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Carolyn Gonter
Macalester College

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Abstract

In order to produce a medically relevant conception of death, an understanding of the philosophical nature of man and what is so essential to man that its loss constitutes a change in the moral and legal status of the individual is necessary. I believe that John Locke's distinction between the man, as defined by the body, and the person, as defined by consciousness, is central to an accurate and meaningful definition of death. While the death of a particular person can be defined as the irreversible loss of his or her personal identity, it is the irreversible loss of the capacity for personhood, i.e., conscious experience, that is most significant. For it is with the irreversible cessation of conscious experience that a patient ceases to be a person, generally speaking, and remains only a human organism. This argument is demonstrated through my examination and minor critique of three published arguments for the higher brain, as opposed to the whole brain, formulation of death, which determines the death of a person based upon the loss of the brain functions that make consciousness, thought, and feeling possible, as opposed to the loss of all integrating functions of the human organism.

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"It is not therefore unity of substance that comprehends all sorts of *identity*, or will determine it in every case. But to conceive and judge of it correctly, we must consider what *idea* the word it is applied to stands for, it being one thing to be the same *substance*, another the same *man*, and a third the same *person*, if *person*, *man*, and *substance* are three names standing for three different ideas; for such as is the *idea* belonging to that name, such must be the *identity*."[1]

"And if that is the *idea* of a man, the same successive body not shifted all at once must, as well as the same immaterial spirit, go to the making of the same man."[2]

"[T]o find in what *personal identity* consists, we must consider what *person* stands for; this, I think, is a thinking intelligent being that has reason and reflection, and can consider itself as itself,...which it does only by that consciousness which is inseparable from thinking, and, as it seems to me, essential to it – it being impossible for anyone to perceive without perceiving that he does perceive...For since consciousness always accompanies thinking, and it is that which makes everyone to be what he calls *self*, and thereby distinguishes himself from all other thinking things, in this alone consists *personal identity*, i.e., the sameness of a rational being."[3]

-John Locke, *Essay Concerning Human Understanding*

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[1] Locke, John. Essay Concerning Human Understanding in Modern Philosophy: An Anthology of Primary Sources. Ed. Roger Ariew and Eric Watkins. Indianapolis: Hackett Publishing Company, 1998. II; XXVII: 7.
[2] Op.cit., II; XXVII: 8.
[3] Op. cit., II; XXVII: 9.

reflexes.[9] The higher brain formulation generally focuses not on the loss of integrating functions, rather only on the functions that make consciousness, thought, and feeling possible. It holds that it is specifically these latter functions that are necessary to personhood and when they are irreversibly lost, the person has died or permanently ceased to exist.[10] In this way a distinction is created between the cessation of personhood and the death of the human organism, similar to Locke's distinction between the person and the man.

Most public and legal policy, though, still adopt a whole brain formulation, due to the supposed inability of physicians to test reliably for the loss of the components of consciousness, the supposed lack of knowledge about which specific brain structures are required for it, and the fact that, unlike whole-brain death, the permanent loss of consciousness is apparently compatible with the indefinite continuation of vitality in other bodily organ systems.[11] In other words, they do not want to distinguish between the cessation of personhood and the death of the organism. Though the foundational distinction may appear to be biological, it is actually the profound philosophical questions about the nature of personhood and personal identity that comprise this controversy between the whole and higher brain formulations for the determination of death.

