

## Editorial

**Vasil Gluchman**

“Man reckons with immortality, and forgets to reckon with death”.  
(Milan Kundera: *Immortality*)

The topic of death is much more complex than can be embraced in everyday reasoning. Such areas can be mentioned as abortion, euthanasia, clinical death, coma, etc. Brain death, which also falls within this framework, is the main theme of the current issue of the *Ethics & Bioethics (in Central Europe)* journal. Its core is formed by a contribution by Peter Singer, who contemplates on the possibility of brain death not meaning the death of the human organism. In this context, he asks questions about whether the harvesting of vital organs from a brain dead patient should be stopped, as brain death does not equal the death of the human organism, or, on the other hand, whether to accept that an innocent human being who has, irreversibly, lost their consciousness, can be killed.

Piotr Grzegorz Nowak holds the opinion that Singer’s latter suggestion could be accepted, as it facilitates the provision of a sufficient number of organs necessary for transplantation and better corresponds with the term ‘death’ in everyday language. Similarly, Vilius Dranseika and Ivars Neiders consider Singer’s latter alternative more acceptable. They base their standpoint on an earlier view by Robert Veatch, who considered the presence of consciousness a criterion when defining death. Ireneusz Ziemiński claims that Singer’s view can also be accepted from the Kantian and Christian standpoint. On the other hand, he points to such cases when organs cannot be harvested for the needs of transplantation, such as in people in a persistent vegetative state or anencephalic children.

Further contributions follow Singer’s text in a broader context. Ján Kalajtzidis deals with the topic of death in the context of contemplations on a moral agent and moral object within ethics of social consequences. Based on the above, he differentiates between the death of the moral agent and the death of the organism. Similarly, Katarína Komenská ponders over the difference between the end of the life of the organism and the end of the life of a person, as this relates to life goals, the idea of a good life, etc. She studies the topic through the lens of the perception of dignity in ethics of social consequences. Furthermore, a philosophical essay by Mariusz Wojewoda is to be found, who considers the relationship to death a test of our humanity and, in the same context, studies how the sense of mortality influences people’s perception of values.

The collective of authors sincerely believe that they have managed to compile a highly interesting issue of the journal focused on a topic that is deeply philosophical and ethical, while touches upon the essence of our being, including its metaphysical and moral issues. We will be most happy if it prompts further discussions and polemics on the topic discussed in the journal or in other specialised philosophical, bioethical as well as medical journals, edited volumes, or books.

## The challenge of brain death for the sanctity of life ethic

Peter Singer<sup>1</sup>

### Abstract

For more than thirty years, in most of the world, the irreversible cessation of all brain function, more commonly known as brain death, has been accepted as a criterion of death. Yet the philosophical basis on which this understanding of death was originally grounded has been undermined by the long-term maintenance of bodily functions in brain dead patients. More recently, the American case of Jahi McMath has cast doubt on whether the standard tests for diagnosing brain death exclude a condition in which the patient is not dead, but in a minimally conscious state. I argue that the evidence now clearly shows that brain death is not equivalent to the death of the human organism. We therefore face a choice: either we stop removing vital organs from brain dead patients, or we accept that it is not wrong to kill an innocent human who has irreversibly lost consciousness.

**Keywords:** definition of death, brain death, sanctity of life, organ transplantation, Jahi McMath

### I. Introduction

In 1968, *Black's Law Dictionary* defined death as follows:

The cessation of life; the ceasing to exist; defined by physicians as a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereupon, such as respiration, pulsation, etc.

Twenty years later, most of the world had accepted, with surprisingly little controversy, a new way in which one could be dead, even if one's heart was beating, one's blood was circulating, and "animal and vital functions", including having a pulse, continued. That new way was defined in terms of the irreversible cessation of all functions of the entire brain, including the brain stem. One reason why this view gained acceptance without controversy was that the new definition was generally presented as an improved scientific understanding of the nature of death, and not as taking a new stance on an ethical issue. This was consistent with an oft-cited statement made by Pope Pius XII at a conference of anaesthesiologists, held in 1957, at a time when ventilators were beginning to be used. Pius XII was asked how a doctor should determine that a patient on a ventilator is dead. He reiterated the Church's view that death occurred when the soul separated from the body; but, aware that this was not of great practical help to the doctors in his audience, he added: "It remains for the doctor, and especially the anaesthesiologist, to give a clear and precise definition of 'death' and 'the moment of death' of a patient who passes away in a state of unconsciousness" (The prolongation of life, 1957, p. 396).

Over the thirty years since brain death became widely accepted as a criterion of death, a few bioethicists and physicians have raised questions about it, but public discussions have been rare.

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More recently, the case of Jahi McMath has raised new questions about brain death, and especially about the standard diagnostic guidelines for diagnosing brain death. In 2013, at the age of 13, Jahi underwent what should have been a routine tonsillectomy in a California hospital. After the operation she bled excessively, and the bleeding was not stopped. Jahi was placed on a ventilator, and two days later, declared brain-dead. A social worker urged her family to take her off the ventilator, and to consider donating her organs. Her mother, Nailah McMath, did not understand how she could be dead when her skin was still warm and she was occasionally moving her arms, ankles and hips – movements that the hospital doctors said were only a spinal reflex. In any case, the family insisted on first finding out what had happened to her before taking her off the ventilator. (The family is African American, and suspected that a white patient would have received better care.) A lawyer agreed to take their case on a pro bono basis.

The coroner issued a death certificate for Jahi, but the family, using funds raised online, took what was then officially a corpse, and flew it (or her), attached to a portable ventilator, to New Jersey, where state law forbids hospitals from treating a patient with a beating heart as dead if the family has religious objections to brain death. Nailah, a Christian, said she did have such objections. Jahi was admitted to St Peter's University Hospital, a Roman Catholic hospital in New Brunswick.

In newspapers and on television, leading American bioethicists criticized both the family's actions and the hospital's decision to admit Jahi. Lawrence McCullough said the hospital's decision was "crazy". Art Caplan managed to say both "Keeping her on a ventilator amounts to desecration of a body" and "There isn't any likelihood that she's gonna [sic] survive very long". Robert Truog, on the other hand, was troubled by criticisms of the family, subsequently telling Rachel Aviv of the *New Yorker*: "I think that the bioethics community felt this need to support the traditional understanding of brain death, to the point that they were really treating the family with disdain, and I felt terrible about that" (Aviv, 2018).

After eight months at St Peter's, Jahi was discharged from hospital: the diagnosis on the discharge was brain death. But her family had not given up. They rented a nearby apartment where, for nearly four years, she remained on a ventilator and was fed through a tube. Her condition remained stable for nearly four years, but then she suffered further medical complications. Her heart stopped and she was declared dead in the traditional way, which her family accepted.

During the years Jahi was on a ventilator, her family engaged a malpractice attorney, and sued the California hospital where the tonsillectomy was performed. If that suit had come to trial, whether Jahi was really dead would have been a central issue, because under Californian law, damages awarded in medical malpractice suits involving children who die cannot exceed \$250,000. There is no limit on damages when patients survive (Aviv, 2018). After Jahi's death, however, the case was settled for an undisclosed amount.

The first aim of this article is to update my earlier writings in which I argued that there are good reasons for rejecting the prevailing view of brain death.<sup>2</sup> A second aim is to show that rejecting brain death raises the stakes in the debate between those who believe in the sanctity of human life, and those who hold that the quality of a life must affect its value. I also take account of a new issue raised by the Jahi McMath case. I conclude by pointing to possible ways forward.

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<sup>2</sup> See especially *Rethinking Life and Death* (Singer, 1994).

## II. The origins of the new definition of death

The first step towards the development of a new definition of death can be traced to Henry Beecher, a distinguished professor of medicine at Harvard University and chair of a committee that oversaw the ethics of experimentation on human beings. In 1967 he wrote to Robert Ebert, Dean of the Harvard Medical School, proposing that the committee should take up the issue of the definition of death. This idea had emerged, he told Ebert, from conversations with Joseph Murray, a surgeon at Massachusetts General Hospital and a pioneer in kidney transplantation. The need for further consideration of the definition of death arose, Beecher wrote, from the fact that “[E]very major hospital has patients stacked up waiting for suitable donors”.<sup>3</sup> The issue gained added urgency when Dr Christiaan Barnard carried out the world’s first heart transplant. Shortly thereafter Ebert set up the Harvard Brain Death Committee, under Beecher’s chairmanship. It published its report in the *Journal of the American Medical Association* in August 1968. The report began 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 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” (Report, 1968, p. 337).

Nowhere in the Harvard committee’s final report does the committee claim that the new definition of death reflects some scientific discoveries about, or improved scientific understanding of, the nature of death. It was, instead, because the committee saw the status quo as imposing great burdens on various people and institutions affected by it, including preventing the proper use of the “life-saving potential” of the organs of people in “irreversible coma” that the committee recommended the new definition of death. But the judgment that it is good to avoid these burdens, and to ensure that organs can be used, is an ethical judgment, not a scientific one.

The Harvard committee’s report was influential. In the decade following its publication, a number of U.S. states changed their legal definition of death so that, if tests showed that the brain had ceased to function, patients could be declared dead, despite the fact that their hearts were still beating, and their blood circulating. That meant that a patient with a beating heart but no brain function might be declared dead in one state, but if moved to another state would legally be alive.

In 1981 the United States President’s Commission for the Study of Ethical Problems in Medicine took up the problem of the definition of death. Its report, *Defining Death*, recommended uniform legislation that would enable people to be declared dead if tests established the irreversible cessation of all brain function (President’s Commission, 1981). The report was endorsed by the American Medical Association, and subsequently every state and territory of the U.S. adopted legislation recognizing that a person whose brain has irreversibly ceased to function is dead.

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<sup>3</sup> Henry Beecher to Robert Ebert, 30 October 1967 (Rothman, 1991, pp. 160–161).

### III. Death as the irreversible loss of integrated organic functioning

A proponent of the view that brain death really is death might argue that the Harvard committee made the right recommendation for the wrong reasons. What reasons, other than the various benefits mentioned by the committee, would there be for holding that the death of the brain really is the death of the whole human being? A typical answer is that the introduction of modern methods of intensive care has exposed a certain vagueness in the concept of death, and a new account is needed to clear this up. The question is what that new account should be.

The President's Commission said that brain death is the death of the human organism because without brain function, the body is no longer an integrated whole, but just a collection of cells and organs. In this they were following two prominent Roman Catholic bioethicists, Germain Grisez and Joseph Boyle, who, in *Life and Death with Liberty and Justice*, had argued that death is to be understood in theoretical terms as "the permanent termination of the integrated functioning characteristic of a living body as a whole..." (Grisez & Boyle, 1979, p. 77; Lamb, 1985).

Since *Defining Death* was published, however, it has become clear that integrated organic functioning can persist despite the irreversible cessation of all brain functions. Already in 1998, a literature search conducted by Alan Shewmon, then professor of paediatric neurology at the University of California, Los Angeles, Medical School, found 175 cases of brain dead patients "surviving" for at least one week, 80 for at least two weeks, 44 for at least four weeks, 20 for at least two months, and seven for at least six months. These were all cases in which there was a formal diagnosis of brain death made by a physician, usually including at least one neurologist or neurosurgeon. Shewmon notes that many examples are of "unequivocal BD [brain death] confirmed by multiple clinical examinations, EEGs, intracranial blood flow, and necropsy findings" (Shewmon, 1998a, pp. 1538–1545; Shewmon, 1999, pp. 1369–1372). Moreover in many of these cases, treatment was eventually withdrawn. The number of patients "surviving" for long periods would have been greater still if treatment had been maintained in all cases. As Shewmon says, the diagnosis of brain death is nearly always "a self-fulfilling prophecy" as it is followed by organ harvesting or the discontinuation of support. Occasionally, however, a family will insist on support being maintained even after a diagnosis of brain death, as Jahi McMath's mother did. Another such case has been described by Shewmon. A patient, known as "TK" contracted a form of meningitis at the age of four and was declared dead. Shewmon visited him when he was 18 years old. He described the case as follows:

"Cerebral edema was so extreme that the cranial sutures split. Multiple EEGs have been isoelectric, and no spontaneous respirations or brain-stem reflexes have been observed over the past 14 1/2 years. Multimodality evoked potentials revealed no intracranial peaks, magnetic resonance angiography disclosed no intracranial blood flow, and neuroimaging showed the entire cranial cavity to be filled with disorganised membranes, proteinaceous fluids and ghost-like outlines of the former brain" (Shewmon, 1998a, p. 1543).

Shewmon examined TK and documented everything photographically. He concluded: "There is no question that he became "brain-dead" at age 4; neither is there any question that he is still alive at age 18 1/2". TK "lived" – if that is the right word – at home on a ventilator, fed by a gastrostomy tube. His heart continued to beat for another six years after Shewmon wrote the account just quoted. During the 20 years he was without brain function, he grew, overcame infections, and healed wounds (Shewmon, 1998b, pp. 125–145; Repetinger, 2006, pp. 591–595).

In cases like TK exhaustive tests have shown that the brain no longer exists, and there can be no brain function at all. Such cases force us to reconsider the assumption on which Grisez and Boyle, as well as the President's Commission, rely for their acceptance of brain death: that a functioning brain is a necessary condition for an integrated organism. Instead, Shewmon concludes: "The body's integrative unity derives from mutual interaction among its parts, not from a top-down imposition of one "critical organ" upon an otherwise mere bag of organs and tissues" (Shewmon, 2001, pp. 457–478; Shewmon, 2012, pp. 423–494). How this is possible, and what parts are interacting to maintain this integrative unity, is an interesting scientific question, but is beyond the scope of this paper.

The development of Shewmon's own views is worth a short digression. A Roman Catholic, in 1989 he presented a defence of a version of "whole-brain death" to the Pontifical Academy of Sciences. Subsequently he rejected all brain-based formulations of death. In this he is joined by another leading Roman Catholic scholar in this area, John Finnis, Professor of Law at the University of Oxford, and by the former archbishop of Cologne, Joachim Cardinal Meisner, who in 1994 declared that "the identification of brain death with death of the person is from a Christian point of view no longer justifiable".<sup>4</sup>

Once it became clear that a human organism can, with the aid of a ventilator and good nursing care, continue to function for months or even years after the irreversible cessation of all brain function, the view that this irreversible cessation is equivalent to the death of the human being was on shaky ground. We can see this in the case of patients with a high spinal cord injury that leaves the patient paralysed below the injury and unable to breathe on his or her own. Although the brain has not lost all functions, it has lost its integrative function, because it can no longer communicate with the body below the injury. Yet patients with such an injury are still conscious. It would be absurd to say that because the brain has lost its integrative function, a fully conscious patient is dead.

#### IV. What do the standard tests for brain death show?

More recently, Shewmon has added another complication to the discussion. He examined Jahi McMath, and also watched videos taken by her family in which she appears to respond, with a frequency Shewmon says is highly unlikely to be chance, to spoken requests to raise a finger or make other movements. His conclusion is that at the time when Jahi was declared dead, she did fulfil the requirements of brain death, but "[W]ith the passage of time, her brain has recovered the ability to generate electrical activity, in parallel with its recovery of ability to respond to commands". Jahi was therefore at the time of Shewmon's statement, in his view, "an extremely disabled but very much alive teenage girl" (Aviv, 2018). Brain death is defined as the *irreversible* cessation of all brain functions, so it is logically impossible for Jahi to have been dead in accordance with this definition, and for her brain to then recover some function. If her brain now has some function, she was never brain dead.

Shewmon knows this, of course, so when he says that Jahi fulfilled the requirements of brain death, he must mean that when Jahi was declared dead, the tests standardly used to establish brain death were correctly carried out, and yielded the readings standardly taken to

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<sup>4</sup> John Finnis expressed his view in unpublished comments on a paper I gave to the Philosophy Society, Oxford University, 14 May 1998; for Joachim Cardinal Meisner, see "Erklärung des Erzbischofs von Köln zum beabsichtigten Transplantationsgesetz" [Declaration of the Archbishop of Cologne on the proposed transplantation law], September 27, 1996, *PEK Pressedienst*, 1996, Erklärung nr. 316, cited by Gerhard Wolf, "Strafbarkeit von Organentnahmen für Transplantationen?" In: Jan Joerden, (ed.): *Der Mensch und Seine Behandlung in der Medizin*. Berlin: Springer, 1999, p. 301, n. 91.

mean that all brain functions have irreversibly ceased. If that is the case, however, it shows that the standard tests are not a completely reliable indicator of brain death. Shewmon believes that Jahi was probably in a minimally conscious state, as a result of a condition known as global ischemic penumbra, in which intracranial blood flow is too low to support synaptic function, but is just sufficient to prevent the death of the cells. At present, the standard tests for blood flow used to diagnose brain death are not sensitive enough to distinguish this low level of blood flow from no flow at all (Shewmon, 2018).

If Shewmon is right about this, it would seem that we have a choice. One option is to devise new tests with the requisite sensitivity and use them instead of the now-standard tests in the guidelines for diagnosing brain death, so that they are able to detect global ischemic penumbra, and possibly other conditions from which the brain can recover some function but which are not detected by the standard tests. This may not be as simple as it sounds. According to Shewmon:

“[T]he “accepted medical standards” do not include ruling out GIP as a confounding factor... and there is no way to rule it out in a given case short of actual measurement of blood flow in every part of the brain, for which no practical test exists (an area ripe for urgent clinical research)” (Shewmon, 2018, p. 169).

Under the present legal definition of death, however, unless we can develop such a test, there is a risk that every removal of a heart from a patient who has been declared to be brain dead is, legally speaking, murder.

The other option is therefore to return to the traditional definition of death, and cease to remove organs from patients with beating hearts. I will now turn to the deliberations of President George W. Bush’s Council on Bioethics, which considered this possibility.

#### **V. President George W. Bush’s Council on bioethics enters the debate**

In 2008, the President’s Council on Bioethics, a conservative-leaning body appointed by President George W. Bush to replace its more liberal predecessor, took up the question of brain death, noting controversy about the view that “total brain failure” (as the Council refers to brain death) is the death of the human being. On the basis of evidence from Shewmon and others, the Council rejected the view that total brain failure means the end of an integrated organism. It might therefore seem that the Council must reject brain death itself. After all, Shewmon concluded, as the Council correctly notes, that to hold that the condition of the brain determines the death of the organism is a mistake (President’s Council on Bioethics, pp. 54–55). Nevertheless, the Council did not recommend a return to the traditional view that death occurs when the heart stops beating and the blood ceases to circulate. Instead a majority of its members found a new rationale for supporting the view that brain death is the death of the organism. The majority proposed that we take note of the fact that living organisms “engage in commerce with the surrounding world” (President’s Council on Bioethics, p. 60). The “commerce” on which the majority focused most attention, and regarded as most critical, is breathing:

“As a vital sign, the spontaneous action of breathing can and must be distinguished from the technologically supported, passive condition of being ventilated (i.e., of having one’s “breathing” replaced by a mechanical ventilator). The natural work of breathing, even apart from consciousness or self-awareness, is itself a sure sign that the organism as a whole is doing the work that constitutes—and preserves—it as a whole. In contrast, artificial, non-spontaneous breathing produced by a machine is not such a sign. It does not signify an activity of the organism as a whole.

It is not driven by felt need, and the exchange of gases that it effects is neither an achievement of the organism nor a sign of its genuine vitality” (President’s Council on Bioethics, p. 63).

The idea that spontaneous breathing could be used as a criterion for deciding whether someone is dead or alive faces several objections; most obviously, many patients placed on ventilators have lost the ability to breathe spontaneously. They will, after an interval, regain it, and walk out of hospital. The Council is aware of this, of course, and sees only the *irreversible* loss of the capacity as a sign of death but people with a high spinal cord injury may have irreversibly lost the ability to breathe spontaneously, and yet be fully conscious. Again, the Council acknowledges this, and adds that “other vital capacities might still be present”. The report continues:

“For example, patients with spinal cord injuries may be permanently apneic or unable to breathe without ventilatory support and yet retain full or partial possession of their conscious faculties. Just as much as striving to breathe, signs of consciousness are incontrovertible evidence that a living organism, a patient, is alive” (President’s Council on Bioethics, p. 63).

The Council therefore decides, though with some dissenting members, to stay with brain death, not because this signifies the death of the integrated organism, but because “total brain failure” indicates the irreversible absence of both spontaneous breathing and consciousness.

This is a desperate attempt to reach a much-desired conclusion. Let’s first see why the Council was so keen to preserve the definition of death in terms of brain death, and then see why its attempt to do so fails.

The Council’s report contemplates the possible conclusion that brain death is not the death of the organism, and that consequently we need to return to defining death in terms of the cessation of heartbeat and circulation of the blood. What practical difference would this make? There are two possible ways of responding to this situation. One is that we preserve the rule that organs may only be taken from dead donors, and therefore do not take organs from donors whose hearts are still beating, even if their brains have irreversibly ceased to function. Because some organs, including the liver and the heart itself, are subject to rapid damage once the heart stops, this is likely to mean that significantly fewer people would benefit from organ transplants, and many lives now saved would be lost. In addition, the Council expresses concern that the need to certify a patient as dead as soon as possible after the heart stops beating would have an adverse impact on the care of dying patients whose hearts stop, but perhaps could be resuscitated. In other words, if we combine the traditional definition of death with a world in which transplants can save lives, we will introduce a new tension between making absolutely certain that the patient is dead, and saving the lives of other patients.

The other possible way of responding to the return to the traditional definition of death is to draw on the present criteria for ascertaining total brain failure in order to determine, not that a patient is dead, but that the patient is eligible to be an organ donor. Such patients would be eligible because (and here I use my own words, not those of the Council) their lives are over, not as organisms, but as conscious beings. They will never again experience anything. In these very specific circumstances, continuing their lives beyond this point is of no further benefit to them. (Singer, 1995; Miller & Truog, 2011).

The Council is aware of the attractions of this view. It requires no questionable arguments defending a new concept of death, and it does not force us to reject or significantly hamper the



practice of organ donation. Nevertheless, the Council finds this view unacceptable on ethical grounds:

“[T]his solution is deeply disturbing, for it embraces the idea that a living human being may be used merely as a means for another human being’s ends, losing his or her own life in the process. For good reason, many recoil from the thought that it would be permissible to end one life in order to obtain body parts needed by another... abandoning the “dead donor rule” would entail dismantling the moral foundations of the practice of organ donation” (President’s Council on Bioethics, p. 17).

In short, the Council knows that if organs cannot ethically be removed from donors with beating hearts, then many people whose lives could be saved by organ transplants will die; but the Council nevertheless believes that it is ethically unacceptable to remove vital organs from living human beings in order to benefit others. No wonder that most members of the Council were desperate to find a basis for retaining a definition of death that includes total brain failure.

