolves around the question of what constitutes human life, life that has the right to be protected from destruction. The discussion, even the Supreme Court's January, 1973, decision, includes such language as "persons in the whole sense" and "capable of meaningful life". Those who insist that biological life of human parents is human life may find it increasingly more difficult to persuade people of their position if medicine adopts a definition that, in principle, separates human life from biological life.

One might also wonder how such a definition of human death would affect the treatment in our society of the mentally retarded. Granted that there is a difference between saying that human life is absent when the physiological prerequisite for consciousness has irrevocably ceased to function and saying that someone with severely diminished mental capacity is not human, the emphasis on the mental and the declaration of non-humanhood despite biological life may reinforce the tendency to treat the retarded as less human or less than human. Joseph Fletcher has suggested that we might want to establish criteria for humanhood that would exclude those whose I.Q. score registers at lower than 20.[13] I do not know if Fletcher's proposal will receive much acceptance in American society, but we cannot suppose that the identification of human life with personal life will have no impact on the ways we treat the mentally retarded.

I reiterate that I am not equating the neocortical definition of death with euthanasia or the defense of euthanasia; I am not equating it with the view that the human fetus is not human; I am not equating it with less than satisfactory care for the mentally retarded. What I am suggesting is that the questions of euthanasia, abortion, and care of the retarded constitute the larger ethical context in which the proposed definition ought to be considered.

The proposal must be considered on its own merits, of course. If the proposal is based on a valid understanding of the nature of human death and if such a clinical definition would be most useful in solving ethical dilemmas in medical practice, then it would probably be worth taking the chance that it might make an unfavorable contribution to the larger ethical context. I have already suggested, however, that this particular understanding of death is questionable. I wonder also if it is the best solution to the ethical dilemma.

The Dying Patient

As was indicated earlier, the presumed merit of such a definition is that it provides for a definite determination of when to cease treatment. That may, in fact, be the merit of testing for neocortical death; evidence of neocortical death probably should be taken as evidence that the person "is in the process of dying organ by organ".[14] Note that the emphasis here is on dying rather than on death; evidence of neocortical death should perhaps be taken as evidence that the person is dying, not that he is already dead. This is facing the ethical dilemma head-on, for the real question is when to cease treating the dying.

As Paul Ramsey has indicated so well, we should not treat the dying

in the same way that we treat the curable.

> It can certainly be said that our duties to the dying differ radically from our duties to the living or to the potentially still living. Just as it would be negligence to the sick to treat them as if they were about to die, so it would be another sort of "negligence" to treat the dying as if they are going to get well or might get well. The right medical practice will provide those who may get well with the assistance they need and it will provide those who are dying with the care and assistance they need in their final passage. To fail to distinguish between these two sorts of medical practice would be to fail to act in accord with the facts . . . It would be to act without responsivity to those who have no longer any responsivity or recuperative powers.[15]

It would seem that the best medical care might be for the physician — who is the only one who can do it — to make the determination that this dying process has begun. Then proper treatment should become care for the dying, not struggle against death. Not all means must be used to prolong life; in fact, last days or hours filled with tubes and a grim losing battle against death might very well constitute "negligence" to the patient.

The determination that the neocortex is "dead" may be one of the ways of knowing that the time has come to treat this patient as dying and not as someone to be saved from dying. Thus the notion of neocortical death can function as the proponents want it to, as a determination that treatment should end. It can function this way without the difficulties associated with defining death as personal death.

It is not easy, for the physician or for the family, to decide to cease all treatment when it has been determined that the dying process has begun. In some ways, it would probably be easier to declare the patient dead than to "allow him to die." In the long run, though, it may be of more benefit to medicine and society to go slowly. In the light of the wider ethical context discussed in these pages, we should recognize that the change involved in the redefinition of death is a much greater departure from traditionally accepted medical practice than the change involved in the practice of not attempting to prevent the dying from dying.

In summary, and with reference to the three questions with which this paper began, this author would urge caution in adopting a neocortical definition of death. Unless further clarification indicates that the biological is not being undervalued as a component of human life the definition may be philosophically unconvincing. The definition, it would appear, would likely lead to the strengthening of ethical attitudes in our society that some of us would consider questionable or worse. And it is possible that the desired benefits could be accomplished without such a definition.

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