I argue that a Lockean approach to personal identity and personhood is central to an accurate and meaningful definition of death, particularly in a medical context. Locke distinguishes most importantly between being the same man and being the same person. The body defines the man while the person is defined by consciousness. The same person is thereby distinguished by having the same consciousness, which defines his/her personal identity. (Locke later qualifies this and notes that the same consciousness is that which is connected through memory.[12]) It

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[9] Pernick, Martin. p.58.
[10] Brock, Dan. p.146-7.
[11] Pernick, Martin. p.59.
[12] Locke, John. II; XXVII: 7-9, 23.

follows that in order to appropriately examine the concept of death, a distinction must be accepted between the death of the human organism and that of the human person. The death of a person can be defined as the irreversible loss of his or her personal identity. But this point is generally irrelevant to the topic, for what is actually significant is the irreversible loss of capacity for personhood, i.e., conscious experience; it is with the irreversible cessation of conscious experience that a patient ceases to be a person, generally speaking, as opposed to having a specific previous identity, and remains only a human organism (or man, in Locke's terms). I will develop this argument through the examination and minor critique of three published arguments for the higher brain formulation.

To begin, Michael Green and Daniel Wikler present an ontological argument which they propose to justify the redefinition of death as brain death. They suggest that there are two prevalent principal arguments concerning the topic, neither of which is valid. First Green and Wikler reject what they characterize as the biological arguments justifying the redefinition of death as brain death. These arguments are rejected through Green and Wikler's conclusion that the permanent cessation of lower brain function, the event that defines brain death in the medical literature, does not bear on the question of whether the patient is alive or dead for any medical reasons.[13] Secondly they also reject, due to a necessarily incorrect foundation, any argument proposing the redefinition of death as a solution to a moral problem. These arguments take the activity of defining death as summarizing the social relationships and actions of "death behavior."[14] By contrast, Green and Wikler believe that in order for the redefinition of death to be viewed appropriately, certain moral premises that are commonly assumed without question or argument must be abandoned: 1) that there is no point in giving medical care to the

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[13] Green, Michael and Daniel Wikler. "Brain Death and Personal Identity." Philosophy and Public Affairs 9 (1980): 105-133. p. 114.
[14] Ibid.

dead and 2) that life should always be preserved.[15] They proceed to present what they propose to be the first satisfactory rationale for regarding brain death as death, an ontological argument having to do with the conditions of existence of persons.[16] Through this argument, Green and Wikler hope to show not that brain dead persons have a worthless existence, but that they actually have no existence at all.

Green and Wikler begin their argument proposing that to state that a particular patient Jones is still alive is to make two claims, the second of which is often taken for granted: 1) that Jones is alive and 2) that Jones is/remains Jones.[17] First they draw a corollary about brain death from the theory of personal identity and then they show that the criteria of personal identity do not permit it to survive the kinds of changes that brain death involves. Their general argument can be summarized with this statement:

> If we do establish that [a] patient [Jones] , even if alive, is not Jones, and if no one else is Jones, then we will have established that Jones does not exist. *Jones'* death thus occurs *either* at the time that the patient dies, if the patient has remained Jones, *or* at the time the patient ceases to be Jones, whichever comes first. If, as we contend, the patient ceased to be Jones at the time of brain death, then Jones' brain death is Jones' death[18]

They propose to offer an argument that can remain agnostic with respect to two related but controversial metaphysical assumptions: the issue of kind essentialism and that membership in a kind is essential to the retention of that identity.[19] An acknowledgment of kind essentialism requires that an account be made of what is essential for an individual to belong to a certain kind. Specifically, in the present case, the claim is that an entity is a

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[15] Op. cit., p. 117.
[16] Op. cit., p. 106.
[17] Op. cit., p. 117-118.
[18] Op. cit., p. 118-119.
[19] Op. cit., p. 120.

person only if it has psychological properties. Further, the assumption that it is essential for the continued existence of an individual that it remain a member of the kind to which it belongs is also controversial, as presently there is no definitive account of the essence of personhood. Green and Wikler's proposed agnostic position is accomplished by means of an argument establishing a claim about the essential properties of a given *individual*: "that the continued possession of certain psychological properties by means of a certain causal process is an essential requirement for any given entity to be identical with the individual who is Jones."[20] It follows that when brain death strips Jones' body of all of its psychological traits, Jones ceases to exist. An adequate account of personal identity is necessary for this argument. Accordingly personal identity is defined as a characteristic causal tie between person stages, which necessitates a continuity of certain brain processes. Therefore, if the brain dies (the argument continues), so does the person whose brain it is. "The death of persons, unlike that of bodies, regularly consists in their ceasing to exist."[21] They conclude then that a given person ceases to exist with the cessation of those processes that normally underlie that person's psychological continuity and connectedness. Because these processes are essentially neurological, irreversible cessation of upper brain functioning therefore constitutes the death of that person.[22]