A strong desire to reach a pre-determined conclusion often leads to poor reasoning. That applies to the Council’s stance that the absence of spontaneous breathing is a sign of death – except when it isn’t, for example when there is consciousness in the absence of spontaneous breathing. This addition to the initial selection of the absence of spontaneous breathing reveals that the Council has been forced to patch together from disparate elements its account of the difference between life and death. As Albert Garth Thomas, an anaesthesiologist with qualifications in philosophy, notes in his discussion of the Council’s report, this conjunction “marks their analysis as *ad hoc* and unconvincing”. Thomas also points out that “[J]ust how one would understand spontaneous respiration as the epitome of human life is difficult to grasp”. That’s because breathing is no more crucial to our normal lives than many other functions, such as those of the kidneys, liver, and pancreas (Thomas, 2012, p. 106). These organs too could be described as “engaged in commerce with the surrounding world” and they can continue to operate spontaneously after spontaneous breathing has ceased. Why is their spontaneous operation not enough to show that a patient is alive?

As we have seen, the Council sought to avoid a return to the traditional definition of death. It rejected, not unanimously but by a majority, the alternative of abandoning the “dead donor rule” on the grounds that this would “dismantle” the moral foundations of the practice of organ donation. That is not so; at most, it would amend the moral foundations of that practice, and even that claim presupposes that these moral foundations have the Kantian basis described in the passage quoted above. Historically speaking, this presupposition is highly dubious. As we saw earlier, the moral foundations of the initial stimulus for the change in the definition of death, and thereby for the development of the modern practice of organ transplantation, seems to have been much closer to utilitarian principles than to Kantian ones.

One might, of course, accept, as a matter of historical fact, that the Harvard committee was thinking upon broadly utilitarian lines, and yet deplore this, and seek to persuade current practitioners that the only defensible moral foundation of the practice is Kantian. The more significant question, however, is whether the Kantian objection to using living, but irreversibly brain-dead human beings as organ donors, is valid. In my view, it is not. Whatever Kant may have meant by his famous statement that we should treat others “never merely as a means to an end, but always at the same time as an end”, the principle is plainly indefensible unless it includes, in the idea of treating someone “merely as a means” the proviso that the person did not freely and voluntarily consent to being so used. Otherwise, why is not mailing a letter wrongly using as mere means the people who collect, sort and deliver the mail? The standard Kantian

answer to this obvious objection is that postal employees freely consent to do their work. Hence the work is an end, for them, and there is no wrong-doing in mailing a letter; but organ donors also consent, prior to their death, at least in countries that have “opt-in” systems of donation, as the United States does. It is also arguable that in “opt-out” systems, people who do not opt out are giving implicit consent, as long as the opportunity to opt out is well-known to everyone and easily accessible.

It might be said that under either opt-in or opt-out systems, donors consent for their organs to be taken after their death, but if we abandon the dead donor rule, the organs will be taken when they are not dead. If that is the concern, then the problem that the President’s Council finds so morally fundamental could easily be overcome. All that is necessary is to rephrase the question potential donors are asked, so that they are asked to consent to organs being taken after irreversible total brain failure, with no hope of any recovery of consciousness. We could then see what proportion of those currently willing to be organ donors would continue to be willing to donate under the new conditions. My hope is that this change would not cause a significant drop in the number of donors, as long as they were accurately informed about the irreversible nature of the condition that they would have to be in before they could be considered as a donor, and the degree of confidence with which that condition could be diagnosed.

## **VI. The significance of irreversible unconsciousness**

We have seen that the Harvard committee thought that people in an “irreversible coma” should be regarded as dead. We have also noted the reasons the Harvard committee gave for this change. It was, in large part, because of the good consequences that would flow from this change, for the families of the person in the irreversible coma, for the hospitals, and for the potential organ recipients. All of these reasons apply not only to patients whose brains have totally and irreversibly ceased to function, but also to patients who have irreversibly lost all capacity for consciousness. Why then did the Harvard committee limit its concern to those with no brain activity at all?

One reason may be that in 1968, the only form of “irreversible coma” that could be reliably diagnosed – with no possibility of a patient being declared dead and then “waking up” – was that in which there was no discernible brain activity at all. Another possible reason for the committee redefining death to cover only those with no brain activity at all is that if the ventilator is removed from such patients, they stop breathing and so will soon be dead by anyone’s standard. People in a persistent vegetative state, on the other hand, continue to breathe without mechanical assistance. So if the Harvard committee had included in its definition of death people who are in an irreversible coma but still have some brain activity, they would have been suggesting that people could be buried while they are still breathing.

Technology has, in many cases, eliminated the first of these reasons. Admittedly, in some cases of patients in a long-term persistent vegetative state, we still lack any completely reliable means of saying when recovery is impossible. In other cases, however, new forms of brain imaging can establish that parts of the brain necessary for consciousness have ceased to exist, and hence that consciousness cannot return. This would be the case, for example, if there has been no blood flow to the cortex for so long that the entire cortex had turned to liquid. The brain stem may still be functioning, however, so the problem of declaring patients dead when they are breathing spontaneously remains. This condition would be visible on a scan, and would also serve to ensure that the patient was not even in a minimally conscious state, as Jahi McMath appears to have been.

Several writers have urged that the solution to the present unsatisfactory state of the definition of death is to draw on our improved diagnostic abilities to move on to a definition of death in terms of the irreversible loss of consciousness. Among those defending this view are Michael Green and Daniel Wikler, John Lizza, Calixto Machado, Jeff McMahan, and Robert Veatch (see for example: Engelhardt, 1975, pp. 587–590; Veatch, 1975, pp. 13–30; Green & Wikler, 1980, pp. 105–133; Machado, 1995; McMahan, 1995, pp. 91–126; Lizza, 2018, pp. 1–19).

The significance of consciousness, and its link with the brain, answers the fundamental question – “why the brain?” – that supporters of the whole brain death criterion have never been able to answer satisfactorily. The death of the whole brain is the end of everything that matters about a person’s life, but so too is the death of those parts of the brain necessary for consciousness. So the definition of death in terms of the irreversible loss of consciousness means that the criterion for death is the irreversible cessation of function of what is variously referred to as the cortex, the cerebral hemispheres, or the cerebrum. To avoid the need to define this more precisely, I shall use the expression “the higher brain” to refer to whatever parts of the brain are necessary for consciousness.

We have already seen that even total brain failure is not the same as the death of the organism. Given that, it is obviously going to be difficult to argue that an irreversible loss of consciousness is equivalent to the death of the human organism. Warm, breathing human beings, with their hearts beating and their blood circulating, are not dead, whether the breathing is spontaneous or mechanically assisted. “Dead” is a term applied much more widely than human beings, or conscious beings, or beings with brains. An oyster has no brain at all, let alone a higher brain, yet oysters are alive, and they can die.

Jeff McMahan’s defence of the higher brain account of the death of human beings is more philosophically sophisticated than most, and worth our attention for that reason. McMahan takes his cue from Mark Johnston’s assertion that we are not “essentially human organisms” (Johnston, 1987, pp. 75–76) and uses this claim to distinguish the death of the person from the death of the organism. Our survival as persons, McMahan claims, requires “continuity of mind”, and so our continued existence, for all practical purposes, “requires the preservation of various mental powers or capacities in the areas of the brain in which consciousness and mental activity occur” (McMahan, 1995, p. 111; Green & Wikler, 1980). Thus, unlike organisms without minds, we can die while our body is still alive. McMahan recognises that the category of “organisms with minds” is not limited to the human species, nor applicable to all members of that species. A dog may die while its body is still living, and an anencephalic human infant is a living human organism without a mind. On this view, the grieving family of the warm, breathing body in the hospital ward are right to think that they are not facing a dead body. But they are also right if they understand that the person they loved is gone forever. In McMahan’s terms, that person is dead.

## **VII. The centrality of ethics**

McMahan’s proposal has the merit of not denying that human organisms die in the same sense that plants die. Hence it does less violence to the common conception of death than other defences of a move to a higher brain definition of death. His view helps us to conceptualise what is going on when the higher brain has been destroyed and the body continues to live, but he acknowledges that it does not resolve the ethical questions. Is it wrong to cut the heart out of an anencephalic infant, which is a living human organism but can never be a person? Or out of an irreversibly unconscious human organism who has been, but can never again be, a person?

The existence, over the past three or four decades, of the definition of death in terms of brain death has, quite literally, made it possible for Christians to get away with what would, under the earlier traditional definition of death, have been murder – and without abandoning their support for the sanctity of all human life. Moreover, if brain death is not the death of the human organism, it is hard to see how defenders of the equal value of all human life can support the removal of ventilators from brain-dead patients with beating hearts. Roman Catholic teaching holds that extraordinary treatment is not obligatory when it imposes a disproportionate burden on the patient or others – disproportionate, that is, in terms of the benefits gained. This doctrine allows Christians to discontinue extraordinary means of life-support that are burdensome to a patient or demand scarce medical resources, and the burden on the patient or the use of resources is disproportionate to the benefit that will be achieved. This may be the case when the patient is suffering and will, in any case, live for only a short time, or when the medical resources could save other patients who will live much longer. Now consider a brain-dead human being who, like TK, could live another 10 or 15 years, cared for at home by his family at relatively modest cost. In what way are the measures taken to keep him alive disproportionate to the benefit of an extra 10 years of life? There is no suffering. Admittedly, there is also no joy nor any other experiences at all but to say that the extension of human life is not a significant benefit because it brings no conscious experiences of any sort, and therefore the life of the human being need not be prolonged, is to invoke an explicit quality-of-life judgment as the basis for discontinuing treatment. That is in direct contradiction to the words of Pope John Paul II in *Evangelium Vitae*: “As far as the right to life is concerned, every innocent human being is absolutely equal to all others...” For those who take this view, if brain dead human beings can be kept alive for many years without the use of scarce medical resources, the distinction between “ordinary” and “extraordinary” or between “proportionate” and “disproportionate” means of care cannot be used to justify withdrawing medical support from them.<sup>5</sup>

If, on the other hand, we reject the view that all human life is of equal value, we have another ethical option. We could accept the traditional conception of death – thus agreeing, in effect, with Shewmon and Finnis on this question – but reject their ethical view that it is always wrong intentionally to end the life of an innocent human being. We could then regard it as justifiable to remove organs for transplantation, when there has been an irreversible loss of consciousness, as long as the donor gave the appropriate consent, applicable to this situation. We would then achieve the same practical outcome as we would achieve by redefining death in terms of the irreversible loss of consciousness. To return to the language used by the Harvard committee, we would be able to relieve the burden on families, hospitals and those in need of hospital beds, not only when the patient’s brain has wholly ceased to function, but also when the patient’s higher brain has irreversibly ceased to function. We would be able to do this without having had to finesse the definition of death in order to achieve our objective. Last, but by no means least, we would have made our ethical judgments transparent, thus advancing public understanding of the issues involved rather than obscuring it.

The most troubling objection to this approach is a practical one: no matter how logically compelling the proposal may be, it may seem to be such a radical ethical change that it stands no chance of success. After all, it is a head-on challenge to the traditional doctrine of the sanctity of all human life. Better, some will say, to do our best to push back the extent of that doctrine’s reach, than to hurl ourselves vainly against its citadel. Better, in other words, to maintain the belief that brain death really is death, and indeed to try to go beyond whole brain death, by

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<sup>5</sup> For a critique of attempts by Catholic ethicists to appeal to these distinctions as a way of avoiding explicit quality-of-life judgments, see *The Sanctity-of-Life Doctrine in Medicine: A Critique* (Kuhse, 1987).

arguing that we die when we irreversibly lose consciousness. Otherwise, we risk denting the public confidence in brain death. That could lead to fewer people giving consent for the removal of organs – their own or those of their loved ones – when brain death is diagnosed, and that would mean that fewer lives could be saved by organ transplantation.

### VIII. Conclusion

We are left with two options that preserve and extend the possibility of organ transplantation without using anyone without their consent, or violating anyone's human rights. We could hold that conscious beings die when they irreversibly lose consciousness, and that this, and not the death of the organism, is what makes permissible the removal of organs from a consenting donor.

Alternatively, we could return to the traditional definition of death in terms of the cessation of heartbeat and the stoppage of the circulation of the blood, but hold that it is not wrong to remove organs from living human beings who have irreversibly lost consciousness, and have consented to the donation of their vital organs in such circumstances. Both of these options avoid the misconceptions involved in the view that organs can only be taken from dead human organisms, and that the test of death for a donor with a beating heart is the irreversible loss of all brain function.

I will not here attempt to choose between these two options, for they converge on the crucial point: the existence of a living human organism is not a sufficient reason for ruling out the removal of vital organs from that organism. There is, however, one remaining problem; both of these options require that we establish that the patient has irreversibly lost consciousness. In the light of the Jahi McMath case, that may not be simple, given that we would not want to wait, in every case, for the liquefaction of the cortex in order to establish it. Such a delay would come at a high price, both in financial and human terms. Nevertheless, this is a technical problem. If solving it became a requirement of continuing organ transplants from beating heart donors, I assume that a solution would soon be found.

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### References

- AVIV, R. (2018): What does it mean to die? In: *New Yorker*, February 5.
- BEECHER, H. (1967): Henry Beecher to Robert Ebert. In: D. Rothman (1991): *Strangers at the Bedside*. New York: Basic books, pp. 160–161.
- ENGELHARDT, T., Jr. (1975): Defining death: A philosophical problem for medicine and law. In: *American Review of Respiratory Disease*, 112(5), pp. 587–590.
- GREEN, M. & WIKLER, D. (1980): Brain Death and Personal Identity. In: *Philosophy and Public Affairs*, 9(2), pp. 105–133.
- GRIZEZ, G. & BOYLE, J. (1979): *Life and Death with Liberty and Justice*. Notre Dame: University of Notre Dame Press.
- JOHNSTON, M. (1987): Human beings. In: *Journal of Philosophy*, 84(2), pp. 59–83.
- KUHSE, H. (1987): *The Sanctity-of-Life Doctrine in Medicine: A Critique*. Oxford: Oxford University Press.
- LAMB, D. (1985): *Death, brain death and ethics*. London: Croom Helm.

- LIZZA, J. (2006): *Persons, Humanity, and the Definition of Death*. Baltimore: The Johns Hopkins University Press.
- LIZZA, J. (2018): Defining Death: Beyond Biology. In: *Diametros*, 55, pp. 1–19.
- MACHADO, C. (1995): A New Definition of Death Based on the Basic Mechanism of Consciousness Generation in Human Beings. In: C. Machado (ed.): *Brain Death: Proceedings of the Second International Symposium on Brain Death*. Amsterdam: Elsevier, pp. 57–66.
- MCMAHAN, J. (1995): The Metaphysics of Brain Death. In: *Bioethics*, 9(2), pp. 91–126.
- MILLER, F. & TRUOG, R. (2011): *Death, Dying, and Organ Transplantation*. New York: Oxford University Press.
- PRESIDENT’S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE (1981): *Defining Death: A Report on the Medical, Legal and Ethical Issues in the Determination of Death*. Washington: U.S. Government Printing Office.
- PRESIDENT’S COUNCIL ON BIOETHICS (2008): *Controversies in the Determination of Death*. Washington, [online] [Retrieved August 30, 2018]. Available at: <https://bioethicsarchive.georgetown.edu/pcbe/reports/death/>
- REPETINGER, S. (2006): Long Survival Following Bacterial Meningitis-Associated Brain Destruction. In: *Journal of Child Neurology*, 21(7), pp. 591–595.
- REPORT OF THE AD HOC COMMITTEE OF THE HARVARD MEDICAL SCHOOL (1968): A Definition of Irreversible Coma. In: *Journal of the American Medical Association*, 205(6), pp. 337–340.
- SHEWMON, D. A. (1998a): Chronic ‘Brain Death’: Meta-Analysis and Conceptual Consequences. In: *Neurology*, 51(6), pp. 1538–1545.
- SHEWMON, D. A. (1998b): ‘Brain-stem death’, ‘brain death’ and death: a critical re-evaluation of the purported equivalence. In: *Issues in Law & Medicine*, 14(2), pp. 125–145.
- SHEWMON, D. A. (1999): Chronic ‘Brain Death’: Meta-Analysis and Conceptual Consequences [response to letters]. In: *Neurology*, 53(6), pp. 1369–1372.
- SHEWMON, D. A. (2001): The Brain and Somatic Integration: Insights into the standard biological rationale for equating ‘brain death’ with death. In: *Journal of Medicine and Philosophy*, 26(5), pp. 457–478.
- SHEWMON, D. A. (2012): You only die once: why brain death is not the death of a human being. In: *Communio*, 39(2), pp. 423–494.
- SHEWMON, D. A. (2018): Truly Reconciling the Case of Jahi McMath. In: *Neurocritical Care*, 29(2), pp. 165–170.
- SINGER, P. (1995): *Rethinking life and death*. Oxford: Oxford University Press.
- THE PROLONGATION OF LIFE: AN ADDRESS OF POPE PIUS XII TO INTERNATIONAL CONGRESS OF ANAESTHESIOLOGISTS (1957): In: *The Pope speaks*, p. 396.
- THOMAS, A. G. (2012): Continuing the Definition of Death Debate: The Report of the President’s Council on Bioethics on Controversies in the Definition of Death. In: *Bioethics*, 26(2), pp. 101–107.
- VEATCH, R. (1975): The whole-brain-oriented concept of death: An outmoded philosophical formulation. In: *Journal of Thanatology*, 3(1), pp. 13–30.

## Brain death as irreversible loss of a human's moral status

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### Abstract

Singer claims that there are two ways of challenging the fact that brain-dead patients, from whom organs are usually retrieved, are in fact biologically alive. By means of the first, the so called dead donor rule may be abandoned, opening the way to lethal organ donation. In the second, it might be posited that terms such as “life” and “death” do not have any primary biological meaning and are applicable to persons instead of organisms. This second possibility permits one to acknowledge that brain-dead patients are deceased because they are irreversibly unconscious. In the commentary which follows, I will argue that Singer's second option is preferable since it (a) provides a higher amount of organs available for transplant, and (b) is better suited to the meaning of “death” which occurs in ordinary language. I will also defend such a concept of death against the objections raised by Michael Nair-Collins in the article *Can the brain-dead be harmed or wronged? On the moral status of brain death and its implications for organ transplantation*.

**Keywords:** bioethics, transplantation ethics, brain death, moral status, critical interests, ulterior interests

In the article *The challenge of brain death for the sanctity of life ethic*, published in the current issue of “*Ethics & Bioethics (in Central Europe)*”, Peter Singer presents and updates his position on brain death. Evoking scientific evidence provided by Alan Shewmon, he points out that brain dead patients are biologically alive because they manifest some level of somatic integration and they are capable of engagement in commerce with the surrounding environment (Shewmon, 1998; Singer, 2018, pp. 156–157, 160; Singer, 1994, pp. 31–32). Nevertheless, in his opinion, the practice of organ retrieval from such patients shall not cease and he claims that such a position might be justified in two mutually exclusive, alternative ways. First, even if brain dead patients are alive, organ retrieval after valid consent is permissible because it does not inflict any harm on irreversibly unconscious patients (Singer, 2018, pp. 159–161, 163–164; Singer, 1994, pp. 52–56). Second, one might argue that the meaning of terms such as “life” or “death” in the context of human beings is not just biological – “[C]onscious beings die when they irreversibly lose consciousness” Singer states. Exactly this kind of “person's” death might make organ retrieval from the consenting donor morally permissible (Singer, 2018, p. 164; Singer, 1994, pp. 47–48). Finally, Singer seems to claim that each of the two alternative options which preserve organ transplantation are equally worthy of adoption (Singer, 2018, p. 164).

In contrast to Singer's last statement, I will point out that the view which admits organ donation associated with killing living humans has important drawbacks: first, it engenders a substantial drop in the number of donated organs and, second, it is associated with a misleading concept of death. I will argue that the right concept of death associates the end of human life with the irreversible loss of consciousness. I will also defend such a view against the latest criticism

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developed by Michael Nair-Collins (2017).

### **Consent for the organ retrieval of the biologically living**

When Singer refers to the practice of organ retrieval without taking into account the dead donor rule, he writes that in such circumstances “[a]ll that is necessary is to rephrase the question potential donors are asked, so that they are asked to consent to organs being taken after irreversible total brain failure, with no hope of any recovery of consciousness” (Singer, 2018, p. 161). In the following sentences he adds:

We could then see what proportion of those currently willing to be organ donors would continue to be willing to donate under the new conditions. My hope is that this change would not cause a significant drop in the number of donors, as long as they received information about the irreversible nature of the condition that they would have to be in before they could be considered as a donor (Singer, 2018, p. 161).

Contrary to what other authors often suggest (Magnus, Wilfond & Caplan, 2014, p. 3; Bernat, 2013, p. 1290; Miller & Truog, 2012, p. 151), these hopes are not so nebulous if we think of American society. The research conducted by Nair-Collins and his fellows indicates that as many as 67% of the surveyed Americans from the sample would be willing to donate their organs if they found themselves in the state termed “irreversible apneic coma”, even if organ retrieval would be described as causing biological death (Nair-Collins, Green & Sutin, 2015). However, the same research results show that 19 to 30% of the participants who express a willingness to donate organs ‘after death’ are unsure or unwilling to donate if the circumstances of organ retrieval are depicted as above (Nair-Collins, Green & Sutin, 2015). It has to be admitted that such a decrease in the number of donors might be considered substantial. For the sake of comparison, let us note that it is almost as large as the expected increase in the number of donors which might be achieved in American and British society thanks to the replacement of an opt-in organ procurement system with an opt-out system.<sup>2</sup> Given the extensive debate concerning the possibility of such change held by bioethicists (see for example Veatch & Ross, 2015, pp. 131–163; Wilkinson, 2011, pp. 81–100), as well as the fact that many European countries have actually decided to apply an opt-out system, it is hard to consider such a change as unimportant, whether there is an increase or decrease in the number of donors. Even more doubts arise with the introduction of the change postulated by Singer outside the borders of the USA and the United Kingdom – for example, in countries located in Central Europe where a commitment to the traditional sanctity of human life ethics and the deontological prohibition of killing seems stronger than in the USA or the UK. From this point of view, the other option mentioned by Singer, which preserves the possibility for organ retrieval, seems more promising; that is the acknowledgement that terms such as “death” and “life” do not have a mainly biological meaning, and that conscious beings die in the proper sense when they irreversibly lose consciousness. Adopting such a concept of death, one might defend the thesis that brain death is really the death of a human. This kind of strategy is related only to the change within the justification currently used for procedures, and does not require any modifications in the process of the authorization of organ retrieval, regardless whether it is based on an opt-in or opt-out system. In

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<sup>2</sup> One might come to such a conclusion by taking into account the systematic review authored by Rithalia et al. (2009). The authors of the study estimate that the introduction of an opt-out system in the USA and the United Kingdom might trigger a 25–30% increase in the number of donors. More recent research conducted by Li, Hawley and Schiner (2013, p. 1123), is much more optimistic and indicates that even a 100% increase is obtainable in the number of donated organs.



the next part of the discussion of Singer, I shall prove that the postulated change which presupposes abandoning the biological concept of death for the sake of an “ethical” one is not only more useful but, first and foremost, more appropriate since it takes into account the fundamental sense of words such as “life” and “death”.

