

BRAIN DEATH: PART II

Classical account of death: A person is dead when there is a permanent cessation of blood flow.

Meshes fairly well with our intuitive notion of a dead person as someone that is “white and stiff.”

Contemporary medical account of brain death: A person is dead when her brain is permanently non-functioning.

Note that this definition does *not* imply whiteness and stiffness. (Consider Marshall and Bloch.)

Why is it relevant when a person dies? Because when she does, she loses her basic *human rights*. She's not given life-support and, with her relatives consent, we can cut her open and harvest her for organs.

THE STORY BEHIND THE NEW DEFINITION

The respirator was developed during the polio epidemic in the 1950's by a Danish doctor who noticed how children stricken with polio died because they couldn't breathe. He developed a means of using air bags to pump oxygen into the children's lungs. At first, this was done by a nurse or student. Eventually, a mechanical pump was attached instead and the respirator was born.

Two uses:

Temporary support: Some accident victims, people who had taken drug overdoses, and diabetics who had gone into a (temporary) coma.

Permanent support: People who would never regain consciousness.

The latter use was problematic for two reasons:

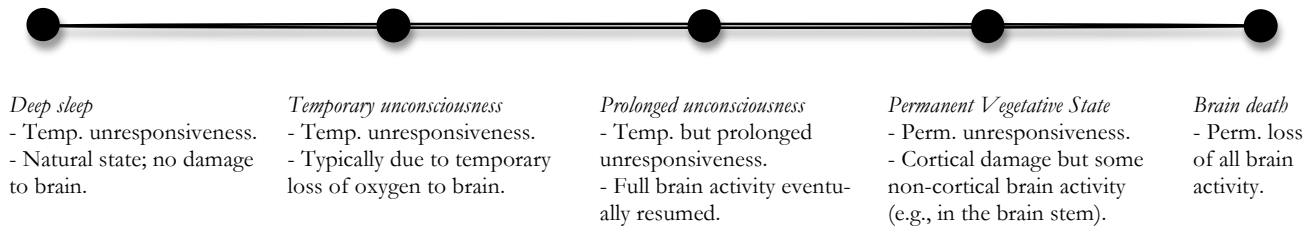
- It prolonged the agony of the family.
- It claimed a lot of resources from hospital, and for an indefinite period of time.

In 1967, the first heart transplant was performed by a South African surgeon, Dr. Christiaan Barnard. To maximize the chances of successful transplant, the heart had to be removed as soon as possible after it has stopped working. In other words, suddenly the increasing number of people on permanent support could save the lives of other patients. What was the problem? Taking their hearts would amount to murder.

It was in this context that Harvard Medical School set up “the Ad Hoc Committee to Examine the Definition of Brain Death,” or the *Harvard Brain Death Committee* (HBDC), as it is usually referred to. The committee states its purpose as follows:

“Our primary purpose is to define irreversible coma as a new criterion for death. There are two reasons why there is a need for a definition: (1) Improvements in resuscitative and supportive measures have led to increased efforts to save those who are desperately injured. Sometimes these efforts have only a partial success so that the result is an individual whose heart continues to beat but whose brain is irreversibly damaged. The burden is great on patients who suffer permanent loss of intellect, on their families, on the hospitals, and on those in need of hospital beds already occupied by these comatose patients. (2) Obsolete criteria for the definition of death can lead to controversy in obtaining organs for transplantation.”

What is “irreversible coma”? Consider the following continuum of unresponsiveness:



The word “coma” actually comes from the Greek word *koma*, which just means “deep sleep.” However, someone in deep sleep is, in the contemporary sense, *not* in a coma. Rather, a coma, roughly, encompasses everything spanning the spectrum from prolonged unconsciousness to brain death. When the committee talks about “irreversible coma,” they have in mind brain death.

A DILEMMA FOR THE DEFINITION

According to Singer, there is no “fact of the matter” when it comes to defining death. He claims that it involves instead an “ethical judgment.” What does he mean by this?

What would it mean for there to be a fact of the matter about death? It would mean that there was a clear-cut truth about when someone is dead. It turns out that there is not.

- In addition to processing information through the nervous system, the brain also supplies the body with *hormones* that regulate various bodily functions, and continues to do so in patients considered brain dead.
- When brain dead patients are cut open (in order to access their organs), their *blood pressure* may rise and *heartbeat* quicken. This suggests that the brain performs some basic functions even in brain dead patients.

In other words, the brains of people considered brain dead by medical practice are not completely void of activity. This presents a dilemma:

- (a) Either we bring medical practice in line with the more strict reading of “brain death,” and accept that many people currently considered brain dead then would have to be considered alive, or
- (b) we give up the idea of death as *complete* cessation of brain activity, stick with medical practice, and identify a new distinction between life and death.

Singer considers taking the first horn of the dilemma to be unviable, and argues that we need to go with the latter. In doing so, however, we need to make a *decision* regarding what level of activity marks the border between life and death. Since there is no way in which that decision can be made on exclusively scientific grounds, the decision is, in essence, an *ethical* one.

NEW YORK TIMES ARTICLE

The case

A 13 year-old boy is declared brain dead as a result of a severe brain infection. Due to miscommunication, a legal conflict ensues between the family, that wants to keep the boy on the respirator, and the hospital, that wants to turn it off. Eventually, the family agrees to turn off the respirator.

Questions

- What was the miscommunication about?
- What factors probably contributed to the confusion?
- Would you say that Singer’s critique of the brain death definition has any bearing on the case? Explain why or why not.