George Agich and Royce Jones, in my view, rightly criticize Green and Wikler's argument in that it does not show that the death of the individual is equivalent to death of the brain of the individual. Agich and Jones suggest that Green and Wikler's theory of personal identity has no bearing on the question at hand for it does not provide information about the conditions that are necessary for an individual's being alive as opposed to dead. In order to justify the brain death view of death, what constitutes the conditions and meaning of death must be known, which explain

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[20] Op. cit., p. 121.
[21] Op. cit., p. 127.
[22] Op. cit., p. 127.

and validate brain death criteria, not whether an individual is the same as an individual who existed before. Agich and Jones thereby believe that in order to justify the brain death view of death, Green and Wikler must show that the death of the individual is equivalent to the death of the individual's brain, which they fail to demonstrate. [23] In other words, Agich and Jones view the problem to be relating brain death criteria, and the clinical signs and tests used to establish their presence, to a concept of the death of the individual person or patient.[24] "The *capacity* for consciousness (an [upper] brain stem function) is not the same as the *content* of consciousness (a hemisphere function) but it is an essential precondition of the latter."[25] Accordingly, Agich and Jones believe that this philosophical task requires at least two steps, a clarification of the competing concepts and criteria of brain death and a systematic explanation or justification of a particular concept of brain death. They thereby conclude that Green and Wikler's approach is misguided in confusing the central issue, through their deviation into the theory of personal identity.[26] They propose rather that the main competing concepts of brain death in the medical literature should be carefully defined prior to their relation to the ontological conditions for being an individual or person alive in the world.[27]

Agich and Jones' critique of Green and Wikler is aimed correctly, but perhaps slightly misses the target, likely due to their insistence that the capacity for consciousness lies solely in the brain stem. Further, in light of the focus of this discussion, i.e., concerning the death of personhood, the unqualified term 'brain death' is irrelevant and only leads to confusion and misunderstanding. Still, Agich and Jones correctly point out that a

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[23] Agich, George and Royce Jones. "Personal Identity and Brain Death: A Critical Response." Philosophy and Public Affairs 15 (1986): 267-274. p. 268.
[24] Op. cit., p. 270.
[25] Op. cit., p. 272.
[26] Op. cit., p. 270.
[27] Op. cit., p. 274.

major distinction must be drawn between personal identity over time and personhood in general. In this respect, in my view, Green and Wikler's conclusion is incorrect as a result of their focus on an irrelevant question, i.e., that of personal identity. Dan Brock is correct in stating, "Theories of personal identity are constructed to determine when one person existing at a particular time is identical with, that is, the same person as, a person existing at another time." [28] He is right, for, in theory, a patient $Jones_1$ could change persons, for example, into $Jones_2$ as far as personal identity is concerned, while still retaining the characteristics of personhood in general. In such a situation, Green and Wikler could argue that if that were to happen, $Jones_1$ would be, in effect, dead, because he disappeared and was replaced by $Jones_2$. As a result, personal identity as a criterion for personhood must be qualified; a psychological *capacity* for personal identity, not personal identity itself over time, is an accurate condition for personhood and thereby for determining a medically relevant conception of death. Brock lays the foundations for this argument, and often alludes to it, though it is never explicitly stated in his argument.