### **Death as an irreversible loss of a human’s moral status**

“Death” in its biological meaning might be defined as follows

(...) [it] is the irreversible cessation of the organismic capacity to maintain homeostasis of the extracellular fluid and thereby resist entropy. Extending the homeostenosis concept of aging, death is the limit beyond which homeostasis cannot be restored, when physiologic reserves are spent (...). It is a thermodynamic point of no return, a state-discontinuous point beyond which entropy and disintegration take over” (Nair-Collins, 2018, p. 33).

If we compare such a scientific concept with the meaning of “death” which occurs in ordinary language, we quickly realize that they are not congruent. This might be easily discernible in the case of the sentence “Adam’s death was a great tragedy” which would be incomprehensible if we meant a biological meaning of “death” in this case. Death is commonly seen as bad for the person whose life ends (particularly if someone young dies who would otherwise have had many years of healthy life left, see for example McMahan, 2012, pp. 95–145; Nagel, 1970). Yet it is rather unclear why for any kind of being that *the mere fact* that it ceases to be a system which is capable of resisting entropy might be bad. The definition proposed by Nair-Collins also does not explain why death might provide the loved ones with the reason to start mourning, although it widely believed that it really does.

In everyday life, determining whether someone is alive or not is of great importance for us. The attitudes and behaviors which we present towards the living differ radically from those which are manifested towards the deceased (Veatch & Ross, 2015, pp. 45–49). As I think one of the main reasons is the widespread belief that only the living might be helped or harmed. However, it is clear that the word “life” appears in this context in an ethical sense, not in a biological one, because biological life itself may have nothing to do with experiencing harms or benefits. The case of an artificially supported amputated arm is the best opportunity to see this (Lizza, 2018, p. 13; Veatch, 2015, p. 19). Such an arm constitutes a system capable of maintaining homeostasis and resisting entropy and thus, in accordance with Nair-Collins’ definition of death, it is undoubtedly biologically alive. However, it is not alive in the fundamental sense of its word, that is, in the ethical sense. The sustained arm is not the patient to whom it belonged and the nursing care it enjoys is not to the benefit of the patient. If medical professionals would really provide care for such arms, we would consider it a waste of time and resources which should be utilized to help living people in the ethical sense. The physicians in an intensive care unit are not biologists or scientists engaged solely in describing natural phenomena or constructing scientific theories which might investigate whether they are witnessing biological life or death. Physicians are first and foremost therapists, and their main task is to promote the wellbeing of a patient in accordance with medical knowledge.<sup>3</sup> For this reason, physicians should be interested in whether the patient is alive or has died in the fundamental meaning of this world – that is in the ethical sense. From such a perspective it is best to define death as an irreversible

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<sup>3</sup> See, for example, section 2 of the Polish Medical Code of Ethics or principle no. VIII in Code of Medical Ethics of the American Medical Association, and the article about the ends of medicine by David Silver (2003, pp. 209–211).

loss of the human's moral status. Humans die when they irreversibly lose the properties which meant that they had morally relevant interests.<sup>4</sup> The end of life in that sense occurs simultaneously with the total irreversible loss of all capacities which different philosophical concepts recognize as determinants for moral status i.e.: the capacity to be sentient, to have desires, be rational, self-conscious, conscious, to communicate, and enter into social relations.<sup>5</sup> Such a view on death, which I call the Moderately Liberal Concept of Death (Nowak, 2016) adopts a potentially wide range of properties (and the presence of each of them might be sufficient to admit that we are dealing with a being with a particular moral status, that is with the "living" being in ethical sense of this phrase) to avoid getting too involved in the controversy concerning the grounding of moral status.<sup>6</sup> It is precisely on the basis of such a position that we can understand why death can be considered as bad for humans (because when humans lose their moral status, at the same time they lose the prospect of further good which might be available for them if they did not die, see McMahan, 2012, pp. 95–145 and Nagel, 1970), and why death gives reasons for mourning.

The tenets of this kind of concept of death, as Singer rightly points out (Singer, 2018, p. 161; Singer, 1994, pp. 48–50), in theory justifies the determination of death not only in case of brain death but also in the case of injuries to the structures of the higher brain on which the mentioned capacities are based. However, the results of research conducted on patients with the clinical diagnosis of a permanent vegetative state (that is, of total and irreversible unawareness and insentience, despite the preservation of the vegetative functions of the organism such as self-driven breathing, see Posner et al., 2007, p. 357), suggest caution during the selection of neurological tests applied to determine death, and remaining conservative regarding this issue by using the same technical criteria which are currently applied to determine brain death. As it transpires, some of these patients are able to maintain cognitive and communicational activity despite this diagnosis, and are able to answer "yes" or "no" to simple questions solely through the activity of their brains as detected on fMRI scans (Fernández-Espejo & Owen, 2013; Monti et al., 2010; Owen et al., 2006; Żuradzki, 2011), while others are pain sensitive (de Tomaso et al., 2013; Yu et al., 2013). Given these findings, brain death should be adopted as a criterion of death on the basis of the Moderately Liberal Concept of Death instead of higher brain death.

### **Do brain dead patients lose their moral status?**

The strategy which aims at preserving the possibility of organ retrieval from brain-dead patients by means of an appeal to the concept of identifying death with the irreversible loss of the patient's moral status has recently been criticized by Nair-Collins (2017). In his recent article

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<sup>4</sup> For the concept of moral status see Galewicz (2013, pp. 15–172), Jaworska and Tannenbaum (2018), Warren (1997).

<sup>5</sup> A similar view concerning the issue of defining death is presented among others by McMahan (2002, pp. 423–455), Lizza (2006) and Veatch (2003, pp. 10–11; 2015).

<sup>6</sup> From the list of properties that are recognized by different philosophical concepts as moral status determinants, only features such as species membership, being an object which preserves its identity thorough space and time, and being a biologically alive entity were removed. The first of the aforementioned properties constitutes an arbitrary criterion leading to speciesism (McMahan, 2002, pp. 212–214; Singer, 1994, pp. 172–183; Warren, 1973, pp. 53–55). The latter two, despite perhaps being sufficient for the objects possessing them to have their own interests, are no longer the interests of a patient and certainly do not provide any agent-neutral reasons (or the agent-neutral reasons which they provide are negligible). The patient is not identical with a body deprived of any mental capacities. If we agree that insentient organisms have their own interests, then we should realize that such interests provide such small agent-neutral reasons that in everyday life we can destroy these kinds of organisms for absolutely trivial reasons. For more about this issue see Galewicz (2013, pp. 22–51; pp. 125–127) and Nowak (2018).

*Can the brain-dead be harmed or wronged?: On the moral status of brain death and its implications for organ transplantation*, Nair-Collins argues that there are some obligations that we have towards brain dead patients which are grounded in their “incompetence-surviving investment interests.” In his terms, the existence of such commitments indicates that these patients have not completely lost their moral status and thus they cannot be considered dead according to the concept which is defended here. In the subsequent part of the article I will focus on this argument and try to defend the Moderately Liberal Concept of Death.

The distinction between investment interests and experimental interests is the first step in Nair-Collins’ reasoning (2017, pp. 529–531, see also Davies, 2007; Dworkin, 1994, p. 201; Feinberg, 1986, p. 37; Regan, 1983/2004, p. 87). Investment interests include all the things that the person is “invested in”. Such interests are connected with a person’s striving for some things or events to actually occur or take place, whereas experimental interests are conditioned by the subject’s ability to be sentient. Among the interests of the second kind are all sorts of pleasure and the avoidance of pain. Investment interests, on the other hand, include interests based on simple desires concerning, for example, what to eat for dinner on a given day, Feinberg’s ulterior interests (1986, p. 37) or the critical interests described by Dworkin (1994, p. 201). The latter are associated with final life goals, with all the things that are perceived as giving meaning to human existence. The next step in this argument is to point out that the status of three hypothetical patients (Daniel, Veronica and Christine) is identical if investment interests are considered and different only from the point of view of their experimental interests (Nair-Collins, 2017, pp. 534–540). Daniel is in end stage dementia, Veronica is reliably diagnosed as being in a permanent vegetative state, whereas Christine is brain-dead, that is to say in a state of irreversible apneic coma.

As Nair-Collins points out, each of these patients might have some investment interests regarding what happens to their bodies after the point when competence is irreversibly lost. He calls such interests “incompetence-surviving investment interests” (Nair-Collins, 2017, p. 535). To move the discussion on a little bit further, let it be noted that such interests are not “created” in a state of irreversible incompetence but rather raised before such a state developed. As an example, we might suppose that each of the patients formulated desires such as “I want my organs to be donated *after the biological death of mine*,” and “I do not want my biological life to be actively ended, although I do accept withholding or withdrawing futile life sustaining treatment.” According to Nair-Collins, interests which are based on such desires might be violated to the same extent in each of the three aforementioned cases, because in each of them organ retrieval is conducted before biological death and biological life is actively ended (Nair-Collins, 2017, pp. 534–540). Experimental interests are the only difference between Daniel, Veronica, and Christine – only Daniel is capable of experiencing pain and pleasure while Veronica and Christine are both irreversibly unconscious. Yet, as Nair-Collins stresses, Daniel’s right to bodily integrity, which he undoubtedly has, is based not on his experimental interests, but on his incompetence-surviving interests (Nair-Collins, 2017, pp. 537–538). Daniel does not differ in this respect from Veronica and Christine and therefore if Daniel has the right to bodily integrity and his incompetence-surviving interests count, the same should be said about Veronica and Christine. Finally, the analysis conducted by Nair-Collins is supposed to result in the conclusion that it is impossible for braindead patients to have lost their moral status, because they might be harmed or wronged if one compromises their interests (Nair-Collins, 2017, pp. 540–542).

Nair-Collins’ argument is the most serious attack on the concept that equates death with the irreversible loss of a patient’s moral status which has taken place in recent years and, therefore,

advocates of this concept such as myself are obliged to discuss it. In the next part of the text, I shall show the reasons why I believe that the concept which identifies death with the irreversible loss of the moral status of human beings, nevertheless allows us to admit that brain-dead patients are truly dead. I will also show how such a view of death coheres with the existence of incompetence-surviving investment interests.

First of all, it should be noted that, if the presence of incompetence-surviving investment interest indicates that the particular being has moral standing, then it must be admitted that not only brain-dead patients have moral status but bodies in a stage of rigor mortis or bodies which have been buried in graves for many years, such as Kant's remains, have moral status as well. To prove this, let me provide the following reasoning: suppose that Kant had a desire "*never* to be slandered" during his life which became the basis for his incompetence-surviving investment interest. Following the examples given by Nair-Collins, it should be stated that Kant, from the point of view of such interests, might be equally harmed or wronged when he is slandered when, let us assume, he is in end-stage dementia, when he loses consciousness and becomes permanently vegetative, or when he lapses into an apneic coma in a state of brain death, although he is still biologically alive. Since Kant might be harmed or wronged at each of these stages, it seems to imply that some things might be good or bad for him at each of these stages, and his interests should be cared for. Therefore, he has moral status, that is to say he is alive in the ethical sense. Yet, we should note that nothing about the nature of incompetence-surviving investment interests suggests that such interests cannot persist after the biological death of a human. Taking this into account, it should be acknowledged that if someone slanders Kant at this moment, he harms or wrongs him to the same extent as he would do at the time when Kant was biologically alive, even though he has become irreversibly incompetent. Thus it seems that Kant might be harmed or wronged at this moment and therefore he has moral status. Consequently if "death" in its fundamental sense means "irreversible loss of moral status," it follows that Kant is still alive, even though he has been biologically dead since 12 February, 1804. This is clearly absurd.

At first glance, such bizarre consequences argue for the immediate rejection of a concept which identifies death with the irreversible loss of a patient's moral standing. Nevertheless, I believe that in fact they stem from some kind of misconception. Before anyone can dismiss such a concept of death, they should consider first the implications for the very concept of moral status which are brought about by Nair-Collins' cases. How should we understand that the possibility of violating Kant's incompetence-surviving investment interests at this moment proves that he has moral status? Does it mean that *at the moment* Kant has moral status? If we answer "yes" to that question then how would we settle our doubts concerning the location of the subject to whom we assign this moral status? Is he identical to the remains of Kant which are buried in Königsberg Cathedral? And what if someone slanders Kant a million years from now, when there will be no remains but only the molecules which once constituted his body dispersed around the world? In such circumstances, would slandering Kant be harmful for these molecules? If one admits that incompetence-surviving investment interests are sufficient grounds to assign moral status to brain-dead bodies, as Nair-Collins does, then the same perfectly moral status should be assigned to Kant's remains at the moment, as well as to the dispersed molecules million years later.

Such consequences are troublesome, especially if we bear in mind the particular kind of incompetence-surviving interests on which Nair-Collins focuses most of his attention. Along the lines of one of his cases (Nair-Collins, 2017, p. 538) one might imagine that Consuela, a woman who highly values her autonomy and right to self-determination, has an interest in *having a say* about what happens to her at the end of her life as well as after her biological death. For such a person, any interference with her body, either at the end of her life or after her biological death,

would constitute harm as long as she had not consented for it personally or through a representative making decisions on her behalf. Without Consuela's valid consent (either prospective or surrogate) it would be equally harmful to cremate her body the week after her biological death, as well as erecting a building a million years later in the place occupied by the molecules that once were a part of her body. Thus, it seems that all dead people who valued their autonomy in the same way as Consuela should have eternal representatives deciding forever on their behalf in accordance with the substituted judgement standard.<sup>7</sup> While making these kinds of decisions might make sense when it comes to issues associated with end-of-life care or even alternative forms of burial, the very notion of the institution of an eternal surrogate decision maker is utopian in the extreme.

The concept of moral status that is implicit in Nair-Collins' article evidently has absurd consequences and involves unlimited moral obligations towards the dead. Its author understands it well and tries to defend it by assuming that incompetence-surviving interests do not count in utilitarian calculus in the same manner as other preferences do, such as "to have a life-threatening disease cured which is easy to treat." The proper way to account for incompetence-surviving investment interests is grounded in respect for persons, which as Nair-Collins states is "largely (though not entirely) a negative obligation, an obligation to avoid interfering, insofar as otherwise morally permitted, in the important choices of other people's lives" (Nair-Collins, 2017, p. 550). Acknowledging that obligations derived from incompetence-surviving investment interests have such a character is supposed to protect the living against the absurd claims of the dead. It seems, however, that this does not work as intended, given that in my version of Consuela's case we are dealing only with a negative duty of non-interference, and yet we still have to struggle with the absurd claims of the dead.

To sum up my discussion of Nair-Collins' argument, I would like to emphasize that his conception is associated with two difficulties. First, on its basis, human remains and even the molecules which once constituted part of the human body are the direct "bearers" of moral status, and *they* might be harmed if one's conduct does not cohere with the incompetence-surviving investment interests. Second, incompetence-surviving investment interests might be a source of unlimited and absurd obligations on the part of the living, even if such interests determine mainly negative obligations forbidding interference without consent.

The problems faced by Nair-Collins might perhaps be solved in several different ways. The path leading to the solution which I prefer can be found, for example, in Kant's writings. He considers the case of posthumous slander as follows:

Someone who, a hundred years from now, falsely repeats something evil about me injures me right now; for in a relation purely of rights, which is entirely intellectual, abstraction is made from any physical conditions (of time), and whoever robs me of my honor (a slanderer) is just as punishable as if he had done it during my lifetime - punishable, however, not by a criminal court but only by public opinion, which, in accordance with the right of retribution, inflicts on him the same loss of the honor he diminished in another (Kant, 1991, p. 296).

In the aforementioned quotation, several things are worthy of our attention. At first glance it is striking that harm in Kant's account is atemporal in character. Yet, the other issue is more important: posthumous harm is bad *for particular persons* in an atemporal sense, or it is bad for them retrospectively, that is, despite the fact that it happened after death, it is bad at the time when the persons were still alive (speaking otherwise, the future has an influence on the past, contrary to the

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<sup>7</sup> For more about substituted judgment standard see Beauchamp and Childress (2001, pp. 99–100).

usual understanding of causal links). Harms of this kind are not bad for the remains, which are not persons in the Kantian sense. Even if Kant's interest in not being ever slandered is capable of persisting through his irreversible loss of competence, and therefore slander at the moment is bad for *him*, it does not mean that Kant's *remains* have a moral status. Moral status, I repeat, is held by entities which possess the properties which cause them to have morally relevant interests. Kant's remains cannot have either the capability of being sentient or the ability to desire, they are neither rational nor conscious, nor do they have the ability to communicate or enter into social relationships. In short, they do not have any property that can be considered to be the determinant of moral status. The last one, however, is possessed by Kant himself who had the ability, among others, to desire certain things. It is precisely on these desires that his investment interests might be grounded, including those which are able to persist through incompetence. If Kant, when he was competent, had a desire to have a say on what happens to him at the end of his life, as well as after his biological death, and then the desire became the basis for his incompetence-surviving investment interest, in such circumstances we really have some sort of obligation towards his remains. Still, it is not derived from the properties of these remains, but is based on the desires formulated by Kant in the past. In other words, our duties towards remains are only indirect, and in this respect are similar to the duties that we have towards the things which are owned by other living people. The mere fact that I have a duty not to repaint your car without your permission does not mean that your car has a moral status. I would not have such a duty if this car did not belong to you or to anyone else, or if you allowed me to repaint it. However, if this car is yours and I repaint it without your permission, then there is something wrong with what I do, although I do not violate the direct duties towards you.

Let me briefly summarize what I am trying to say here: our obligations might bind us directly or indirectly; direct obligations are those which we have towards subjects of moral status, whereas indirect obligations are towards things which themselves are deprived of morally relevant interests. Nevertheless, some behavior which affects these things might still be good or bad for beings which have moral status (Galewicz, 2013, p. 13; Warren, 1997, p. 439).

We shall now return to the problem of brain-dead patients. These patients, just as is the case with Kant's remains, do not have any properties which could constitute criteria for moral status. The only thing that distinguishes them from the remains is the fact that they are biologically alive, and this on its own, as Nair-Collins realizes, does not make a morally sound difference (Nair-Collins, 2017, p. 550). The concept of death, which identifies the end of human life with the irreversible loss of moral status, provides sufficient reasons for considering them dead in the fundamental sense. We have no direct obligations towards brain-dead human bodies, yet it obviously does not mean that we can completely ignore our indirect obligations. The latter are derived precisely from the incompetence-surviving investment interests which are based on the desires of once living (in the ethical sense) people. Analogically, the fact that we have no direct obligations towards our neighbor's car does not mean that we can treat it as we please, for example by breaking in to it when we want to go on a summer ride. Nonetheless, I believe that the obligations which we have directly towards beings of moral standing are usually stronger than these which have only an indirect character.<sup>8</sup> For example, if I break into my neighbor's car to bring my dying son to the hospital, my action is more justified

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<sup>8</sup> This belief might be justified by an appeal to Korsgaard's (1983) distinction of conditional and unconditional value. Taking into account her idea, it might be said that only the subjects of moral status have an intrinsic value, which means that only they are valuable unconditionally as "objective value conferrers". They have a capability of conferring value to the things which are external to them, making them objectively good and worthy of promotion or protection by other moral agents. The fact that subjects of moral status are the source of objective values might explain why we should usually care more about them. However, I will not pursue this issue further here.

than if I force the neighbor to “donate” his blood which I use for a life-saving transfusion. My obligations towards other people’s property might be easier to overcome than the direct obligations towards them, especially when rescuing someone’s life or health is at stake. From such a perspective, the practice of organ retrieval from brain-dead donors that is based on an opt-out system seems legitimate. Such a policy might be perceived as a compromise based on the appropriate weighting of indirect obligations towards brain-dead bodies and direct commitments towards people awaiting a transplant. The obligations towards brain-dead bodies due to their indirect character are of lesser importance than the interests of the living to be rescued from death.

### **Conclusion**

For the sake of all the practical decisions that are made in everyday life, it is of great importance whether they concern the living or the dead. Facing someone’s premature death, we are overwhelmed with grief, and death is seen as bad for the person who has died. When we think of our death, it frightens us a lot or, on the contrary, we look forward to it, believing that it will let us escape a misery foreseen. Almost never is death something which is indifferent for us. The dead are not cared for by physicians, unlike the living. We believe that the dead cannot be helped anyhow (only humans in an atemporal sense might be helped if we pursue their will, but we cannot help the dead, that is we cannot help the body which presently constitutes the remains of a once living person). Death is also traditionally a moment which is appropriate to begin mourning. In all these contexts it is clearly visible that “death” has value-laden meaning which completely does not fit the biological understanding of this notion. Let me recall here that through “biological death” Nair-Collins understands “irreversible cessation of the organismic capacity to maintain homeostasis of the extracellular fluid and thereby resist entropy” (Nair-Collins, 2018, p. 33). This scientific notion of death is, I think, totally incomprehensible for the average language user, who has no basic knowledge of statistical mechanics or knows what entropy is. Bearing in mind that the fundamental meaning of “death” is ethical, it seems quite appropriate to retrieve the organs from brain-dead donors on the basis of their consent (or lack of objection) for “the deceased organ donation” instead of the consent (or lack of objection) for “organ donation causing the biological death”. The second policy might trigger conceptual confusion, not only because of the fact that in this case the meaning associated with the attribute “biological” is incomprehensible, but also because the combination of the words “biological” and “death” creates a peculiar kind of oxymoron. The word “death” carries a strong ethical load, while the term “biological” eliminates this charge, pointing attention to the fact that we are supposed to deal here with a concept from the natural sciences, and natural sciences are not interested in morals.

In closing, I would like to point out that I limited myself in this article to presenting an argument advancing the thesis that organ retrieval after brain death really occurs after the donor’s death, therefore people who consent or do not object to deceased organ donation are not exploited if the retrieval actually takes place. I was not concerned here, however, with the issue of the legitimacy of the dead donor rule or with answering the question of whether organs for transplantation should be retrieved only after the natural death of the patient. The only thing which I stated was that natural death (accompanied by consent or lack of objection) is a sufficient condition for the permissibility of organ retrieval. Notwithstanding, it might be right to retrieve organs from dying patients if it is done at their request and if the organ retrieval does not inflict any harm on them. The experience of DCD protocols seems to support such a policy. DCD protocols were intended to utilize additional sources of organs for transplantation while simultaneously respecting the dead donor rule. However, organ retrieval under such circumstances is associated with the risk of harming the dying patient and does not guarantee that the dead donor rule will not be infringed on (Marquis, 2010; Miller & Truog,

2012, pp. 97–112; Nowak, 2018a; Nowak, 2018b; Truog, 2016; Wilkinson & Savulescu, 2012, pp. 45–46).

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### References

- AMERICAN MEDICAL ASSOCIATION (2015): *Code of medical ethics of the American medical association*. Chicago: American Medical Association.
- BEAUCHAMP, T. L. & CHILDRESS, J. F. (2001): *Principles of Biomedical Ethics*. Oxford & New York: Oxford University Press.
- BERNAT, J. (2013): Life or death for the dead-donor rule? In: *The New England Journal of Medicine*, 369(14), pp. 1289–1291.
- DAVIES, J. K. (2007): Precedent autonomy, advance directives, and end-of-life care. In: B. Steinbock (ed.): *The Oxford handbook of ethics*. New York: Oxford University Press, pp. 349–374.
- DE TOMASO, M., NAVARRO, J., RICCI, K., LORENZO, M., LANZILLOTTI, C., COLONNA, F., RESTA, M., LANCIONI, G. & LIVREA, P. (2013): Pain in prolonged disorders of consciousness: Laser evoked potentials findings in patients with vegetative and minimally conscious states. In: *Brain Injury*, 27(7–8), pp. 962–972.
- DWORKIN, R. (1994): *Life’s dominion: An argument about abortion, euthanasia, and individual freedom*. New York: Vintage Books.
- FEINBERG, J. (1986): *The moral limits of the criminal law, vol. 1: Harm to others*. New York: Oxford University Press.
- FERNÁNDEZ-ESPEJO, D. & OWEN, A. M. (2013): Detecting awareness after severe brain injury. In: *Nature reviews neuroscience*, 14, pp. 801–809.
- GALEWICZ, W. (2013): *Status ludzkiego zarodka a etyka badań biomedycznych [The status of the human embryo and the ethics of the biomedical research]*. Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego.
- JAWORSKA, A. & TANNENBAUM, J. (2018): The Grounds of Moral Status. In: E. N. Zalta (ed.): *The Stanford encyclopedia of philosophy* (Spring 2018 Edition), [online] [Retrieved September 9, 2018]. Available at: <https://plato.stanford.edu/entries/grounds-moral-status/>.
- KANT, I. (1991): *The metaphysics of morals*, transl. Mary Gregor. New York, Port Chester, Melbourne & Sydney: Cambridge University Press.
- KORSGAARD, Ch. (1983): Two distinctions in goodness. In: *The Philosophical Review*, 92(2), pp. 169–195.
- LI, D., HAWLEY, Z. & SCHINER, K. (2013): Increasing organ donation via changes in the default choice or allocation rule. In: *Journal of Health Economics*, 32(6), pp. 1117–1129.
- LIZZA, J. P. (2006): *Persons, humanity, and the definition of death*. Baltimore: The John Hopkins University Press.
- MAGNUS, D. C., WILFOND, B. S. & CAPLAN, A. L. (2014): Accepting Brain Death. In: *The New England Journal of Medicine*, 370(10), pp. 891–894.
- MARQUIS, D. (2010): Are DCD donors dead? In: *The Hastings Center Report*, 40(3), pp. 24–31.
- MCMAHAN, J. (2002): *The ethics of killing: Problems at the margins of life*. Oxford & New York: Oxford University Press.



- MILLER, F. & TRUOG, R. (2012): *Death, dying, and organ transplantation*. Oxford & New York: Oxford University Press.
- MONTI, M. M., VANHAUDENHUYSE, A., COLEMAN, M. R., BOLY, M., PICKARD, J. D., TSHIBANDA, L., OWEN, A. M. & LAUREYS, S. (2010): Willful modulation of brain activity in disorders of consciousness. In: *New England Journal of Medicine*, 362(7), pp. 578–589.
- NAGEL, T. (1970): Death. In: *Noûs*, 4(1), pp. 73–80.
- NAIR-COLLINS, M. (2017): Can the brain-dead be harmed or wronged?: On the moral status of brain death and its implications for organ transplantation. In: *Kennedy Institute of Ethics Journal*, 27(4), pp. 525–559.
- NAIR-COLLINS, M. (2018): A biological theory of death: Characterization, justification, and implications. In: *Diametros*, 55, pp. 27–43.
- NAIR-COLLINS M., GREEN, S. R. & SUTIN, A. R. (2015): Abandoning the dead donor rule? A national survey of public views on death and organ donation. In: *Journal of Medical Ethics*, 41(4), pp. 297–302.
- NOWAK, P. G. (2016): Umiarkowanie liberalna koncepcja śmierci jako uzasadnienie dla neurologicznych kryteriów śmierci [The moderately liberal concept of death as a basis for neurological criteria of death]. In: *Przegląd Filozoficzny – Nowa Seria* [Philosophical Review – New Series], 25(2), pp. 200–211.
- NOWAK, P. G. (2018a): Pobieranie narządów po zatrzymaniu krążenia. O nadrzędności neurologicznego kryterium śmierci nad krążeniowym – kwestie regulacyjne [Donation after circulatory determination of death: About the precedence of neurological criterion of death over circulatory criterion – regulatory issues]. In: *Analiza i egzystencja* [Analysis and existence], 42, pp. 35–53.
- NOWAK, P. G. (2018b): Pobieranie narządów po zatrzymaniu krążenia. O nadrzędności neurologicznego kryterium śmierci nad krążeniowym – kwestie filozoficzne [Donation after circulatory determination of death: About the precedence of neurological criterion of death over circulatory criterion – philosophical issues]. In: *Analiza i Egzystencja* [Analysis and existence], 42, pp. 55–71.
- OWEN, A. M., COLEMAN, M. R., DAVIS, M. H., BOLY, M., LAUREYS, S. & PICKARD, J. D. (2006): Detecting awareness in the vegetative state. In: *Science*, 313(5792), p. 1402.
- POLISH MEDICAL CODE OF ETHICS [online] [Retrieved August 29, 2018]. Available at: [http://www.nil.org.pl/\\_data/assets/pdf\\_file/0003/4764/Kodeks-Etyki-Lekarskiej.pdf](http://www.nil.org.pl/_data/assets/pdf_file/0003/4764/Kodeks-Etyki-Lekarskiej.pdf)
- POSNER, J. B., SAPER, C. B., SCHIFF, N. D. & PLUM, F. (2007): *Plum and Posner's Diagnosis of Stupor and Coma*. Oxford & New York: Oxford University Press.
- REGAN, T. (1983/2004): *The case for animal rights*. Berkeley: University of California Press.
- RITHALIA, A., MCDAID, C., SUEKARRAN, S., LINDSEY, M. & SOWDEN, A. (2009): Impact of presumed consent for organ donation on donation rates: a systematic review. In: *BMJ*, 338, p. a3162.
- SHEWMON, A. D. (1998): Chronic “brain death”: Meta-analysis and conceptual consequences. In: *Neurology*, 51(6), pp. 1538–1545.
- SILVER, D. (2003): Lethal injection, autonomy and the proper ends of medicine. In: *Bioethics*, 17(2), pp. 205–211.
- SINGER, P. (1994): *Rethinking life and death: The collapse of our traditional ethics*. New York: St. Martin's Press.
- SINGER, P. (2018): The challenge of brain death for the sanctity of life ethic. In: *Ethics & Bioethics (in Central Europe)*, 8(3–4), pp. 153–165.

- TRUOG, R. (2016): The price of our illusions and myths about the dead donor rule. In: *Journal of Medical Ethics*, 42(5), pp. 318–319.
- VEATCH, R. M. (2003): The dead donor rule: True by definition. In: *The American Journal of Bioethics*, 3(1), pp. 10–11.
- VEATCH, R. M. (2015): Killing by organ procurement: Brain-based death and legal fictions. In: *Journal of Medicine and Philosophy*, 40(3), pp. 289–311.
- VEATCH, R. M. & ROSS, L. F. (2015): *Transplantation ethics*. Washington, D. C.: Georgetown University Press.
- WARREN, A. M. (1973): On the moral and legal status of abortion. In: *The Monist*, 57(1), pp. 43–61.
- WARREN, A. M. (1997): Moral status. In: R. G. Frey & Ch. H. Wellman (eds.): *A Companion to applied ethics*. Malden, MA: Blackwell, pp. 439–450.
- WILKINSON, T. M. (2011): *Ethics and the acquisition of organs*. Oxford & New York: Oxford University Press.
- WILKINSON, T. M. & SAVULESCU, J. (2012): Should we allow organ donation euthanasia? Alternatives for maximizing the number and quality of organs for transplantation. In: *Bioethics*, 26(1), pp. 32–48.
- YU, T., LANG, S., VOGEL, D., MARKL A., MÜLLER, F. & KOTCHOUBEY, B. (2013): Patients with unresponsive wakefulness syndrome respond to the pain cries of other people. In: *Neurology*, 80(4), pp. 345–352.
- ŻURADZKI, T. (2011): Rola świadomości w decyzjach dotyczących zaprzestania podtrzymywania funkcji życiowych [The role of consciousness in the end-of-life decisions]. In: *Rocznik kognitywistyczny [Yearbook of cognitive science]*, 5, pp. 191–198.

## In defense of a pluralistic policy on the determination of death

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### Abstract

In his paper “The challenge of brain death for the sanctity of life ethic”, Peter Singer advocates two options for dealing with death criteria in a way that is compatible with efficient organ transplantation policy. He suggests that we should either (a) redefine death as cortical death or (b) go back to the old cardiopulmonary criterion and scrap the Dead Donor Rule. We welcome Singer’s line of argument but raise some concerns about the practicability of the two alternatives advocated by him. We propose adding a third alternative that also – as the two previous alternatives – preserves and extends the possibility of organ transplantation without using anyone without their consent. Namely, we would like to draw readers’ attention to a proposal by Robert Veatch, formulated 42 years ago in his 1976 book “Death, dying, and the biological revolution” and developed further in his later publications. Veatch argues for a conscience clause for the definition of death that would permit people to pick from a reasonable range of definitional options. This autonomy-based option, we believe, is more likely to be practicable than the two options advocated by Singer. Furthermore, we present data from a study with Lithuanian participants that suggest that there is quite pronounced variation of preferences concerning death determination.

**Keywords:** death, death determination, dead donor rule, organ transplantation

### Introduction

In his paper “The Challenge of Brain Death for the Sanctity of Life Ethic”, Peter Singer presents – in his usual clear and straightforward manner – an updated version of the views he defended more than twenty years ago in his bold book *Rethinking life and death* (Singer, 1995). Although the claims Singer defends are the same, he has updated his exposition by adding some recent cases and by utilizing arguments and conceptions that were not around at the time the book was published. The main thrust of Singer’s argument is that provided that the whole brain death criterion of death is philosophically indefensible and provided that it is important to have an efficient organ transplantation policy we should either (a) redefine death as irreversible loss of consciousness or alternatively (b) go back to the good old cardiopulmonary criterion and scrap the Dead Donor Rule (DDR), i.e., we need to allow taking organs from people who have irreversibly lost consciousness and have agreed to donate organs in such a condition. We agree with Singer’s objections to the whole-brain death criterion. We think, however, that Singer’s conclusion neither covers all available options nor is practicable.

Let us, first, clarify why we think that Singer’s position is impracticable. No doubt, Singer himself is aware of that. After presenting his arguments against DDR, Singer admits that “the most troubling objection” against his position is a “practical one: no matter how logically compelling the proposal may be, it is so out of touch with political reality that it stands no chance of success” (Singer, 2018, p. 163).<sup>3</sup> We believe that the same objection applies to the other horn of Singer’s dilemma as the so-called higher brain criterion of death seems to be as controversial

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<sup>3</sup> But see empirical study by Nair-Collins, Green, and Sutin (2014, p. 297): “There appears to be public support for organ donation in a scenario explicitly described as violating the dead donor rule.”

as rejection of DDR. Its acceptance – at least in McMahan’s version that Singer uses in his paper – relies on the claim that we essentially are entities with the capacity of consciousness, i.e., minds and not organisms (McMahan, 2012, p. 295).<sup>4</sup> Therefore, we cease to exist as soon as we irreversibly lose the capacity for consciousness and the fact that our organism still functions, i.e., is still alive, is not relevant as far as our death is concerned. But these are highly controversial claims that many people would find rather strange. Moreover, the view has its own philosophical problems as well.<sup>5</sup>

Before we move forward, it is interesting to note, that, while formulated as a disjunction, Singer’s conclusion most probably might appeal to the same arguably narrow demographic. The reason for that is quite simple. Suppose you agree (with McMahan and others) that death is irreversible loss of consciousness or in other words, you accept the claim (a) in Singer’s conclusion. What would you say about the disjunct (b)? Now, if you think that you are dead as soon as you have irreversibly lost consciousness and you have agreed to donate your organs after death, then it turns out that you might accept (b) as well, because (b) states that it is acceptable to harvest organs before cardiopulmonary death. In this case, exactly this happens if organs are harvested after your consciousness is irreversibly lost and you have already agreed to that under (a). Further, after your vital organs are removed you will be dead according to the cardiopulmonary criterion of death which is the criterion of death in (b). And the same move might work in the opposite direction as well. Suppose you believe that you are dead only when your heart stops beating and breathing stops and you also think, that it is acceptable to harvest your organs as soon as irreversible loss of consciousness is diagnosed. What would you think about option (a)? It seems that after giving it some thought you wouldn’t find anything wrong with (a). Of course, according to our hypothesis, you don’t believe that irreversible loss of consciousness means death, but as soon as you agree that your vital organs can be harvested when you are in this condition, what difference does it make? Besides, as soon as your organs are taken you will be dead according to the criterion which you believe to be right. To summarize, if you agree to (a) then you most probably will not object to (b) and *vice versa*. In other words, there seems to be no substantial disagreement between holders of either position. Singer himself admits that both views (a) and (b) have “the same practical outcome” (Singer, 2018, p. 163). Our point is that, unfortunately for Singer, it seems that both views most probably will appeal to the same – arguably narrow – population.

Now, what are our options if brain death criterion is indefensible and Singer’s proposal impracticable? We believe that there are no scientific facts that would dissolve disagreements between those who hold different beliefs about death. The differences between those who, for example, hold a conception of whole brain death and those who embrace higher brain criterion are metaphysical and moral rather than scientific. If that is the case, then there are no good reasons to expect a wide consensus on the issue and the only viable option is to embrace pluralism, i.e., the view that reasonable people may have different conceptions of what does it mean to be dead. Pluralism about this issue has been proposed by several authors (e.g. Miles, 1999, Engelhardt, 1999), however from our point of view the most elaborate and strongest formulation is that of Robert Veatch and Lainie Ross (Veatch & Ross, 2016).<sup>6</sup> We believe that a

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<sup>4</sup> A similar version of higher brain criterion is defended by W. Glannon (2007, pp. 156–170).

<sup>5</sup> See e.g., DeGrazia (2005, pp. 124–141).

<sup>6</sup> The position was originally developed by R. Veatch (see Veatch, 1976; Veatch, 1999). Chapter 6 in Veatch & Ross (2016) is an updated version of Veatch (1999). For this reason, further in the text this view will be associated mostly with Veatch.

view along the lines defended by Veatch and Ross can attain the aim that Singer is after in his paper (i.e., it is compatible with efficient organ transplantation policy) without the shortcomings of Singer's proposal as it stands a better chance to be accepted as a policy.

Veatch has been famous for his defense of the higher brain criterion of death.<sup>7</sup> However, he is well aware that whatever the philosophical merits of higher brain conception of death, one cannot reasonably expect that it will be widely accepted view on death in the current society. But the same applies to both alternatives defended by various authors in biomedical literature – whole-brain death and cardiopulmonary death. Although the whole-brain criterion of death is legally supported in many countries around the world, there are a considerable number of people who still don't share it. Either because they (together with, for example, orthodox Jews or Shintoists in Japan) incline towards the cardiopulmonary conception of death or because as Veatch, McMahan and others they think that the higher brain conception of death is a conceptually more plausible candidate for the role. Provided that there are no good reasons to expect that these different groups will reach a consensus on the issue, the only practicable solution, according to Veatch, is to tolerate the differences and to allow different groups to act on their opinions. Therefore, Veatch suggests that persons while competent should be free within reason to choose the criteria under which they should be considered dead. As there is an indefinite number of theoretically possible conceptions of death, Veatch argues that people should be offered to choose from the three plausible accounts mentioned above, i.e., cardiopulmonary, whole-brain and higher brain. Further, since for different reasons not everyone will make an explicit choice among the offered concepts of death, there must be a default position on death, so that is clear for, e.g., doctors how to proceed in such cases. Veatch proposes that the best candidate for that role is the whole-brain conception. Moreover, in some cases where patients have not made their view on death clear while competent, the decision within certain limits should be made by the next of kin as it is already done in other similar situations.

The same or essentially similar view has been endorsed by other authors as well. For example, individual choice about the definition of death has been defended by Alireza Bagheri (Bagheri, 2007). Bagheri examines the then current Japanese law that in certain situations allow patients to choose between cardiopulmonary and whole-brain death, but this only is permitted for potential organ donors and besides, the choice must be accepted by the members of a family. Bagheri endorses Veatch's view and stresses the importance of respect for the patient's autonomy. Although Bagheri considers only two conceptions of death in the paper (cardiopulmonary and whole-brain) he is open to other candidates as well.<sup>8</sup> A similar position has also been advanced by Sass (Sass, 1992). Like Veatch, he also argues that patients should be able to make the choice between the three conceptions of death with whole-brain death as the default view. But he differs in his view on proxy decision making. According to Sass, proxy decision making about the conception of death should be accepted only in cases of parents deciding about their minor children. Linda Emanuel in her 1995 paper (Emanuel, 1995) argues for what she calls the asymptotic model of death that recommends a bounded zone approach to life cessation. Emanuel rejects the traditional model according to which life and death are poles in binary opposition. This model, she thinks, should be modified. Emanuel suggests that we should think about death as a gradual process that can be depicted more like an asymptotic curve. Accordingly, each of the three mentioned conceptions of death should be considered as three different points on this curve. The continuum between irreversible loss of consciousness and irreversible cessation of

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<sup>7</sup> See e.g. Veatch (1993).

<sup>8</sup> For further discussion of Japanese law see Kato (2013).

pulmonary and cardiac function constitutes what Emanuel calls the zone of life cessation (Emanuel, 1995, p. 32). Emanuel points out that no position within the zone can lay claim to absolute correctness. Therefore, although starting from different conceptual considerations her conclusion is practically the same as the one proposed by Veatch, i.e., that within the provided limits we should tolerate personal differences on this issue.

Do we have evidence that such personal differences are widespread? It is important to study public attitudes to learn about this. In general, there seems to be much public misunderstanding of the medical facts as well as legal realities. As indicated in a recent literature review, “the existing data on public attitudes regarding brain death and organ transplantation reflect substantial public confusion” (Shah et al., 2015, p. 291). However, there seems to be quite consistent public support for DDR (see DuBois and Anderson 2006 for a review), even though some studies have registered divergences from the rule (Nair-Collins et al., 2014). Another important tendency registered in the literature is that it seems that in research conducted in Japan and China (see Yang & Miller 2015, p. 216 for a brief overview) a strongly pronounced preference for the cardiopulmonary understanding of death can be observed. However, to the best of our knowledge, there are no studies that allow study participants to choose their preference from a wide set of answers that refer to different stages in the process of dying. In order to provide some preliminary data on these issues we’ve conducted a study.

### Study

**Participants.** 160 Lithuanian participants completed an online survey (63% females, 33% males, 3% chose ‘other / prefer not to answer’, 1% did not indicate their answer; mean age: 30.7; age SD = 8.26; age range 18–60, 3% did not indicate their answer).

**Materials and procedure.** After providing consent, participants read the following possible description of the process of dying, divided into stages:

(1) The patient had a fever and headaches for 3 days. The patient cannot tolerate bright light or noises. The patient is nauseated, and when he moves too fast he has vertigo. The doctor stuck a needle into the patient’s back to get some of the fluid in his brain and the results came back indicating inflammation. The doctor diagnosed meningitis.

(2) The patient has been in hospital for 3 days. First, in the Neurology unit, but after a day he was transferred to the Intensive care unit. Patient’s memories of the recent past are fragmented, he has intense hallucinations. Medication is used to calm him down. In the ICU he is asleep most of the time. When he opens his eyes he cannot recognize the relatives. Sometimes when awake he mumbles random words or screams.

(3) The patient’s state deteriorated rapidly. His brain herniated. Due to that the cerebral cortex of the brain stopped functioning. The patient is still breathing on his own and his heart is beating, but he cannot feel anything or make himself move. Consciousness has been irrevocably lost. The patient does not react to any attempts to talk to him. However, the patient responds to some stimuli: when the neurologist poured some ice-cold water into the patient’s ears and looked for his eyes to move, they did move. The patient has been in this state for two weeks.

(4) The patient’s brain stopped functioning. The patient is intubated and breathing is done by mechanical lung ventilator. If removed from it, the patient would not be able to breath. The heart is beating, but medication is needed to sustain it. The patient does not move and does not feel anything. The patient no longer reacts to painful stimuli but some

very basic reflexes remain: when the neurologist hits the knee with a little rubber hammer, the leg moves. The patient has been in this state for two weeks.

(5) The patient's heart stopped and the patient was disconnected from the ventilator. The patient is not breathing; the body temperature starts to drop below 36<sup>0</sup>C. The skin is becoming cold and grey. The patient is not responsive to any stimuli whatsoever.

(6) After a day, the body is cold and stiff. The temperature is the same as room temperature. The blood in blood vessels has pooled in the lower parts of the body due to gravity. The abdomen is distended because guts are starting to decay due to bacteria there.

Stage 3 was designed to reflect the higher brain criterion of death, Stage 4 – whole-brain death, Stage 5 – cardiopulmonary criterion. This 6-stage description was always available for participants at the bottom of each page with questions.

On the next page some additional background information was provided in order to make the study task more intelligible to the participants:

In different countries of the world, different criteria for the determination of death are used. For example, in some countries, death is declared after full brain death, while in others – when the heart no longer beats. In some countries, people have the right to choose what criterion will be applied to them or to their relatives.

The next two pages contained questions on preferences for determining death. One concerning the self and the other concerning a close relative. The order of presentation of these two questions was randomized and participants were not allowed to come back to the previous page to change their responses.

Question about the self read as follows:

Try to think about your own preferences concerning your death. Suppose that you also can end up in a situation that resembles the one described. (If you want to refresh your memory, description of the process of dying is repeated at the bottom of this page.) Please indicate the stage of the process of dying at which you would prefer your own death to be stated and all medical procedures stopped.

While the question about relatives read:

Try to think about your preferences concerning the death of your closest relatives. Suppose that a close relative of yours can end up in a situation that resembles the one described. (If you want to refresh your memory, description of the process of dying is repeated at the bottom of this page.) Please indicate the stage of the process of dying at which you would prefer the death of your relative to be stated and all medical procedures stopped.