Brock argues that due to "the crucial role played by memory and other forms of psychological continuity in maintaining the identity of a person through time, the loss of personal identity occurs before and in the absence of a complete and irreversible loss of consciousness[.]"[29] My primary critique of Brock concerns this and similar statements, in which it is unclear as to what his term 'personal identity' is referring in context (personal identity over time or personhood in general). He does define a present or future capacity for conscious experience as a necessary condition for personhood itself: "personhood is incompatible with the complete absence of *any* present or future capacity for purposive agency, social interaction, or conscious experience of any sort whatever", but he does not steadily

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[28] Brock, Dan. p. 367.
[29] Op. cit., p. 357.

distinguish between personal identity and personhood and often uses the terms ambiguously.[30]

Still, by means of two common theories of justice and health care, the prudential allocator approach and the interpersonal distribution approach, Brock shows how primary the maintenance of personhood is to the determination of just claims to health care: "Implicit in virtually all such accounts is that only persons have any rights against others that health care be provided to them[.]"[31] The one exception, and a very important one at that, is that obligations or rights concerning the relief of suffering and therefore claims to health care extend to non-persons.[32] Brock proposes that it is widely agreed that at least for the sake of a particular person, there is no obligation to use any social resources to maintain bodily functions in a person who is dead, for nothing that health care can do for the body makes possible any benefit to the person who has ceased to exist.[33] In this way (the argument continues) the dead no longer have any moral claims to health care grounded in justice, for on all common views of personal identity, when a person dies, he/she ceases to exist and only his/her body remains.[34] Unfortunately, this is another statement in which Brock is troublingly ambiguous in the use of the term 'person', for I believe that even if a given patient no longer holds the same personal identity as he or she originally had, if he or she still retains the capacity for personhood, we still have a medical obligation to treat him or her.

It follows that patient Jones, who is in a persistent vegetative state (PVS), having suffered an irreversible and complete loss of consciousness, has ceased to be Jones. In other words, as Green and Wikler proposed, the person Jones has ceased to exist. Though the PVS patient retains some lower brain activity or brain stem function permitting circulation of many self

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[30] Op. cit., p. 374, 366.
[31] Op. cit., p. 360.
[32] Ibid.
[33] Op. cit., p. 361.
[34] Op. cit., p. 362.

regulating bodily functions, "with the irreversible loss of consciousness all capacity for experience – hopes and fears, joys and sorrows, pleasures and pains, plans and purposes – has now been irreversibly lost, and with it as well all capacity for purposive action or agency."[35] The death of the person must therefore be distinguished from the death of the human organism. Following the death of the person, sustaining the life of the patient's body is of no benefit whatever to the patient for "a thing's having interests of its own in some object or state of affairs *x* is usually tied to the thing's present or future capacity for sentience and to its capacity to care about *x*."[36] Even allowing that human life, if not a person, still exists in a PVS patient (the argument continues), the nature of that life is not itself such as to ground claims to health care, for the irreversible loss of all capacity for any conscious experience of the PVS patient warrants distinguishing between the death of the person and the death of the human organism.[37]

Brock proposes here a strong argument for the importance of a distinction, concerning death, between person and organism for a theory of justice in health care. Unfortunately he never explicitly distinguishes personhood from personal identity over time: it is when the capacity for personhood has been lost, not when a particular patient Jones ceases to be that particular person Jones, that the patient can be considered no longer a person, but only a human organism. And it is this distinction that has primary medical importance (as opposed to perhaps ethical or moral significance, which will be discussed below).

Roland Puccetti adds to Brock's viewpoint that the prevalent 'sanctity of human life' argument is completely irrelevant since one can do neither good nor harm to an irreversible comatose being, which should hold true independently

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[35] Op. cit., p. 363.
[36] Op. cit., p. 364.
[37] Op. cit., p. 368-9.