For both questions, participants had to choose the stage as numbered in the description of the process of dying.

After answering questions about death determination, some additional background was provided on the next page concerning organ procurement for donation.

The time at which death is determined is also very important in the context of organ donation, since organs are suitable for transplantation only when they are not damaged. Most frequently, organs are procured for donation after the complete death of the brain (Stage 4 in the description of the process of dying), but sometimes a medical professional wait till the heart stops beating (Stage 5), but in such a case it is necessary to procure the organs no later than five minutes after the heart stops beating.

The next two pages contained questions on preferences for organ procurement. One concerning the self and the other concerning a close relative. The order of presentation of these two questions was randomized and participants were not allowed to come back to the previous page to change their responses.

The question about the self read:

Try to think about your own preferences concerning organ donation. Suppose that you also can end up in a situation that resembles the one described. (If you want to refresh your memory, description of the process of dying is repeated at the bottom of this page.) Please indicate the stage of the process of dying at which you would prefer your organs to be procured for transplantation.

While the question about the relative read:

Suppose that a close relative of yours can end up in a situation that resembles the one described. (If you want to refresh your memory, description of the process of dying is repeated at the bottom of this page.) Please also suppose that your close relative expressed a wish to become an organ donor after they die. Please indicate the stage of the process of dying at which you would prefer the organs of your close relative to be procured for transplantation.

For both questions, participants had to choose a stage as numbered in the description of the process of dying. They were also allowed to choose an additional option; “I would not agree to organ donation in such case”. Participants then provided information on their gender and age and were thanked for participation.

**Results.** Since our measures asked to indicate the stages in the process of dying presented in a temporal order, we treat our data as answers on ordinal scale, and thus run non-parametric tests.

**Death determination, the main analysis.** The Mann-Whitney U test was performed in order to test for order effects. No differences in ranks were observed in either responses to the first person scenario ( $U = 3148.0$ ,  $p = .855$ ,  $r = .01$ ) or the scenario about the relative ( $U = 2964.5$ ,  $p = .388$ ,  $r = .07$ ). Thus, all participants were pooled for related samples analysis.

Preferences are displayed in Table 1:

Stages	First-person		Relative	
	<i>n</i>	%	<i>n</i>	%
1	0	0 %	0	0 %
2	4	2.5 %	0	0 %
3	48	30.0%	22	13.8%
4	72	45.0%	76	47.5%
5	30	18.8%	53	33.1%
6	6	3.8 %	9	5.6 %

Table 1. Preferences of participants concerning stages of the dying process in which their death and the death of their relatives should be stated (N=160). *n* indicates the number of participants choosing a given stage and % indicates the percent of participants choosing a given stage. Percentages may not add up to 100 due to rounding,

In both cases, the top 3 most frequently chosen stages were 3, 4, and 5, with 4 being the most frequent (45% in first-person question and 47.5 % in relative question).



Looking in more detail, out of 160 participants, 55 (34%) chose the later stage for determining a relative's death than their own death while only 3 (2%) chose the earlier stage for themselves. The remaining 102 (64%) preferred the same stage for both cases. A Wilcoxon Signed-ranks test indicated that participants were more often willing to choose a later stage for relatives than for themselves,  $Z = 6.29$ ,  $p < .001$ ,  $PS_{dep} = .34$ . Here and later in the paper we use the probability of superiority estimation for dependent groups ( $PS_{dep}$ ) as a measure of effect size for Wilcoxon Signed-ranks tests (as recommended by Grissom & Kim, 2014, pp. 114–115).  $PS_{dep} = .34$  means that there is a 34% probability that within a randomly sampled pair of responses, the score for the relative will be higher than the score for self.

**Additional analyses.** For subsequent analyses that involve decisions concerning transplantation, 6 participants were removed since they chose “I would not agree to organ donation in such a case” as an answer to at least one transplantation question (2 were opposed in first-person case; 2 – in the relative's case; 2 – in both). The reason for their exclusion is that leaving them in would not allow answers to be treated as choices on an ordinal scale anymore.

Remaining participants (N=154) exhibit the following pattern (Table 2):

Stages	Death determination				Organ removal for transplantation			
	First-person		Relative		First-person		Relative	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
1	0	0 %	0	0 %	0	0 %	0	0 %
2	4	2.6 %	0	0 %	3	1.9 %	0	0 %
3	47	30.5%	22	14.3 %	37	24.0%	20	13.0%
4	70	45.5%	73	47.4 %	93	60.4%	99	64.3%
5	27	17.5%	51	33.1 %	20	13.0%	34	22.1%
6	6	3.9 %	8	5.2 %	1	0.6 %	1	0.6 %

Table 2. Preferences of participants concerning stages of the dying process in which their death and the death of their relatives should be stated and in which theirs and their relatives' organs can be taken for transplantation (N=154). *n* indicates the number of participants choosing a given stage and % indicates the percent of participants choosing a given stage. Percentages may not add up to 100 due to rounding,

In all four cases, the top 3 most frequently chosen stages were 3, 4, and 5, with 4 (full-brain death) being the most frequent (45.5% in first-person question, 47.4 % in the relative's question, 60.4 % in transplantation first-person case and 64.3% in transplantation relative case).

**Death determination.** Out of 154 participants, 53 (34%) chose the later stage for determining the relative's death than their own death while only 2 (1%) chose the later stage for themselves than for their relatives. The remaining 99 (64%) preferred the same stage for both cases. A Wilcoxon Signed-ranks test indicated that participants were more often willing to choose a later stage for relatives than for themselves,  $Z = 6.31$ ,  $p < .001$ ,  $PS_{dep} = .34$ . Results are nearly identical to those achieved in the full sample before 6 participants were removed.

**Transplantation.** Out of 154 participants, 37 (24%) chose a later stage for harvesting a relative's organs than their own while only 2 (1%) chose a later stage for themselves. The remaining 115 (75%) preferred the same stage for both cases. A Wilcoxon Signed-ranks test indicated that participants were more often willing to choose a later stage for relatives than for themselves,  $Z = 5.51$ ,  $p < .001$ ,  $PS_{dep} = .24$ .

*First-person case.* Out of 154 participants, 19 (12%) chose a later stage for harvesting their organs than for determining their death while 21 (14%) chose an earlier stage for harvesting their organs than for determining their death. The remaining 114 (74%) preferred the same stage for both cases. A Wilcoxon Signed-ranks test indicated that there was no difference in first-person cases between stages preferred for death determination and for organ procurement,  $Z = .73$ ,  $p = .464$ ,  $PS_{dep} = .14$ .

*Relative case.* Out of 154 participants, 12 (8%) chose a later stage for harvesting the organs of the relative than for determining the death of the relative. 33 (21%) chose an earlier stage for organ procurement than for determining their death. The remaining 109 (71%) preferred the same stage for both cases. A Wilcoxon Signed-ranks test indicated that there was a difference: in the relative's case, death determination tended to be later than organ procurement,  $Z = 3.46$ ,  $p < .001$ ,  $PS_{dep} = .21$ .

**Discussion.** In the study, participants tended to choose an earlier stage in the process of dying for determining their own death than for determining the death of their relative. This has potential implications for situations in which relatives are entrusted with making a decision concerning which criterion is to be applied: relatives may be inclined to choose a later stage for determining their death than the patient herself would be inclined, would she be able to make such a decision. This can be mitigated by encouraging people to write advance directives and putting more weight on them.

The same pattern was observed concerning the time at which organs are procured for transplantation. Participants tended to choose an earlier stage for themselves than for their relatives. This can also raise a similar concern in which relatives push for a later stage for organ procurement from their dying/dead relative.

Concerning the dead donor rule, the results are largely consistent with the rule: the vast majority prefers organs to be taken at the same stage at which death is declared or at a later stage. However, there was also a minority who exhibited a different pattern for themselves (14% of participants chose earlier stage for procurement of organs than for determining death) and also for the relatives (21%).

Looking at preferences for determining death, all three candidate criteria seem to have some support in our sample. The vast majority chose one of the three options that were designed to mimic death determination criteria familiar from the literature. This was true both for preferences concerning determination of their own death and the death of their relatives. Stage 4 (whole-brain death) was the most popular option for self (45%) and for relatives (47,5%), but Stage 3 (higher-brain death; 30% for self and 13,8% for relatives) and Stage 4 (cardiopulmonary death; 18,8% for self and 33,1% for relatives) were also popular.

The latter result supports the idea of widening the set of criteria available for choice: higher-brain death should also be in the choice-set, as argued for by Veatch but not Bagheri.

The limitations of the present study include that only one potential description of the dying process was used. Also, a relatively small sample of online participants does not allow generalization to the whole Lithuanian population. However, it provides some evidence that there is a plurality of preferences. Moreover, the results are consistent with a much larger study we conducted with Latvian participants (Neiders & Dranseika, unpublished manuscript).

## Conclusions

Peter Singer in his paper argues that in order to have an efficient transplantation policy we should either redefine death as irreversible loss of consciousness or return to the old conception

of death as irreversible loss of cardiopulmonary function in combination with scrapping the dead donor rule. In our commentary we have argued that this conclusion is neither practicable nor necessary. We think that there is a better option available – the pluralistic approach defended in literature by Veatch and other authors. According to his view, we must admit that reasonable people have different views on how death should be determined and therefore there must be a possibility for them to make their own decision about the matter as long as nobody else is harmed. This solution might resolve many conflicts and enforce the value of autonomy.

Our empirical data give preliminary evidence that there is a wide variety of opinions concerning death determination criteria. This provides some support for the claim the policy recommended by Veatch will be able to accommodate the plurality of preferences that exists in the society. This may help the policy to achieve acceptance. Besides, our data show that the three conceptions of death that are widely discussed in bioethics literature and suggested by Veatch as candidates for people to choose from are not entirely arbitrary. In addition, since whole brain criterion was the most frequently chosen answer, this would provide some *prima facie* evidence that – if a default option is needed – this criterion can be used as the default. Also our data provides some support for the Dead Donor Rule. Finally, our study provides some evidence that people have a tendency to make a different judgment about the death of their close relatives than they apply to themselves. This suggests that in such cases the use of advance directives should be encouraged.

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### **References**

- BAGHERI, A. (2007): Individual choice in the definition of death. In: *Journal of Medical Ethics*, 33(3), pp. 146–149.
- DEGRAZIA, D. (2005): *Human identity and bioethics*. Cambridge: Cambridge University Press.
- DUBOIS, J. M. & ANDERSON, E. E. (2006): Attitudes towards death criteria and organ donation among healthcare personnel and the general public. In: *Progress in Transplantation*, 16(1), pp. 65–73.
- EMANUEL, L. L. (1995): Reexamining death: The asymptotic model and a bounded zone definition. In: *Hastings Center Report*, 25(4), pp. 27–35.
- ENGELHARDT Jr., H. T. (1999): Redefining death: The mirage of consensus. In: S. J. Younger, R. M. Arnold & R. Schapiro (eds.): *The definition of death: Contemporary controversies*. Baltimore: The John Hopkins University Press, pp. 319–331.
- GLANNON, W. (2007): *Bioethics and the brain*. Oxford: Oxford University Press.
- GRISSOM, R. J. & KIM, J. J. (2014): *Effect sizes for research: Univariate and multivariate applications*. New York: Routledge.
- KATO, Y. (2013): Conscience in health care and the definitions of death. In: *Croatian Medical Journal*, 54(1), pp. 75–77.
- MCMAHAN, J. (2012): Death, brain death, and persistent vegetative state. In: H. Kuhse & P. Singer (eds.): *A companion to bioethics*, 2nd ed. Malden, MA: Wiley-Blackwell, pp. 286–298.
- MILES, S. (1999): Death in a technological and pluralistic culture. In: S. J. Younger, R. M. Arnold & R. Schapiro (eds.): *The definition of death: Contemporary controversies*. Baltimore: The John Hopkins University Press, pp. 311–318.

- NAIR-COLLINS, M., GREEN, S. R. & SUTIN, A. R. (2014): Abandoning the dead donor rule? A national survey of public view on death and organ donation. In: *Journal of Medical Ethics*, 41(4), pp. 297–302.
- NEIDERS, I. & DRANSEIKA, V. (unpublished manuscript): Pluralistic policy of determination of death: A report on public views.
- SASS, H. (1992): Criteria for death: Self-determination and public policy. In: *The Journal of Medicine and Philosophy*, 17(4), pp. 445–454.
- SHAH, S. K., KASPER, K. & MILLER, F. G. (2015): A narrative review of the empirical evidence on public attitudes on brain death and vital organ transplantation: the need for better data to inform policy. In: *Journal of Medical Ethics*, 41(4), pp. 291–296.
- SINGER, P. (1995): *Rethinking life and death: The collapse of our traditional ethics*. New York: St. Martin's Press.
- SINGER, P. (2018): The challenge of brain death for the sanctity of life ethic. In: *Ethics & Bioethics (in Central Europe)*, 8(3–4), pp. 153–165.
- VEATCH, R. M. (1976): *Death, dying, and the biological revolution*. New Haven: Yale University Press.
- VEATCH, R. M. (1993): The impending collapse of the whole-brain definition of death. In: *Hastings Center Report*, 23(4), pp. 18–24.
- VEATCH, R. M. (1999): The conscience clause. How much individual choice in defining death can our society tolerate? In: S. J. Younger, R. M. Arnold & R. Schapiro (eds.): *The definition of death: Contemporary controversies*. Baltimore: The John Hopkins University Press, pp. 137–160.
- VEATCH, R. M. & ROSS, L. F. (2016): *Defining death: The case for choice*. Washington, DC: Georgetown University Press.
- YANG, Q. & MILLER, G. (2015): East–West differences in perception of brain death. In: *Journal of Bioethical Inquiry*, 12(2), pp. 211–225.

## **The ethical problems of death pronouncement and organ donation: A commentary on Peter Singer's article**

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### **Abstract**

The article is a critical commentary on Peter Singer's thesis that the brain death definition should be replaced by a rule outlining the conditions permitting organ harvesting from patients who are biologically alive but are no longer persons. Largely agreeing with the position, I believe it can be justified not only on the basis of utilitarian arguments, but also those based on Kantian ethics and Christianity. However, due to the lack of reliable methods diagnosing complete and irreversible loss of consciousness, we should refrain from implementing upper brain death into medical practice. Organs also should not be harvested from people in a persistent vegetative state or from anencephalic children, for similar reasons. At the same time, patients who suffered from whole-brain death should not be artificially sustained; in light of current knowledge they can be declared dead and become organ donors.

**Keywords:** brain death, person, organism, donation, transplantation, Peter Singer

### **Introductory remarks**

The irreversible end of brain functions is a criterion for human death in most countries nowadays, however it turns out to no longer be sufficient due to the advancement of medicine – it is now possible to keep people alive even if their brain is completely damaged (Lizza, 2018b, p. 86). It shows that complete brain damage does not necessarily result in the death of the entire organism as an integrated entity (Singer, 2018, pp. 156, 162), because many biological functions can be artificially replaced. A person connected to a respirator, fed with a feeding tube can continue to live as a biological organism capable of digestion, fighting infections, or maintaining temperature, even after the loss of all brain functions. For example, a patient who was declared brain dead at the age of four but is connected to a respirator and artificially fed, remained alive for over fourteen years (Singer, 2018, p. 156). This raises the question of whether one can be disconnected from a respirator and have their organs retrieved for transplants just because their brain is dead. Singer's article is an attempt to answer this question. In the first part of the commentary I will limit myself to presenting Singer's position (which I largely agree with) and adduce a few arguments which could justify it but have been omitted by him. In the second part I will sketch out the difficulties of putting Singer's propositions into practice.

### **Part I: Singer's position and its justification**

Singer defines human death as the death of the upper brain (Singer, 2018, p. 162), because it is one's personal life consisting of conscious actions rather than biological functions, that is the essence of human existence. Therefore, if the death of cerebral hemispheres results in an irreversible end of consciousness (Singer, 2018, p. 164) it should be considered human death regardless of the body's continued life (Singer, 2018, p. 164).<sup>2</sup> This solution should contribute to the advancement of transplantation medicine; if the death of a person is different from the death of the body and can happen independently of its continued life, then it is allowed to retrieve

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<sup>2</sup> Other authors such as Jeff McMahan (McMahan, 1995, pp. 91–126; McMahan, 2006, pp. 44–48) or John P. Lizza suggest similar solutions (Lizza, 2018a, p. 13).

organs not only from biologically dead people, but also from those who are alive but have permanently lost consciousness (Singer, 2018, p. 164). This conclusion suggests that Singer's goal was not necessarily to formulate a new criterion of death, but rather settling whether a living person can become an organ donor (Singer, 2018, pp. 160–161).<sup>3</sup> The answer is simple: the end of upper brain function resulting in irreversible loss of consciousness is a necessary and sufficient condition of a patient becoming an organ donor (Singer, 2018, p. 164).

The lack of any (at least subjective) value to the life of the potential donor, who does not have any conscious experiences after the death of their upper brain, serves as justification; after all they are not even aware that their body is alive. Meanwhile life is only valuable to us as long as it is conscious, the possibility of which needs to be excluded in the case of upper brain death. Thus, since the person will never know about it, harvesting their organs does not harm them.

Further justification for cerebral death is linked to the development of transplantation medicine. According to Singer, this was also the reason behind replacing the cardiopulmonary criterion of death with the whole-brain criterion, formulated in 1968 by the Harvard Brain Death Committee. The new definition of death was not a result of new scientific discovery, but rather the desire to help those patients who could be saved by transplants; in reality it determined the conditions of harvesting organs from potential donors (Singer, 2018, p. 155). Although the Harvard Committee only allowed for retrieving organs from the dead while Singer believes that those who remain biologically alive can also become donors, in both instances the issue is to not artificially keep people alive if they are irreversibly deprived of consciousness, especially if their organs could save other people (Singer, 2018, pp. 161–162).

At first glance, replacing the definition of death with a rule regulating the circumstances of becoming an organ donor seems unacceptable; after all, whether a person died has nothing to do with the value of their life or the needs of other people. Therefore, the issue of defining death should be determined on the grounds of science (biology and medicine) and not axiology (morality). The definition of death should not be dependent on evaluating life, but rather on what life is and when it ends. Positioning the argument within an axiological framework leads to the question of who is allowed to determine the value of a patient's life and whether consciousness is a determining factor in this evaluation. After all, one cannot exclude the possibility that someone suffering from terrible pain or experiencing loneliness after losing their loved ones would want to become unaware of their state; a conscious life is not always more valuable than an unconscious one. While consciousness is a key factor in the prohibition on inflicting pain, we have the right to live because we were born, not because we are conscious; even permanent loss of consciousness does not mean losing the right to live.

Making death pronouncements dependent on other people's needs is equally difficult. Even if the organ recipients are conscious while the donors have irreversibly lost it, they are both alive in a biological sense. Therefore, if an organ transplant is performed, someone is killed to save another which undermines the universality of the human right to live.

These counterarguments do not, however, refute Singer's position; on the contrary, they confirm his belief that classifying someone as an organ donor is not a matter of science but ethics. Both proponents and opponents of harvesting organs from living donors agree with this thesis; the first group care about those whose conscious lives can be extended without harming others, while the second group is concerned with taking away the right to live from innocent people (even if they are permanently deprived of consciousness) for the sake of transplants.

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<sup>3</sup> Other authors hold similar views; Norman Foster believes that there is no need to change the definition of death in order to save transplantation medicine, it is enough to change the rules of organ donation (Lizza, 2018b, p. 87).

Therefore, the argument is fought on the grounds of ethics and not medicine; it is not about whether the potential donor is dead, but whether a specific action (performing a transplant or not) will harm someone (the donor or the recipient).

The definition of death is not a purely empirical problem, it is also an axiological one because its content is dependent on what we determine to be true human life. The pursuit of a universal definition of death which would apply to all living creatures is itself destined to fail; even brain death is not a universal criterion since there are organisms who do not have brains and yet are born and die (Singer, 2018, p. 162). Therefore, there is no one, universal concept of death (Lizza, 2018b, p. 81), the death of each individual depends on what type of being they are (Lizza, 2018a, p. 14). It is equally difficult to offer a definition which would apply to all people and only to people; e.g. in the case of upper brain death anencephalic children, who are born without cerebral hemispheres, pose a problem.

Another obstacle in defining and declaring death is its processuality which makes it harder to point to a specific event which turns a living person into a dead one. While it is obvious that if all of somebody's cells died then they too are dead, but it would also be a mistake to wait until the last cell dies in order to declare somebody dead. Searching for a specific event that makes the process of dying irreversible is equally problematic because it is not clear that such an event exists. Even the irreversibility of the process of dying is questionable and depends on the situation; a patient experiencing a massive heart attack can be saved if they immediately receive medical attention. On the other hand, even a minor cut in the jungle, without access to medical help, can result in death. A physician deciding whether to continue treatment or let the patient die is a similar situation, each decision like this is based not only on medical data but also moral beliefs. This suggests that a death pronouncement can be as arbitrary as declaring someone to be an adult because it is affected by various factors (including an understanding of the value of life).

One should also keep in mind that in some cases the cost of saving one person is the death of another, otherwise they both die. Therefore, giving up on transplants because of the universal right to live is just as morally suspect as taking one person's life to save another; however, a decision must be made. Moreover, it is obvious that medical practice does distinguish people on the grounds of the value of their lives. The reasons behind treating one person and not treating another are not only medical (predicted success of treatment) but also social – linked to the person's prestige and their importance to the community. Those who govern (and make strategic decisions), soldiers (who defend the borders), or doctors (who save lives) are a priority when it comes to treatment, which shows that the lives of some people are considered more valuable than the lives of others.

Anthropological factors connected to how we understand human nature are another important factor in death pronouncement or agreement to harvest one's organs (Lizza, 2018a, pp. 5, 14). Singer refers to dualistic concepts of human existence by distinguishing between one's organism (biological life) and person (consciousness). Consciousness is significantly more important and its irreversible loss (regardless of the organism's continued life) allows for declaring a person dead and harvesting their organs (Singer, 2018, p. 157). However, as long as a person has consciousness, they cannot be declared dead, even in the case of complete bodily dysfunction. This means that actual death is the death of the person and not the body (Singer, 2018, p. 162). However, this solution is problematic given the existence of anencephalic children who are born without cerebral hemispheres. By adhering to Singers assumptions, one would have to claim that these children are not, never were, and never will be persons and so they fulfill the criteria to become organ donors.

The dualism of organism and person suggests that the body is not an integral element of a human being; it is only important as a foundation or tool of consciousness. However, the moment consciousness is irreversibly dead, the biological organism ceases to be human. Therefore, if it were possible to separate the upper brain (which is the physical foundation of consciousness) from the rest of the body and keep it alive, then one would have to conclude that the person is still alive. Conversely, the body is an integral element of a human being and without it one is not fully human; therefore, as long as the biological organism is alive, one should not be declared dead. A person ceases to live neither when they irreversibly lose consciousness (while their organism remains alive), nor when they remain conscious (thanks to artificially maintained bodily functions); they are dead after both the death of the body and the person.

Even if one does assume that this argument is correct, it should be acknowledged that it does not refute Singer's position because dualism (which highlights the role of consciousness) is a more accurate description of a human being than animalism (which equates them with a living organism). It is confirmed by the fact that we are more likely to assign more human impulses to a person who remains conscious despite a completely dysfunctional body than to one in a permanent vegetative state. For example, one could consider a thought experiment concerning the possibility of a head transplant. If such surgery could indeed be performed<sup>4</sup> then one would have to assume that the person whose head was attached to a different body is the one still alive rather than the one whose body was preserved. Similarly, if it were possible to detach a head from a body and keep both of them alive, we would be more likely to identify the person as the head rather than the body (Lizza, 2018b, pp. 83–84) because consciousness is generated by the brain which is inside of the head. If a headless body which is artificially kept alive is not a human then it would follow that a body is no longer human after the death of the upper brain, despite being connected to a respirator and artificially fed (Lizza, 2018b, pp. 73–74).

This conclusion (which resembles Singer's beliefs) does not solve the issue of consent to harvest organs from people irreversibly deprived of consciousness. The main problem is posed by anencephalic children who are clearly alive even though, to best of our knowledge, they do not have any conscious experiences; thus, they are not persons but organisms (Singer 2018, p.162). If they are not conscious, then according to Singer's assumptions, shortening their life in order to harvest their organs does not cause them harm. However, one could assume that such an action would be deemed morally suspect at least on the grounds that if these children were never persons, they could not have consented to the donation. Therefore, their case is different from that of people in a permanent vegetative state, who at least were persons in the past and could have consented. Moreover, lack of consciousness alone is not a sufficient argument to deprive anyone from their right to continued life (even if it is only biological).

Another issue is the diagnosis of permanent lack of consciousness itself, both due to insufficient machinery which could confirm its complete and irreversible loss, as well as the difficulty with formulating an unequivocal definition; consciousness is subjective (private) and gradable (Nguyen, 2018, pp. 56–57). There is anecdotal evidence of a patient who was declared brain dead and yet could hear what was being said around them, however they were unable to react (Nguyen, 2018, p. 57). Therefore, one cannot be certain that currently available medical procedures guarantee foolproof diagnoses which means that legalizing the definition on death proposed by Singer would be too risky. It does not mean that upper brain death is a bad criterion for death, but it should not be utilized due to lack of reliable methods for diagnosing it. Death

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<sup>4</sup> Experiments like this were already performed on monkeys (Lizza, 2018b, p. 73).



pronouncement and organ donation require the highest levels of caution, minimalizing the risk of mistakes.

Besides ethical and anthropological justifications, Singer's argumentation also uses cultural justifications. There is no doubt that the dilemmas surrounding death pronouncement and donation are settled in a broader religious, moral, and social context in which the doctors and patients function. After all, science (including medicine) is not axiologically or ideologically neutral (Lizza, 2018a, p. 4); the formulation of medical laws is influenced by superstitions, myths, and social customs. Moreover, one should keep in mind that legal regulations often come later than medical practice and only sanction it ex post. For example, in Poland the brain criterion is the standard for death pronouncement, however, the cardiopulmonary criterion is allowed in transplant practice; this means that it is possible to harvest organs from donors who are legally alive (Nowak, 2018a, p. 38). Similar practice is present in the United Kingdom, where almost half of all harvested organs in 2016 came from donors who were declared dead based on the cardiopulmonary criterion (Nowak, 2018a, p. 36). The argument in favor of this practice is the assumption that cardiopulmonary death inevitably leads to brain death ; it is conceivable that the operative observation period of five minutes is too short to ensure that the organs were retrieved from a dead person (Nowak, 2018a, p. 40; Nowak, 2018b, p. 66). However, if this is in fact medical practice, then it is all the more reason to consider revising the criterion for death. It is hard to conceive that an increasing number of people irreversibly deprived of consciousness will be kept alive using up resources which could be devoted to treating those patients who are conscious of their state and who can recover. It is a problem that concerns everybody because everyone can become either an organ donor or recipient. Perhaps this is why Singer is an optimist and believes that most people, if they have knowledge about transplant medicine, will consent to their organs being used to save others (Singer, 2018, p. 161). Consent can be expressed in a declaration of will signed while one is conscious and can make decisions about their future (Singer, 2018, p. 163).

Contrary to Singer's optimism, convincing people to consent to the donation may be difficult, not necessarily due to bad will, egoism, or excessive attachment to life, but rather fear that a declaration of will result in a patient being declared an organ donor even in a situation when treatment could be continued. This fear should not be treated lightly, especially since there have been cases which could justify it – for example events that took place years ago in Łódź, a Polish city. There was a group of employees in an emergency room who injected patients with deadly poison and proceeded to inform a funeral business about the deaths. The company then contacted the family of the deceased and offered their services (Kołakowska, Patora & Stelmasiak, 2000). If it was possible that patients were killed for financial gain then it is conceivable that they could also be killed for their organs.<sup>5</sup> Therefore, legal regulations require caution regarding organ retrieval from living people. Avoiding abuses is not conditioned upon social debate about transplants or declarations of will but rather on restrictive legal and medical procedures of donation. While there are plenty of people prepared to give up their lives to save others, there are also those who will not be reluctant to benefit from the deaths of others.

Regardless of possible abuses, a declaration of will is also problematic on other grounds. It is a form of social contract (one agrees to the harvesting of their organs trusting that others will do the

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<sup>5</sup> An equally drastic, albeit fictional, situation was described by Roman Bratny in the novel *Radość nagrobków* [Tombstone Joy] (Bratny, 1978). One of the characters is a physician who loves to give eulogies and so he kills his patients to create more opportunities for his rhetorical displays. One cannot exclude the possibility of similar actions in real life, after all history shows that people are capable of anything.

same), however it is difficult to execute. If someone does not consent to organ donation and wishes to be kept alive even after the death of their upper brain, then the medical system becomes reliant on the will of the patients, which goes against the rule of everyone being equal under the law; those who consent to becoming organ donors will not be kept alive, while those who do not give such consent will be treated. To avoid this inequality, individual declarations of will should be replaced by a law which would affect everyone.

The problems with implementing Singer's proposal do not undermine the fact that it is fundamentally right; it should be possible to harvest organs from people who are irreversibly deprived of consciousness, in order to save the lives of others. In some cases, we not only have the right, but even an obligation to kill innocent people to save other, equally innocent, people. If there is a plane with two hundred people on board flying in the direction of a hotel with a thousand people, everyone who can, should shoot it down. Although passengers will die as a result, the hotel guests will be saved; if one takes no action, both the passengers and the guests will die. Medicine is similar, if some people can be saved by harvesting organs from those who will never regain consciousness, then this is the appropriate course of action, otherwise everyone will die.<sup>6</sup>

However, this seemingly simple solution can turn out to be dangerous; if permanent loss of consciousness (caused by upper brain death) is to be the condition for organ harvesting then those whose brain stems (lower brain) are intact and are capable of breathing on their own, could be considered organ donors. In these cases, donation would not be the result of death caused by other factors, but the cause of death; the patient will stop living only because their organs were needed to save other people. This would lead to a radical instrumentalization of humans as organ banks and to violation of the right to live. Singer himself sees this problem and admits that the donor rule he proposes goes against both Kantian ethics of human dignity and Christian ethics of equality of all people.

References to Kantian ethics which prohibits using a human solely as means to an end, can be found in a report by the President's Council on Bioethics from 2008, which excludes the option of treating patients as organ donors (Singer, 2018, pp. 158–159). According to Singer the reference is a mistake because transplant medicine is based on utilitarian arguments (Singer, 2018, p. 160); the categorical imperative can only be applied as an addition and only if its content is extended (Singer, 2018, p. 160). It would have to be acknowledged that the prohibition on treating a person as means to an end only applies to actions against their will; if, however, the person voluntarily agreed to become a donor, then their organs can be harvested (Singer, 2018, pp. 160–161). In these circumstances they are not being treated instrumentally; they freely expressed how they wish to be treated in case of irreversible loss of consciousness.

One could also argue that even a donor who did not consent is not treated completely instrumentally by transplant medicine. In a society which allowed organ donation after upper brain death everyone would be a potential organ donor and recipient. Therefore, everyone would be both the means and the end, which is compatible with Kantian ethics prohibiting only those actions in which a person is just the means and not the end.

The donor rule proposed by Singer is also compatible with another formulation of the Kantian imperative which warrants actions in accordance with the rule we would like to become universal. Therefore, if I consent to the harvesting of my organs after my upper brain dies, I want others to give similar consent. If I am against such actions, it means I also do not want others to

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<sup>6</sup> A total prohibition on abortion, as advocated for by radicals, is a similar issue; in a case when the pregnancy is a direct threat to the life of the mother a ban on abortion results in the death of the mother and the child.

consent to becoming organ donors. Thus, I seal my fate not only as a potential donor, but also as a potential beneficiary of transplant medicine.

Singer's view can also be justified as compatible with Kantian ethics by arguing that those who suffered brain death and irreversibly lost consciousness are no longer persons. If reason and freedom are essential to a person, then purely biological organisms without a mental life are not persons; therefore, the Kantian imperative does not apply to them. It should be noted, however, that the prohibition on instrumental treatment of people can be used in other cases important to medical ethics. While considering a person after upper brain death as purely an organ donor is unacceptable (it would mean using them as just means to an end), it is acceptable to put an end to someone's suffering through death and at the same time harvest their organs; in this scenario, the person is not just the means, but also the end. These examples show (contrary to Singer's suggestion) that Kantian ethics can solve the dilemmas surrounding death pronouncement and transplants (Singer, 2018, p. 160).

Singer also notes the incompatibility of his proposal with the Christian principle of equality of life (Singer, 2018, p. 163). If the life of every human (including those who are no longer persons) is equally valuable and falls under the same legal protections, then harvesting organs from people who suffered upper brain death is out of the question. It would seem that in order for transplant medicine to continue developing one has to reject the Christian sanctity of life ethic which prohibits the intentional killing of an innocent human being (Singer, 2018, p. 163).

This opinion is too pessimistic, because the revision of rules for donation proposed by Singer can be made compatible with Christian ethics. First of all, it should be noted that the evangelical concept of life is not about maintaining biological functions but rather spiritual unity with God. Therefore, artificially maintained bodily functions is not true human life, but spiritual adoration of the Creator certainly is; as Jesus taught, one should not fear those who kill the body, but those who can kill the soul (Mt 10, 28).<sup>7</sup> If earthly life is not the highest value but only a preface to the afterlife then there is no reason to sacrifice it because of the greater good. It would suggest that due to eschatological hopes a Christian would be more likely to consent to ending treatment and harvesting their organs than someone who does not believe in eternal life.

The philosophical interpretation of Christianity expressed by Thomas Aquinas is also close in spirit to Singer's dualism. He assumed that the soul is the source of personal life and it makes acts of intellect and will possible. However, when the body is damaged, the soul can no longer function (STh, I, 1 75–76). While it is not equivalent to death (which according to Aquinas meant the separation of body and soul), we do observe a lack of personal life; this conclusion is compatible with Singer's thesis that people whose upper brain was damaged are no longer persons. Since personal life, from a Christian perspective, is better than non-personal life, one should save the patient whose soul can express itself through a body rather than the one whose soul is no longer capable of actions (due to brain damage).

One should also keep in mind that Christian ethics teach mercy for those who are suffering; in practice it means the necessity of helping them, also by putting an end to their torment. While one should not shorten human suffering on the grounds of religions which identify suffering with punishment for one's sins in previous incarnations (so as not to extend the period of atonement),

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<sup>7</sup> The dualism of bodily (earthly) life and spiritual (eternal) life was the reason behind cruel forms of converting Pagans to Christianity; because of saving a person's soul from hell their earthly body was tortured, and even killed. The practice of converting pagans (unbelievers, infidels) in itself showed that until they became Christians their lives had no meaning because they would not be saved. Fortunately, nowadays Christian communities reject these radical beliefs.

in Christianity suffering is an evil from which people should be saved. In practice it would mean the possibility of shortening earthly life as a way of saving people from excessive and unnecessary suffering (regardless of what theologians claim).

The incentive to sacrifice oneself for others is another element of Christian doctrine; dying for a fellow human is considered to be the highest form of sacrifice. Therefore, one who gives their life to save others follows Jesus' example most closely; consent to organ donation is also a form of such sacrifice. This example shows that Christianity can support the development of transplant medicine by inspiring people to selflessly sacrifice everything they have, including their bodies.

The fact, that regardless of declarations, followers of Christ do not in reality support the equality of all people, is a separate problem. It is showcased i.e. in the way candidates for priesthood are selected in the Roman Catholic Church, which does not ordain people who do not have a right hand (or even a thumb) due to the supposed inability to perform sacraments. This means that a person with a disability is considered less valuable than someone fully abled by the Roman Catholic Church; after all they are deprived of the possibility to perform priestly duties meaning that, according to Catholic theology, they cannot be an intermediary between God and people, leading them to salvation.<sup>8</sup> Another example of the belief that people are not indeed equal in the Catholic Church is the prohibition on female priesthood, as well as valuing people based on their religious affiliation. This sentiment is also apparent in the actions of the current Polish government which often invokes Christian values yet declined to welcome refugees (including women and children) from war-torn Syria, with the exception of Christians (Pędziwiatr, 2015, p. 2) suggesting that they view the life of a Christian as more valuable than the lives of non-believers or those who adhere to different religions. Breaking the principle of equality among people is further evident by the different levels of access to medical care among Christians. After all, the pope is provided with far superior treatment conditions than regular believers (who are sometimes more in need). While these differences are based on a rational assumption that the pope is more important to the Roman Catholic Church than other people, it still suggests that the rules of sanctity and equality of life are not fulfilled even within Christian communities; in that case they should not be an obstacle in changing the rules of transplant medicine following Singer's proposal.

If these remarks are valid, Singers position on donation can be justified not only by utilitarian arguments, but also ones based in Kantian ethics and Christianity. However, this does not necessarily mean that it should be implemented into medical practice due to the aforementioned problems in diagnosing complete and irreversible loss of consciousness. The issue of changing the definition of death or the donor rule concerns not only whether they are right but also their reliability in medical practice; this problem will be addressed in part two.

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<sup>8</sup> In the past only the pope could allow a priest who suffered from a permanent disability to perform mass; for example, Isaac Joques who was tortured by the Iroquois was allowed by Urban VIII to perform mass despite his mutilated hands because he suffered the wounds as a martyr for Christ (Tüchle & Bouman, 1986, p. 212). The prohibition is surprising inasmuch as sacraments should not be understood as magical; turning bread into the body of Christ is not dependent on which hand is used to make the sign of the cross over it because it is not the priest's physical gesture that decides the power of the sacrament but rather God's action. Moreover, priesthood is also about preaching, absolving sins, and uttering Eucharistic formulas which do not require a right hand. Therefore, while it is understandable to prohibit a person without their right hand from driving a car or flying a plane, a similar prohibition on priesthood is hard to understand.

## **Part II: Practical proposals**

Let us once again consider three cases: persistent vegetative state, locked-in syndrome, and people who artificially kept alive after brain death. There are two questions that need to be asked regarding each of them: are we dealing with people who are alive or dead? If they are alive, are we allowed to retrieve their organs for transplant purposes?

Persistent vegetative state means the patient's cerebrum is completely destroyed, however their brain stem, which is responsible for organic functions such as reaction to stimuli, digestion, and breathing, remains functional (Singer 2018, p. 159). Although the patient is not independent (they need to be fed), they do not require a respirator to remain alive. Due to the complete destruction of cerebral hemispheres they will never regain consciousness and therefore will never know what is happening to their body.

In this case, the question whether the patient is alive or not, is not easy to answer. While it seems obvious that they have died as a person (Lizza, 2018a, p. 8), it is just as obvious that they are alive as a biological organism (Nair-Collins, 2018, p. 27). If they breathe on their own (and fulfill other physiological functions) then they can hardly be declared dead; loss of consciousness alone is not enough for a pronouncement of death.

The answer to the second question is also difficult. While at first glance it would seem that there is no reason not to harvest organs from someone in a persistent vegetative state, this action would in fact be murder (Singer, 2018, p. 158). Regardless of whether there are moral arguments (not only utilitarian, but also Kantian and Christian) justifying this action, as I have previously indicated, it is not an obvious case. After all, there is no doubt that one cannot give away somebody's wealth to their heirs before they die (unless they consented to it) and it is unacceptable to accelerate their death in order to receive an inheritance sooner. If we are prepared to legally protect a patient's property, potentially harvesting integral parts of their body seems even more troubling. Therefore, it would seem that harvesting organs from people in a persistent vegetative state should not be allowed, at least until a social consensus is reached. Although it may seem that a social contract in this matter is a utopian idea, an attempt to negotiate different moral beliefs and legal systems should be made. Until we are able to work out at least the foundations of such a (preferably global) solution, a lot of caution is advised due to the danger of a slippery slope. Singer himself acknowledges that and gives the example of anencephalic children as potential donors (Singer, 2018, p. 162). Although Singer does not unequivocally solve the issue, he does suggest that we should be less conservative. However, it seems that the opposite is true; regardless of moral arguments (including judging how valuable the lives of irreversibly unconscious people are) when it comes to legally allowing for the killing of a living human (for the purpose of harvesting their organs) one should be highly cautious so as to avoid hurting somebody. If current medical technology is unable to reliably diagnose lack of consciousness (Lizza, 2018a, p. 8), then the question whether harvesting organs from people in a persistent vegetative state is allowed, should be answered in the negative.

Locked-in syndrome is an entirely different matter; those patients' brain stems are so damaged that they are unable to perform life functions, including breathing and therefore they need to be connected to a respirator to remain alive. However, since their cerebral hemispheres are intact, patients remain conscious, they are able to express emotions and even attempt to make contact with their environment, e.g. through blinking (Singer, 2018, p. 157).

The answer to the first question is obvious in this case; if a patient is conscious they cannot be declared dead despite the dysfunction of the body (Singer, 2018, p. 157; Lizza, 2018a, p. 7). The answer to the second question seems just as obvious; if the patient is alive as a person then their life must not be shortened for the purpose of organ donation. However, it is indisputable that

keeping them alive may result in unbelievable suffering and it is thus possible that they would prefer to die even if they are unable to communicate it. A potential declaration of will from earlier does not aid the decision about continuing or ceasing treatment because there is no guarantee that the patient in their current state would want to uphold their decision. The difficulty in this situation is the fact that whatever we do, we have no idea if we acted in accordance with the current will of the person and whether our actions were good or harmful to them. However, it is clear that in the case of locked-in syndrome the driving force behind a decision should be the good of the patient and not the potential benefits for transplant medicine. Thus, the answer to the question whether in this case the patient's organs can be harvested has to be negative. They could only be harvested as a side effect of shortening the patient's life to save them from unbearable suffering. The question whether they should be kept alive or allowed to die for their own good has to remain unanswered because we do not know what their current will is. Neither the Christian sanctity of life ethic (in the case of someone whose life is unbearable suffering this rule could be cruel), nor the Kantian imperative which says one should act according to rules they would want to be universal (after all we do not know what we would consider the right course of action in a situation in which we have not yet found ourselves and which we cannot imagine) can help in this situation. The utilitarian cost-benefit analysis is equally ineffectual because we cannot know what would be best for the patient, their loved ones, and society overall in this situation. The example of people with locked-in syndrome shows that in the most dramatic situations in which a person may find themselves our moral understanding fails; we do not know what we should do, knowing that whatever we decide could be wrong.

The third case is people who suffered from whole-brain death and thus irreversibly lost consciousness and their body is being artificially sustained (Lizza, 2018a, p. 1). Here, the answer to the first question seems obvious; if their consciousness is irreversibly lost and their body would not function without medical equipment, they should be considered dead. However, one could argue to the contrary that artificially sustaining an organism after brain death means that the patient is not dead (Nair-Collins, 2018, p. 28). It is supposedly proven by the fact that their body – connected to a respirator and fed through a stomach tube – remains in homeostasis, keeps a stable body temperature, and even fights infections (Nair-Collins, 2018, pp. 35–36). The respirator only provides the oxygen they are unable to acquire on their own, however it does not affect the functioning of the heart, liver, kidneys, or metabolism, all of which work on their own (Nair-Collins, 2018, pp. 35–36). Therefore, if breathing is the only function aided by a machine, then a brain-dead patient is no more artificially sustained than a diabetic who is alive because of the insulin they receive (Nair-Collins, 2018, p. 36).

This line of argument is difficult to agree with; after all there is no doubt that the situation of a brain-dead patient is radically different from someone in a persistent vegetative state who breathes on their own (Lizza, 2018b, p. 84). The difference between a brain dead patient and a diabetic or any other person who takes life-saving medicine (whether occasionally or on a regular basis) is even starker. In the case of a brain dead patient there is no chance of recovery, both in a biological sense and regaining consciousness; thus they can be considered dead whereas it is not an option in the case of a diabetic (Lizza, 2018b, p. 84).<sup>9</sup> The reason behind a brain dead patient being considered alive is the masking action of the respirator (Lizza, 2018a, p. 2).

If we concede that one is no longer alive after brain death, the answer to the second question should not be controversial because there are no serious moral arguments supporting the

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<sup>9</sup> Lizza goes as far as to claim that a brain-dead patient is not a human being, just remains (Lizza, 2018a, p. 1); they are no more a person than an arm separated from the body and artificially sustained (Lizza, 2018a, p. 13).

prohibition on organ harvesting from a dead person. Therefore, if a brain-dead patient is being artificially sustained, we should agree to disconnect them from a respirator and other medical equipment; if they do not start breathing on their own, the suspicion that they were already dead will be confirmed. If they started to breathe on their own it would mean that they were misdiagnosed as brain dead because at least their brain stem remains functional; in this case we are dealing with a patient in a persistent vegetative state and thus, as concluded earlier, we should not harvest their organs.

This solution should not raise any serious moral or legal concerns. If we reject it, we risk a slippery slope, this time resulting in an inability to cease treatment at any time. If we prohibit disconnecting a patient from a respirator after brain death, we will likely be able to pronounce them dead only after the death of every cell in their body. This solution would not only exclude the possibility of any transplants, it would also require a change in the definition of a human being; a person would no longer be a rational, conscious, or social being, but simply a collection of live cells, which is hard to agree with.