of a particular species identity.[38] (Peter Singer proposes this same argument in his article entitled "Unsanctifying Human Life".[39]) Further, Puccetti contributes a case study of a patient having "neocortical death without brain stem death," otherwise known as the "apallic syndrome," confirmed by autopsy findings.[40] In such a state the patient can breathe spontaneously and demonstrates cephalic reflexes (which are brain stem mediated), so that if fed nasogastrically or intravenously and kept free from infection, can sustain somatic life (i.e. irreversibly without the basis for a conscious and hence personal life in this world) for years or even decades after losing the top of the brain. This state is normally and, as Puccetti contends, mistakenly distinguished from that of a patient with encephalic or whole-brain death, including the brain stem that monitors respiration and provokes cardiac activity, who can be sustained on a ventilator for only up to a week in adults and two in children.[41] Puccetti concludes, similarly to Brock, "Permanent unconsciousness is permanent unconsciousness whether the condition is associated with a body that lives by virtue of being able to breathe spontaneously or not."[42] He suggests that to deny this statement is to elevate spontaneous breathing to a principle of personhood. His argument continues that either human life (i.e. personhood) is rooted in brain stem function or it is rooted in the capacity for personal experience. If the latter, then there must necessarily be no ethically relevant difference in the status of encephalically and cerebrally dead people for they have both lost the neocortical basis of an ongoing personal life.[43] Here

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[38] Puccetti, Roland. "Does Anyone Survive Neocortical Death?" Death: Beyond Whole-Brain Criteria. Ed. R. M. Zaner. Dordrecht: D. Reidel Publishing Company, 1988. p. 76.

[39] Singer, Peter. "Unsanctifying Human Life." Ethical Issues Relating to Life and Death. Ed. John Ladd. New York: Oxford University Press, 1979. p. 41

[40] Puccetti, Roland. p. 81-2.

[41] Op. cit., p. 82-3.

[42] Op. cit., p. 83.

[43] Op. cit., p. 84-5.

again is the distinction drawn between death of the person and death of the human organism.

In his argument, though it still is not explicitly stated, Puccetti appears to be importantly implying that death of the person is that of the capacity for personhood rather than that of a particular person. I believe that this distinction is of the utmost significance concerning the definition of death, at least for medical purposes. The death of the person in general can then be defined as the irreversible loss of capacity for personhood, consisting in the cessation of conscious experience. The primary distinction should then become that between a patient in a persistent coma and a patient in an irreversible coma, as opposed to that between a patient with hemispheric brain death and a patient with brain stem death, for only the patient in a persistent coma can still have the potential for personhood.

Locke's distinction between being the same man and being the same person therefore provides much insight regarding the problem of the determination of death in a medical context. His conclusion that personal identity consists in consciousness alone can also be interpreted as saying that personhood consists primarily in the capacity for consciousness. My conclusion begins with this important point. It is the capacity for conscious experience and thereby for personhood that is of utmost importance in considering a meaningful definition of death for medical purposes. Irreversible cessation of conscious experience therefore constitutes an irreversible loss of capacity for personhood. This loss of capacity for personhood can easily occur before the death of the body of the human organism, as is the case with patients in a persistent vegetative state. It is also often the case, though, that the death of the particular person, according to personal identity over time, can occur prior to the loss of the capacity for personhood: A patient Jones, perhaps suffering from severe dementia, could first lose his self, his personal identity, Jones, i.e., any conscious relatability to the person Jones – this constitutes the death of the person Jones – but could still have the physical/mental capacities for conscious experience. Accordingly,

it is not until the irreversible cessation of conscious experience occurs that all capacity for personhood is lost. And therefore, though the death of the person Jones may have occurred prior to this point, this is the medically important point for the determination of death. It is at this stage when a patient would be considered no longer a person but only a human organism and thereby no longer justly deserving or having the potential to benefit from medical care, with the one exception of being provided relief from suffering. Finally, according to Roland Puccetti, the irreversible cessation of conscious experience can be certainly tested by means of Positron Emission Tomography: "In PET scanning, the uptake of oxygen and particularly glucose in selective subregions of the cerebral cortex can be measured and displayed in color on a video screen: yellow or green for normal metabolic activity, blue or purple for low or no uptake."[44]

To approach the question of the medically significant determination of death from a different perspective, the particular case of anencephalic infants provides further insight. The argument proposed by David Thomasma concerning anencephaly is very much in agreement with the views proposed by Dan Brock, Roland Puccetti and myself concerning the importance of the capacity for personhood regarding the question at hand. Anencephaly is defined as "a congenital absence or poor development of the cranial vault with reduction in or absence of the hemispheres[,]" leading to an undeveloped or severely underdeveloped cortex.[45] The brainstem is intact, so that the newborn demonstrates basic body functions, though the infant is not viable as there is insufficient cerebral function to support even minimal growth and development: between 55-75% of all anencephalics are still births and the remaining 25-45% live births

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[44] Op. cit., p. 85-86.

[45] Thomasma, David. "Should Abnormal Fetuses Be Brought To Term for the Sole Purpose of Providing Infant Transplant Organs?" Biomedical Ethics Reviews 1989. Ed. James Humber and Robert Almeder. Clifton: Humana Press, 1990. p. 30.

will die within hours or days after delivery.[46] The primary dilemma arises in that newborn anencephalics are usually born with normally developed primary organs that are useful for transplantation if the procedure is done immediately, but which deteriorate quickly as the baby dies naturally.

According to the whole brain formulation, anencephalic infants are not brain dead at birth, for they still have an intact brain stem, just as a patient in a permanent vegetative state cannot be so described. Thomasma argues, though, "[a]lthough it may have ontic value as a form of human life, a child born anencephalic is locked in a state that is a form of meaningless existence in itself."[47] He is thereby employing a distinction between human being and person. He defines a human being as each being that emerges out of the human race, who therefore has the right to equal respect for life on the basis of the ontic value of human life. Personhood, on the other hand, is what leads prescriptively to specific moral duties and occurs in a normal and healthy child with the growth and development process.[48] Thomasma continues with a maximizing approach to deal with this issue in practice, but his theoretical point has been made: the anencephalic infant has no potential for personhood and should thereby be described as a non-person.[49] I agree that an anencephalic infant does not have the physical potential for personhood and that this is the medically significant distinction, just as the irreversible cessation of conscious experience and thereby the irreversible loss of capacity for personhood in a severely demented or otherwise traumatized patient is the point of primary medical significance.

In summary, I hope to have demonstrated that a Lockean approach to personal identity and personhood is central to an accurate and meaningful definition of death, especially within a medical context. It is the irreversible loss of capacity for personhood, or conscious experience, rather than a person's loss of

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[46] Ibid.
[47] Op. cit., p. 29.
[48] Op. cit., p. 34-5.
[49] Op. cit., p. 38, 43.

his or her personal identity, that is significant for a medical conception of death. That is, it is with the irreversible cessation of conscious experience that a patient ceases to be a person, generally speaking, and remains only a human organism. Accordingly, a major distinction must be drawn between personal identity over time and personhood in general, for it is the psychological capacity for personal identity, rather than the continuity of personal identity itself over time, that is an accurate condition for personhood and thereby relevant to the medical determination of death.

Finally, one might now be quite intent upon asking what legal implications the view I am proposing would have. Such a question is of great importance, but is not possible to more than mention here. My thesis is meant to be merely a theoretical analysis and thereby not to suggest practical guidelines. It rather necessitates much further ethical, moral and social contextual analysis before practical consideration is possible. Issues such as euthanasia, transplantation and economic concerns must be balanced against the symbolic importance of how our society cares for the most vulnerable of its patients. Significant concerns such as how "limiting life sustaining care for other patients, together with a generally undesirable deterioration in our society's care and concern for its frail and vulnerable members" (a portrayal of the so-called slippery slope argument) must be seriously considered.[50] More individual ethical issues also arise out of my primarily medically significant thesis, such as whether decisions and obligations hold through a 'change' in personhood and how much proxy control such a patient's family should have over those decisions. These issues must be further considered in their own light.

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[50] Brock, Dan. p. 381.