One cannot exclude the possibility that the reason behind rejecting whole-brain death as the criterion for human death, is not medical development, or ethical concerns, but a hidden desire for immortality. The hope of conquering death appears at various times in history, even if it is expressed differently. In the 19th century, Nikolai Fiodorov, a Russian philosopher, proclaimed medicine as a science that would enable the bringing all of the dead back to life which would be the fullest expression of 'love thy neighbor.' For to love fellow humans would be to do anything in our power to keep them alive; since many people died already we have a responsibility to bring them back to life on Earth (Fiodorow, 2012). Cryogenics also seems to stem from the hope for some sort of immortality, or at least longevity. It seems that a similar hope lies at the foundations of arguments criticizing whole-brain death; it is possible that those making these arguments want to believe that thanks to medical progress, patients who are considered dead today could regain consciousness or even biological functions in the future. However, in light of current knowledge, these hopes are baseless.

In advocating for whole-brain death as a criterion for human death I also agree with Peter Singer that we need a broad social debate on changing this criterion and broadening the allowing of organ harvesting from biologically alive patients. Perhaps Laura Specker Sullivan is right when she argues for a definition of death that would have the least harmful ethical consequences (Sullivan, 2018, p. 67). However, due to the constant progress in medicine and the fluidity of our concepts (including the concepts of life and death) we should abandon hope for the discovery of one formula to solve all moral dilemmas. It is equally difficult to expect that any principle defining the conditions of organ donation will be final. They will all be temporary and require revisions in the future. Although introducing any new solution must be cautious to minimize the risk of harm, caution also should not be paralyzing; inaction (including prohibiting organ harvesting from patients whose entire brain was destroyed) can have very negative consequences, sentencing to death people who could have been saved by a transplant. Taking all these arguments into account I advocate for organ harvesting from patients who suffered whole-brain death. However, I would postpone implementing Singer's proposal until medical procedures can diagnose irreversible loss of any human consciousness (meaning upper brain death) with a lesser risk of error than is currently possible.

Translated by Agnieszka Ziemińska

## References

- BRATNY, R. (1978): *Radość nagrobków* [Tombstone joy]. Warszawa: Iskry.
- FIODOROW, N. (2012): *Filozofia wspólnego czynu* [Philosophy of shared action]. Kęty: Wydawnictwo Marek Derewiecki.
- KOŁAKOWSKA, A., PATORA, T. & STELMASIAK, M. (2000): *Zabijali pacjentów dla pieniędzy* [They killed patients for money], [online] [Retrieved September 2, 2018]. Available at: <http://wyborcza.pl/1,76842,2638033.html>
- LIZZA, J. P. (2018a): Defining death: Beyond biology. In: *Diametros*, 55, pp. 1–19.
- LIZZA, J. P. (2018b): In defense of brain death: Replies to Don Marquis, Michael Nair-Collins, Doyen Nguyen, and Laura Specker Sullivan. In: *Diametros*, 55, pp. 68–90.
- MCMAHAN, J. (1995): The metaphysics of brain death. In: *Bioethics*, 9(2), pp. 91–126.
- MCMAHAN, J. (2006): An alternative to brain death. In: *Journal of Law, Medicine, and Ethics*, 34(1), pp. 44–48.
- NAIR-COLLINS, M. (2018): A biological theory of death: Characterization, justification, and implications. In: *Diametros*, 55, pp. 27–43.
- NGUYEN, D. (2018): A holistic understanding of death: Ontological and medical considerations. In: *Diametros*, 55, pp. 44–62.
- NOWAK, P. G. (2018a): Pobieranie narządów po zatrzymaniu krążenia. O nadrzędności neurologicznego kryterium śmierci nad krążeniowym – kwestie regulacyjne [Donation after circulatory determination of death: About the precedence of neurological criterion of death over circulatory criterion – regulatory issues]. In: *Analiza i Egzystencja*, 42, pp. 35–53.
- NOWAK, P. G. (2018b): Pobieranie narządów po zatrzymaniu krążenia. O nadrzędności neurologicznego kryterium śmierci nad krążeniowym – kwestie filozoficzne [Donation after circulatory determination of death: About the precedence of neurological criterion of death over circulatory criterion – philosophical issues]. In: *Analiza i Egzystencja*, 42, pp. 55–71.
- PĘDZIWIATR, K. (2015): Uchodźcy muzułmańscy nad Wisłą niemiłe widziani. [Muslim refugees unwelcome in Poland]. In: *Biuletyn migracyjny*, 52, p. 2 [online] [Retrieved September 2, 2018]. Available at: [www.biuletynmigracyjny.uw.edu.pl](http://www.biuletynmigracyjny.uw.edu.pl)
- SINGER, P. (2018): The challenge of brain death for the sanctity of life ethic. In: *Ethics & Bioethics (in Central Europe)*, 8(3–4), pp. 153–165.
- SULLIVAN, L. S. (2018): What does a definition of death do? In: *Diametros*, 55, pp. 63–67.
- TÜCHLE, H. & BOUMAN, C. A. (1986): *Historia Kościoła* [History of the Church], vol. 3: 1500–1715. Warszawa: Instytut Wydawniczy Pax.



## Death, ethical judgments and dignity

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### Abstract

In Peter Singer's article "The Challenge of Brain Death for the Sanctity of Life Ethic", he articulates that ethics has always played an important role in defining death. He claims that the demand for redefining death spreads rather from new ethical challenges than from a new, scientifically improved understanding of the nature of death. As thorough as his plea for dismissal of the brain-death definition is, he does not avoid the depiction of the complementary relationship between science and ethics. Quite the opposite, he tends to formulate a stronger, philosophically more consistent argument to help science and medical practitioners to define life, death, and the quality of life. In my commentary, I would like to focus on two issues presented in Singer's study. Firstly, I will critically analyze the relationship between science and ethics. Secondly, I will follow on from Singer's arguments differentiating between end of life as an organism and end of life as a person. The latter case is necessarily linked with man's participation in her/his life, setting life goals, and fulfilling her/his idea of good life. Through the consequential definition of the dignity in ethics of social consequences, I will try to support Singer's idea.

**Keywords:** death, life, ethical judgments, medical law, dignity

### Introduction

Peter Singer's interest in reevaluating the traditional definition of death has been significant for a long time. Examples of these attempts are the book *Rethinking life and death* (1995) or a number of (scientific as well as commentary) articles.<sup>2</sup> Since then, his thoughts and arguments have evoked vivid and controversial discussions on moral and legal aspects of life, death, dying, and quality of life. Nevertheless, in the light of new, and widely-covered stories in the media about patients' rights, medical life/death decisions, and hard cases of irreversibly sick patients, Singer returns to the debate on delimitation of death. He offers new arguments not only to sustain his own position, but also to critically re-evaluate the position of the US President's Council on Bioethics in its efforts to found a scientifically, legally, and morally plausible criterion of death. For this purpose, his article *The challenge of brain death for the sanctity of life ethic* reflects on improvements in medical and clinical praxis, methodology of determination of death, as well as individual arguments of the Council on the definition of death in legal and moral discourse. In his conclusions, he proposes rejecting the prevailing view of brain death (Singer, 2018). He also explains, how this rejection could move forward the whole debate on death, despite the differences in ethical positions of understanding human life and death.

There are two main propositions formulated by Peter Singer which have raised my interest and on the basis of which I develop my thoughts in this study. The first one is Singer's demand for ethics to be more involved and considered in the debate on death. Ethical judgements, according to Singer, are still somehow in the shadow of medical and scientific arguments. He claims that the determination of death criterion, whether in the legal or moral sense, is also of public and societal interest (emotional suffering, costs to society and the family, organ donation, etc.), and therefore should also contain ethical judgments.

Singer's second proposition is elementary to his ethical conclusions. According to him, it is necessary to differentiate between the concept of the death of an organism and the death of a person. This I found compatible with my understanding of dignity (as a dynamic model presented in ethics of social consequences) as well as relevant for contemporary discourse on

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<sup>2</sup> Articles and commentaries published for example in *The Guardian*, *The Independent* or the website *Project Syndicate* (Singer, 2017; 2014; 2012; Hari & Singer, 2004).

dying as an important part and aspect of quality of life. In the final part of this paper, I will try to compare his conclusions with my methodological approach to understanding dignity of life (and possibly death).

### **Need for ethical judgments in the legal and medical discourse?**

Since the 60's, the brain-death (or irreversible coma) criterion of death had been discussed and proposed in the light of new, modern medical and clinical technologies (transplantation, life-support and resuscitation methods) and the societal and ethical challenges arising from them. The need for such a definition was explained as an increasing burden on patients who, with the help of new methods of resuscitation and life-support, are able to breathe and sustain some bodily functions, despite an irreversibly damaged brain, as a burden on their families, and the whole society. Increasing the amount, time, and expense of health-related-services (provisions of which are scarce and limited in each society), the need for implementing a new type of care (e.g. palliative care), and even the demand for organ-transplants (US President's Commission for the Study of Ethical Problems in Medicine, 1981), has created the pressure to delimitate the elementary function of living organism whose termination will characterize the end of life. Answers for these ethical questions were formulated through the language and methodology of science and medicine and, since then, death had been directly related to the understanding of life in its biological sense. In other words, it started to be formulated through naturalistic perspectives of life, health, and death (as brain-death).

In 2008, the President's Council in Bioethics opened the debate on the definition of death again. The goal of its report *Controversies in the determination of death: A white paper* (President's Council in Bioethics, 2008) laid in redefining death as total brain failure, a concept widely accepted in clinical, legal, and even public discourse as a criterion of death for over three decades. Its main arguments spread from the research of Alan Shewmon, Germain Grisez, and Joseph Boyle, who presented a number of cases showing the definition of death to be vague; cases, in which patients, at first proclaimed dead, showed a state of "reversible" brain damage. This has created a platform for debating methods and modern techniques for determination the state of (irreversible) brain-death, as well as the whole concept of brain death.

According to Singer, the weakest point of this report is not the critique of the brain death concept as such,<sup>3</sup> but rather the dominant prevalence of the naturalistic point of view in the discourse. This approach remains focused on finding scientifically measurable, exact and verifiable facts on when the moment of death occurs. Therefore, most of the discourse on the elementary criterion of death focuses on depicting the death of an organism with limited (or no) regards to the wider understanding of said patient's life, its purpose, or quality. Despite the fact that the initial purpose and the need for this definition has spread from moral issues linked to end-of-life decisions, the humane and ethical aspects of life/death are obeyed in the discourse.

Singer clearly states the question on the role of ethics and ethical judgments in medicine and medical law discourse. Ethics has proven itself in past decades to be very useful for science by stating some (common sense) rules and limits for research, its mechanisms, and methods, but does it mean that *ethics* should be the judge of what is the best decision in medical and clinical praxis? To intervene with the biological functioning of one's body? To fill in the gap in knowledge of science? And, in some sense, to define what is legally appropriate in life/death decisions?

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<sup>3</sup> Mainly because it does not bring any new conclusions and, in the end, the position of the President's Council in Bioethics remained the same as the traditional definition of death. At some point Singer even claims that, despite criticism of the brain-death definition and its limits, experts in medical and natural sciences have not uncovered any new facts about life and death and therefore cannot contribute to the definition of death in its naturalistic sense (death of the living organism) (Singer, 2018).

Singer's response can be reviewed by presenting his analysis of the relationship between the world of facts and values, judgements of science and ethics. Peter Singer argues that the distance between facts and values cannot be overcome by exploring solely natural patterns of the world (Singer, 1981, pp. 73–74). He argues that both these worlds have, in their essence, a different nature. Values help to determine reasons for the action, but facts themselves are not able to give us reasons, purpose for the action. Simply, facts cannot determine what is valuable and our ethical premises cannot emerge purely from the biological essence of life (or, in this case, death). The main reason is that we, as persons, rationally choose ourselves and our own understanding of what is valuable (Singer, 1981, p. 77). Singer therefore asks himself whether it is actually possible to bring the natural world closer to the world of values through extending our (scientific) knowledge.

On one hand, it can be agreed on that ethics and ethical judgements cannot be constructed exclusively on the basis of scientific knowledge and examination of our biological nature. On the other hand, ethics do not arise from outside the natural world. Through natural sciences, we can at least clarify our relationships with others and with the world itself. Therefore, although it can be argued that moral values are formulated and declared by moral agents,<sup>4</sup> their promotion is fulfilled in moral agents' ability to recognize and reflect the world in which they live (including the natural world). Reflecting on facts and knowledge discovered by science can help moral agents to determine what is right and what moral obligations and responsibilities they have. Even Peter Singer later concludes that persons (as subjects of morality) are, with their intellectual and cognitive abilities, able to proximate the world of facts and world of values and consciously reduce the distance between them and their perspectives. Nevertheless, according to him these worlds never intercept; they still have to be perceived separately (Singer, 1981, p. 150).

Different conclusions are formulated in ethics of social consequences. Unlike Singer, ethics of social consequences directly links the moral value with its manifestation in the world. While referring to L. Grünberg, it can be said that this ethical theory assumes that values are not (and cannot be) independent from the factual, real world. Moral agents formulate ethical judgements in complex interactions with the real world, either biological, or social (Grünberg, 2000, p. 13). Ethical judgements are elementary for moral agents to promote life and its survival, but they cannot be formulated outside of judgments based on facts and knowledge. A full and complex understanding of the world of values (morality) and facts can spread only from the well understood reality of the world and its nature. Therefore, values of life and death cannot be separated from its biological essence, but neither can they be perceived in such a restricted way.<sup>5</sup> The life of a human being is a complex phenomenon, thus making decisions about its ending should consider all of its ethically relevant aspects.

Either perspective we choose to follow (Singer's or ethics of social consequences), the necessary conclusion is that ethical judgements and arguments are essential for medical and legal discourse on life/death decisions. Not only do ethics itself initiates the discourse, it also helps to reflect on the difference between the life of an organism and the life of a complex human being with its goals, quality, and purpose.

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<sup>4</sup> In Singer's terminology, persons.

<sup>5</sup> It should be emphasized that ethics of social consequences understands there are qualitatively different manifestations of life and it has several significant aspects, e.g. social, emotional, psychological. This affects the attribution of the moral value of life to these living entities. I will address this issue further in the following part of this study while defining the value of dignity in ethics of social consequences. At this point, I merely tried to explain that the very first step in determining the moral value of life is its existence.

### **Death of a person and death with dignity**

As stated above, Peter Singer proposes for medical ethics and law to focus on the definition of the death of a person (in comparison to the biologically determined criterion of brain-death). This approach, on the one hand, does not reject the biological understanding of death as a natural consequence of life. On the other hand, it accepts that declaring someone to be alive or dead in medical and clinical praxis should not ignore a particular human being and his or her moral value. Therefore, in the words of William R. Clark, “clearly death must also have a biological meaning independent of the human condition. In the death of our cells, we are no different from all of the other organisms on earth condemned to die as a condition of birth. [...] we normally think of death in the terms of death of the person – the integrated whole composed of personality, will, memory, passion, and the hundreds of other things that make each of us unique [...] and the loss of “personhood” [...] is increasingly viewed as one of the most important aspects of human death” (Clark, 1996, pp. x–xi).

Singer argues in a similar way. Not only has personhood a specific moral significance in moral decision making (Singer, 2001, pp. 87–88),<sup>6</sup> but it also allows us to focus on what is valuable and what is of some quality in a person’s life. It helps us to realize that the biological life of a patient, who has lost all abilities to make any conscious, rational decisions about their own goals, plans and purpose of life, is not something that should be unlimitedly protected. It is a life of an organism that, at this point, is already dead as a person and, therefore, expendable and replaceable. Personhood, as a patient’s ability to make conscious and free decisions, will not return (despite any limited activity and reaction of the brain that can be detected by physicians and other medical professionals). Singer would then say that this patient has a moral concern not to suffer (as a sentient being), but this concern has different moral significance than moral concerns of other patients-persons (for example patients who need organ transplantation).

In ethics of social consequences, a similar tendency for differentiation of moral concerns can be detected. It spreads from understanding the concept of life and its dignity. A dynamic model of dignity allows us to consider different aspects of life in our decision making, without ignoring the moral obligations towards non-human forms of life. In regards to the discourse on defining death in medical ethics and law, a further understanding of dignity might help to differentiate between the moral rights for life (and death) of particular patients.

The debate on dignity has been established in this ethical theory to determine the possible criteria for differentiation of the moral value of life, either with the help of the criterion of the biological form of an individual living being and/or by other aspects of its life, e.g. consequential aspect (Gluchman, 2017, pp. 131–144; Švaňa, 2016; Klembarová, 2015; Lešková Blahová, 2010). The value of dignity is then delimited via considering three aspects of dignity. The first aspect is tied to the respect and the reverence for all living things (their existence in a particular life-form), the second aspect of dignity can be ascribed only to those objects which fulfil the criteria of moral agency, and the third aspect is directly linked to actions and consequences of these actions conducted by moral agents (Gluchman, 2008, p. 111).<sup>7</sup> Accordingly, we can say that the value of dignity is a dynamic concept, which quantitatively and qualitatively differentiate. Similarly, other values within the primary axiological basis of this ethical theory (values of moral right and humanity) are understood as

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<sup>6</sup> Of course, Singer considers all sentient beings to be members of the moral community with their own moral standing. Nevertheless, there is a difference in moral significance between persons and sentient non-persons (Singer, 2001, p. 87).

<sup>7</sup> Ascribing this third aspect of dignity is based on the consequences of concrete actions of moral agents, in other words, the dignity of moral agents can increase/decrease according to how s/he can contribute to the “good” of the moral community and how s/he can guarantee the prevalence of positive social consequences over negative ones.

dynamic concepts connected with one's life rather than in its absolute and rigid axiological sense.

Quantitative and qualitative differences between individual members of the moral community must be reflected and considered in the process of ethical decision making and actions towards them. To create a practical framework for setting priorities between individual moral concerns within the moral community, authors of this ethical theory have started to discuss the idea of moral significance.<sup>8,9</sup> Adela Lešková Blahová claims that it is an attribute of the concept of the moral value of life. It expresses qualitative and complex characteristics, which individual living things have (or don't have) with regards to their morally relevant interests (e.g. sensitivity, reproduction, movement, perception, instinctive behavior, the ability to learn, to associate, practical intelligence, self-reflection, autonomy, etc.) (Lešková Blahová, 2010, p. 90). Following thoughts on differentiation among members of the moral community and the dynamic model of dignity, ethics of social consequences accepts the variability of moral significance. It affects not only the delimitation of value of dignity but the understanding of values of humanity and moral right for life, its protection, and promotion, too.<sup>10</sup> Subsequently, discussing the definition of death in medical ethics and law must also emphasize the discourse on the moral concerns of human patients (who either are or are not moral agents), their dignity, and their morally relevant interests.<sup>11</sup>

Does it mean that death should come hand in hand with dignity? Can death become a morally relevant interest of man? Is there a way to sufficiently connect the value of dignity (respect and reverence for life) to death as a biological part of life? According to ethics of social consequences, this relation is considerable. In comparison to Peter Singer's conclusions, ethics of social consequences understands the difference between the death of a person and death as a purely biological attribute, too, but does not consider these two aspects of death (biological and ethical) as two separate and non-related arguments. Nevertheless, this theory offers an even more extended understanding of death through its definition of dignity. Consequently, death could be perceived as having various qualitative and quantitative differences.<sup>12</sup>

Let us present a possible understanding of death with dignity in ethics of social consequences. Firstly, patients, who fulfil the criteria of moral agency (Kalajtzis, 2012), might relate death to the question of quality of life. In these cases, moral agents are able to understand their life with their purpose and they are able to set their own vital goals.<sup>13</sup> In a state of health, they can freely, responsibly and consciously promote their life and its moral value in their actions and in reaching their vital goals (consequential aspect of dignity). But (how) should we protect the moral right for life of patients, if they lose the ability to reach

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<sup>8</sup> Topic introduced to ethics of social consequences by Adela Lešková Blahová (2010). She was influenced by authors such as Kenneth E. Goodpaster (1978) and Robin Attfield (1999).

<sup>9</sup> Another issue related to the problem of setting priorities within the moral community is the delimitation of the extended concept of moral community in which morally relevant relationships play an important role in setting the priorities between the moral concerns of its members in practical and everyday moral experiences (Komenská, 2018; 2014).

<sup>10</sup> Which are, together with the value of dignity, recognized as primary values in ethics of social consequences and which all are directly linked to a complex understanding of moral value of life.

<sup>11</sup> Here a confrontation with Nicolai Hartmann's view might be productive, who claimed that death is a disvalue (in comparison to the value of life that is given to us to protect and care for) and could hardly have a positive (or at least right) connotation (Cicovacki, 2017, pp. 155–168).

<sup>12</sup> Gradual evaluation of the meaning of death is not an idea exclusively reflected on only in secular thinking. Even in theological and religious discourse, the differentiation of death as a meaningful or worthless event in life can be perceived (Davies, 2007, pp. 153–175).

<sup>13</sup> Term used by Lennart Nordenfelt in his holistic theory of health (2007). In ethics of social consequences, a similar aspect of active participation of moral agents on their lives (and their moral value) can be perceived. This aspect of moral agency has been recently compared to Spinozian ethics (Petrůvová Joppová, 2018, pp. 46–48).

their vital goals or set any new, adequate ones? The same possibility for an ethical choice should be guaranteed to all moral agents in their conflicts between life, health, and death. In such cases, the wishes and goals of moral agents should be of highest importance in making any decision regarding their death.<sup>14</sup> Dying with dignity might be for them an eligible answer to ethical dilemmas, mostly if they cannot fulfil their goals and if they consider their life to be irreversibly bad and full of suffering.

In the second type of case, the situation gets more complicated. What happens if the patient's condition deprives him/her of the status of personhood/the status of moral agency? The moral value of life is not lost to the patient, but the qualitative and quantitative differences are obvious. At this point, ethics of social consequences would partially agree with the conclusions of Peter Singer. There is a significant contrast between the morally relevant interest of this patient (not moral agent) and the interests of members of the moral community, who still preserve their status of moral agency. The difference between ethics of social consequences and Peter Singer lays in perspectives on how these theories support their arguments in considering such a patient as dead (as a person/moral agent). Oppositely to Singer, who will argue through the utilitarian perspective of the good of others and greater utility for the rest of the moral community (organs for transplantations, lesser costs of health care, ending emotional and social suffering of family members), ethics of social consequences would determine the patient to be dead as a moral agent because of the protection of patient's life, quality of life and dying, and, last but not least, to protect his/her dignity. This approach puts focus on what is good for the patient and it promotes moral right, humanity, and dignity in the final moments of this patient's life.

### Conclusion

Life and death are complex phenomena which, in everyday decision making, manifests in different perspectives. In ethics of social consequences, the focus in understanding these phenomena lies in delimitation of their moral value and their reflections via relevant knowledge about their appearance in the natural world. This might also be a reason why the moral value of life is not understood in this ethical theory as an invariant and absolute value, but rather as something to be reflected on and evaluated in the given context and situation. Consequently, death (as a natural component of life) is a part of the ethical conceptualization of the moral value of life. This might be an important and effective approach to solve various contemporary bioethical issues. It can help us to define the different needs and morally relevant interests of members of the moral community. Through the analysis of dignity and its dimensions in ethics of social consequences (biological, intellectual-cognitive, consequential), it was concluded that death might be understood as a morally relevant interest of any members of the moral community. This applies if (and only if) it promotes the dignity of one's life (and its end).

Nevertheless, either through the argument of the sanctity of human life, the argument of the quality of life, or the argument of utilitarianism, the involvement of ethicists and philosophers in reentering the debate on death is required and welcomed to overcome the limits of medical and legal discourse on redefining death.

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<sup>14</sup> Following this argument, the moral agent has the right to choose death above life (either in the form of euthanasia, (assisted) suicide) or in rejecting any treatment), if s/he believes his/her life is deprived of dignity and quality.

## References

- ATTFIELD, R. (1999): *The ethics of the global environment*. Edinburgh: Edinburgh University Press.
- CICOVACKI, P. (2017): On the puzzling value of human life. In: *Ethics & Bioethics (in Central Europe)*, 7(3–4), pp. 155–168.
- CLARK, W. R. (1996): *Sex & the origins of death*. Oxford: Oxford University Press.
- DAVIES, D. J. (2007): *Stručné dějiny smrti [A brief history of death]*. Praha: Volvox Globator.
- GLUCHMAN, V. (2008): *Etika a reflexie morálky [Ethics and Reflections of Morality]*. Prešov: FF PU.
- GLUCHMAN, V. (2017): Nature of dignity and human dignity. In: *Human Affairs: a postdisciplinary journal for humanities and social sciences*, 27(2), pp. 131–144.
- GRÜNBERG, L. (2000): *The mystery of values: Studies in axiology*. Amsterdam: Rodopi.
- GOODPASTER, K. E. (1978): On being morally considerable. In: *The Journal of Philosophy*, 73(6), pp. 308–325.
- HARI, J. & SINGER, P. (2004): Peter Singer: Some people are more equal than others. In: *Independent*, 1<sup>st</sup> July 2004, [online] [Retrieved November 5, 2018]. Available at: <https://www.independent.co.uk/news/people/profiles/peter-singer-some-people-are-more-equal-than-others-551696.html>
- KALAJTZIDIS, J. (2012): *Etika sociálnych dôsledkov a hospodárska etika (so zameraním na finančný sektor [Ethics of social consequences and business ethics (with focus on financial sector)])*. Brno: Tribun EU.
- KLEMBAROVÁ, J. (2015): *Etické a morálne aspekty mentálneho postihnutia [Ethical and moral aspects of mental impairment]*. Prešov: FF PU.
- KOMENSKÁ, K. (2018): The concept of moral community in ethics of social consequences. In: V. Gluchman (ed.): *Ethics of social consequences: Philosophical, applied and professional challenges*. Newcastle: Cambridge Scholars Publishing, pp. 196–211.
- KOMENSKÁ, K. (2014): *Etika vzťahu k zvieratám (cez optiku etiky sociálnych dôsledkov) [Animal ethics (through the perspective of ethics of social consequences)]*. Prešov: VPU.
- LEŠKOVÁ BLAHOVÁ, A. (2010): *Bioetika v kontextoch etiky sociálnych dôsledkov (aplikácia zvolenej paradigmy na vybrané bioetické problémy) [Bioethics in the context of ethics of social consequences (Applications of chosen paradigm on selected bioethical issues)]*. Prešov: FF PU.
- NORDENFELT, L. (2007): The concepts of health and illness revisited. In: *Medicine, Health Care and Philosophy*, 10(1), pp. 5–10.
- PETRUFOVÁ JOPPOVÁ, M. (2018): Spinozian consequentialism of ethics of social consequences. In: *Ethics & Bioethics (in Central Europe)*, 8(1–2), pp. 41–50.
- PRESIDENT'S COUNCIL IN BIOETHICS (2008): *Controversies in the determination of death: A white paper*, [online] [Retrieved November 5, 2018]. Available at: <http://bioethics.georgetown.edu/pcbe/reports/death/index.html>
- SINGER, P. (1981): *The expanding circle: Ethics and sociobiology*. Oxford: Clarendon Press.
- SINGER, P. (1995): *Rethinking life and death: The collapse of our traditional ethics*. Oxford: Oxford University Press.
- SINGER, P. (2001): *Osvobození zvířat [Animal liberation]*. Praha: Práh.
- SINGER, P. (2012): The 'Unnatural' Ashley Treatment Can Be Right for the Profoundly Disabled Children. In: *The Guardian*, 16<sup>th</sup> March 2012, [online] [Retrieved November 5, 2018]. Available at: <https://www.theguardian.com/commentisfree/2012/mar/16/ashley-treatment-profoundly-disabled-children>
- SINGER, P. (2014): Choosing death. In: *Project Syndicate*, 9<sup>th</sup> September 2014, [online] [Retrieved November 5, 2018]. Available at: <https://www.project-syndicate.org/commentary/choosing-death/peter-singer>

syndicate.org/commentary/peter-singer-makes-the-case-for-allowing-patients-to-decide-when-to-end-their-lives?barrier=accesspaylog

SINGER, P. (2017): We should end the suffering of patients who know they are dying and want to do so peacefully. In: *The Guardian*, 18<sup>th</sup> September 2017, [online] [Retrieved November 5, 2018]. Available at: <https://www.theguardian.com/commentisfree/2017/sep/18/we-should-end-the-suffering-of-patients-who-know-they-are-dying-and-want-to-do-so-peacefully>

SINGER, P. (2018): The challenge of brain death for the sanctity of life ethic. In: *Ethics & Bioethics (in Central Europe)*, 8(3–4), pp. 153–165.

ŠVAŇA, L. (2016): „*Etika*“ vojny a terorizmu [*“Ethics” of war and terrorism*]. Bratislava: Veda.

US PRESIDENT’S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE (1981): *Defining death: A report on the medical, legal and ethical issues in the determination of death*. Washington, DC, [online] [Retrieved November 5, 2018]. Available at: <https://archive.org/details/definingdeathrep00unit>



## The challenge of death and ethics of social consequences: Death of moral agency

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### Abstract

The present paper focuses on the issue of death from the perspective of ethics of social consequences. To begin with, the paper summarizes Peter Singer's position on the issue of brain death and on organ procurement related to the definition of death. For better understanding of the issue, an example from real life is used. There are at least three prominent sets of views on what it takes to be called dead. All those views are shortly presented and analysed. Later, the theory of ethics of social consequences is briefly presented. The paper looks for the position of this ethical theory in connection to the issue of death. The issue of organ procurement, which is closely connected to the problem of defining death, is used as a means for a better understanding of the issue. The issue of death is studied through the categories of moral subject and moral object. Using the standpoint of ethics of social consequences enables us to distinguish between the death of a moral agent and the death of the organism. That helps to soften many issues associated with the topic.

**Keywords:** moral agent, ethics of social consequences, death, organ procurement

### Introduction

The main aim of this paper is to present the views of ethics of social consequences on the issues that are presented in Singer's paper *The challenge of brain death for the sanctity of life ethics*. However, the task is large and the issues involved are complex. That is why I settle only for a very sketchy account of them. To accomplish the aim, it is firstly necessary to briefly summarise the issues mentioned in Singer's paper. Then the paper proceeds with a brief introduction of several values and positions of ethics of social consequences. In the conclusion, the paper tries to explain the theory's position towards the understanding of death and organ procurement issues.

The present paper agrees with the claim that defining death is not an exercise in coining the meaning of the term. It is an attempt to reach an understanding of the philosophical nature of the human being. It is an attempt to understand what it is that is essentially significant to humans that is lost at the time of death (Veatch & Ross, 2016, p. 16).

### Singer's position and underlining of problems

Singer starts his paper (Singer, 2018) with an outdated definition of death<sup>2</sup> based on the stoppage of the circulation of blood, and cessation of animal and vital functions. He explains that two decades later this physiological definition was replaced with a newer one, based on the irreversible cessation of all functions of the entire brain, including the brain stem.<sup>3</sup> He states that this new definition is understood as a scientifically improved understanding of the nature of death, but without deeper ethical analysis of the issue. Singer connects this new definition of death with rising demand for organs (donors) emerging from a newly (in the nineteen-sixties) developed medical procedure – transplantation.

He proceeds with the recent example of Jahi McMath, whose story has the potential to disrupt the definition which has been almost seamlessly accepted for the last thirty years. McMath was declared brain-dead after an unsuccessful medical procedure, but kept breathing with the help of a ventilator. The family was asked to take her off the ventilator and donate her organs. They disagreed and took her to a different state with different legislation, more

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<sup>2</sup> Physiological death, sometime called circulatory-based death definition.

<sup>3</sup> The paper will use the term brain-death, but in other literature it might be called the whole brain view.

supportive of their decision.<sup>4</sup> After a while, she was discharged from the second hospital as well (with a brain-dead diagnosis). According to the latest information, she died recently (summer, 2018), as a result of complications associated with liver failure. McMath remained with her parents, on a ventilator and fed through a tube (despite being officially declared brain-dead) for almost five years. One of the many outcomes of this case is the trial in which the definition of death will be a central issue. In his paper, Singer updates his earlier ideas on the definition of death to show that there are reasons for rejecting the nowadays prevailing view of brain-death. Equally, his aim is to show that rejecting this definition will shake up the debate between those who believe in the sanctity of human life, and those who hold that the quality of life must affect its value.

The main idea behind the definition of brain-death is that, without brain function, the body is no longer an integrated whole, just a collection of cells and organs. But this view, as Singer suggests, is no longer convincing, since there is evidence that organic functioning can persist despite the irreversible cessation of all brain function. Besides the already mentioned Jahi McMath, other cases of “living”<sup>5</sup> brain-dead patients were described by the paediatrician Alan Shewmon. Another argument in support of the weakness of brain-death’s definition is the new findings in the McMath case made by Shewmon. Those findings suggest that there is a possibility of unreliability in the test used for indicating brain-death. Despite all the findings (“living” brain-death patients) and doubts (people with locked-in syndrome, or spinal cord injuries), the brain-death definition is still universally accepted (only the rationale for the support has changed).<sup>6</sup>

The President’s Council on Bioethics in the United States considers the issue of defining death and the practice of organ procurement doubtful. The beating heart of a donor (with brain-death) is necessary for the safe extraction of organs and as such is desired. Many people who need organs will otherwise die. But it is believed that it is ethically unacceptable to remove vital organs from living human beings (and as such to harvest the organs from humans with beating hearts). The question which arises in this context is – is it morally defensible to use “living” but irreversibly brain-dead human beings as organ donors? There are a lot of objections against it. Singer answers the most frequent one, raised by Kantian supporters (based on the categorical imperative in its second formulation). And he dismisses it as invalid. He argues that organ donors in most developed countries have the right to permit or refuse donation (or give this choice to relatives). So even though the legislative process of donation varies in different countries, consent (explicit/opt-in or presumed/opt-out) is needed. Donors are never used only as a means, and thus Kant’s requirement is fulfilled. The issue which remains is the legislative one. Should we (as organ donors) consent to donate organs only after we are dead (the issue of what is dead remains), or is it satisfactory to consent to donate after we are diagnosed as brain-dead (even if some of our bodily functions might still be operating).<sup>7</sup>

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<sup>4</sup> Before legislative updates, it was legally possible to be declared dead in one state of the USA (when the heart is beating and blood circulating, but there is no brain function), and alive in a different state with the same condition. The criteria by which the death of the human being is defined vary not only within the USA, but between countries as well. While the prevailing criterion applied in the USA is the brain death criterion, according to which people die just when their brains as wholes irreversibly cease to function, in the UK the prevailing criterion is the stem criterion. People are considered dead only when their brain stems irreversibly cease to function (Luper, 2009, pp. 58–59).

<sup>5</sup> As support for the statement that patient lives even when brain-death, he states that patients can grow, overcome infections and heal the wounds.

<sup>6</sup> From understanding of brain failure as determinant of the organism’s disintegration, to brain failure as an end of engagement in commerce of the organism with the surrounding world. The argumentation changed in effort to maintain the definition.

<sup>7</sup> See the Shewmon findings and works, such as D. A. Shewmon & Calixto Mechado (eds.) (2004).

But why should we use the criterion of brain-death, and not include as donors also patients who lost all capacity for consciousness as well, asks Singer? As can be seen in the next paragraphs of his paper, he is not the only one in favour of this move. Are not brain-death and the death of consciousness the same thing, after all?<sup>8</sup> It is not that hard to imagine the (positive) answer to the question, but it is without doubt difficult to make a clear equivalent of it to the death of the human organism. The argumentation is tightly connected with the customary use of terms such as death. As Singer notes, “Living things with no brain at all, let alone a higher brain, can be alive, and they can die”.

Singer works with the interpretation of those issues as they are presented in the work of Jeff McMahan and Mark Johnston. The assertion is that we are not “essentially human organisms” and with this claim we can distinguish the death of a person from the death of the organism. The differentiation is quite easy. To survive as a person, we need to have “our mind”, so to exist as a person we need to have functional those areas of brain which are responsible for consciousness and mental activity. Even though it sounds contradictory, if we accept this proposition, we can die and still be alive. We die as a person, but our body can survive this death and still be “alive”.

Singer accepts McMahan’s proposition that this pattern can be applied for all organisms with a mind but is not applicable to all members of a specific species (as some individuals might have non-functional necessary parts of the brain e). In the context of the paper, the question which arises is whether it is morally defensible to harvest organs from human bodies that are not a person any more.<sup>9</sup>

### **Understanding the issue**

It can be claimed that since the 1970s to the present, three prominent (even though not exclusive)<sup>10</sup> sets of views on what it takes to be called dead have been formed. One group focuses on the irreversible loss of function of the entire brain (including the brain stem). The second group insists on the former (traditional) definition, focusing on the circulatory-based concept of death. The third group holds that only certain brain functions are critical as an indicator of life (Veatch & Ross, 2016, p. 3).

For the purpose of this paper, death can be easily defined as an irreversible<sup>11</sup> cessation of the vital processes that sustain us. In this sense, to understand what death is, is to understand who we are. There are many ways to do so, from which the three best known are animal essentialism, person essentialism and mind essentialism. Animal essentialism states that we are essentially animals; the second says that we are essentially self-aware beings; and the third that we are essentially minds. With those views, various accounts of persistence conditions are connected. The animalist account says that we persist when we remain the same animals. The psychological account states that our persistence hinges on our psychological attributes. And the mind account claims that we persist when our minds remain intact (Luper, 2009, p. 5–7).

The reason why we are trying to find out how to describe and define death opens another array of problems. It is only when the defined criteria are met that it is appropriate to take

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<sup>8</sup> There is a terminological inconsistency in philosophy when using terms such as “death”, “person” and indications such as “to be” or “to exist”. In this paper, the term person refers to a human being that not only “is” (as in has some physiological signs of existence such as wounds healing) but is able to fulfil other higher criteria which will be explained later on, so we can say “he/she exists”.

<sup>9</sup> Or have been born as bodies without that part of the brain which constitutes us as a person.

<sup>10</sup> Traditionally there are four of them from which one is not acknowledged as scientifically acceptable.

<sup>11</sup> In literature focusing on the issue of death, one might find a discussion on using the terms irreversible vs. permanent interchangeably. The emphasized difference is that permanent loss will never be restored (even if medically possible), irreversible loss could not be restored (even if someone tried) (Veatch & Ross, 2016, pp. 5–6).

various actions, such as ending medical treatment, transferring the property of the deceased, or retrieving organs for donation (which is of interest for the paper). There is an obvious connection between the definition of death and organ transplantation.<sup>12</sup> We cannot take life-prolonging organs until someone is dead<sup>13</sup> (Luper, 2009, p. 49; Veatch & Ross, 2016, p. 6).

The major catalyst for the debate about when a person is classified as dead was the “dead donor rule”. It is a simple deontic constraint that categorically prohibits causing death by organ removal. By this definition, before life-prolonging organs can be procured for transplantation, the human being from whom they are taken must be dead. The removal of paired organs such as the kidneys, or organs which are not taken whole such as the liver, are excluded from the rule. The exclusion assumes that their procuring would not cause the end of life. Although not by everybody, this rule is generally accepted. The killing of others, even for good reasons such as saving the lives of others, has been universally viewed as against morality and against the law. On the other hand, the definition of what it means to be dead has caused and is still causing great controversy (Nair-Collins, Green & Sutin, 2015, p. 297; Veatch & Ross, 2016, pp. 16–17).

The earlier mentioned concepts of who we are (animals, self-aware beings or minds) are closely connected to concepts of death. There are several concepts, from which the four most important are: traditional, circulatory (somatic), whole-brain death and higher-brain death. Each of those concepts have many variants within them. What they have in common is an attempt to determine what is so significant to humans that when we lose it, we lose our legal and/or moral status. The traditional concept of death is based on religious tradition. Even though it is still used in some discussions, the view that we die at the time when the soul leaves the body can be considered as a retreating one nowadays. The second concept was mostly used until the beginning of organ procurement issues. This view identifies the death of the human being with the flow of fluids in the animal species. The third concept connects the complete loss of the body’s integrating capacities with brain functions; popularly known as brain death, generally used for the past half century, but recently strongly criticized. The criticism is mostly based on claims that it is either too inclusive (including brain functions which are not critical), or on other hand not inclusive enough (as in omitting integrative functions which are not brain based) (Veatch & Ross, 2016, pp. 19–21).

The last concept rejects that the whole brain and/or its integrative function is important for defining death. Contemporary discussion suggests that only certain more critical brain functions are important and should be taken into account when discussing the death of a human.<sup>14</sup> Proponents of this last concept are not able to agree on which function of the brain is the critical one. Once again, the question which is asked is: which function of the brain is the one which makes us humans (moral agents)? There are several candidates for the answer from which the most notorious are: the capacity for rationality, personhood or personal

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<sup>12</sup> One example would be a heart transplantation, which is very specific. Heart transplantation poses a special problem in relation to organ procurement following cardiac-based/circulatory-based death pronouncement. Once it is determined that the heart has stopped irreversibly, the organ is useless for transplantation due to functional irreversibility. Therefore, the definition of death and the type of definition which is in use is fundamental. For more on this specific issue see Robert M. Veatch (2010).

<sup>13</sup> Almost all (paired) organs used for transplant (except for those from living kidney donors) come from the bodies of the newly deceased. To ensure that those organs are in a viable condition, it is necessary to get them as soon after death as possible. That is why it is critical to be clear on exactly what it means for a human to be dead (Veatch & Ross, 2016, pp. 15–16).

<sup>14</sup> It is important to notice that not only in this, but in all mentioned concepts which are presented, this paper studies the normative part of the questioned issue. The ideas presented in this paper focus on a normative understanding of what is death and how it is connected to human beings (to who we are). The scientific answers to the question might be quite different. It is something different to give a scientific answer to the question what it means to be dead (biologically), and a normative answer to the question what it means to be dead as a human (person, moral agent, etc.).

identity, capacity to experience, the capacity for social interaction or embodiment of capacity (Veatch & Ross, 2016, pp. 88–106). The answer suggested by ethics of social consequences connects some of those answers, but likewise is not able to answer the question fully.

### **Ethics of social consequences and the issue of death**

Ethics of social consequences can be characterized as a consequentialist ethical theory with the inclination to act utilitarianism and a case-oriented approach. The case-oriented approach is acknowledged as a better way of dealing with specific moral issues of everyday life. Other aspects of ethics of social consequences are: moderate subjectivity, hedonism and partial eudemonism. Even though this might signalize a certain similarity with utilitarianism, ethics of social consequences refuses to be associated with it.<sup>15</sup> The core values of ethics of social consequences are: humanity, human dignity and moral right. Secondary, or auxiliary values closely interconnected with the primary ones are: responsibility and justice.

The values which are closely connected with the issue of this paper are humanity<sup>16</sup> and human dignity. They are understood in connection with the protection, support and development of human life that usually bring positive social consequences. The theory assumes that protection and support of the development of life (including human life) brings positive social consequences.<sup>17</sup> That is why people naturally tend to protect and support life in any forms. The reason is not only our awareness of our duty to act to produce positive social consequences, but predominantly our compassion with suffering people and our need to help to protect and support life.

Gluchman states that every adult moral agent gains the value of human dignity as a human, based on the fact of his/her existence. Nevertheless, the demand on the respect of his/her dignity and humanity in relation to him/herself must be permanently confirmed by his/her actions, more specifically by the character of his/her actions that should be in accordance with valid and acceptable moral norms (even legal norms to some point – e.g. the right to live) or at least should not be in contrast with them (Gluchman, 1997, p. 156). According to ethics of social consequences, every human being (even mentally disabled individuals) has the primary equivalent value of human dignity. When promoting the value of humanity, ethics of social consequences differentiates on the grounds of the qualitative criteria of human life. Realization of the value of humanity in ethics of social consequences then can bring us to a situation in which terminating the life of a constantly suffering being is a demonstration of humanity.

Dignity<sup>18</sup> in ethics of social consequences is understood as a value which we assign to entities following a body of qualities or values they have and which are worthy of esteem and respect (Gluchman, 2008, pp. 92–93). All living entities have a certain basic degree of dignity with regards to their being. This is called the ontological grounds of the value in ethics of social consequences. But the value is neither absolute nor constant. As already stated, it greatly depends on the stage of development of an entity and its activity. To be more terminologically clear, it is necessary at this point to distinguish the difference between “to

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<sup>15</sup> An explanation of this rejection is not the aim of the paper and can be found in different papers, for example: Kalajtšidis & Gluchman (2014); Kalajtšidis (2013). Ethics of social consequences is lately denominated as a hybrid form of ethical theory. Example of how this might help to understand the theory better can be found in: Švaňa (2016).

<sup>16</sup> Humanity is, in ethics of social consequences, expressed as respect for the human being per se (Gluchman, 2018, p. xv).

<sup>17</sup> Positive social consequences can be characterized as consequences which help to satisfy the necessity of moral agents, the social community or society as such. They are an essential condition (and at the same time part) of the good (Gluchman, 1994, p. 16; Gluchman, 1999, p.18).

<sup>18</sup> For a complex explanation of the (human) dignity value in ethics of social consequences see Polomská (2018).

exist” and “to be” (to be alive).<sup>19</sup> The being of the entity, so when an entity “is”, it means that he/she “lives” and because the entity “is” – lives, he/she has a basic degree of dignity. However, if the entity not only lives, but additionally he/she lives actively (is in interaction with its surroundings on a required level), then it can be stated that he/she exists. Death is considered as something bad (usually not desired) for several reasons. One of the most vigorous ones is the fact that death deprives us of the good things we would have enjoyed had we lived on (others might include fear of the unknown, or of pain during the process of dying, etc.). Of course, the former is true only under the assumption that we have the ability to enjoy the good. We have this ability only if we really exist as active beings, not only “are” as living entities.

In ethics of social consequences, the actions and activities of existing beings are regarded as a criterion for the differentiation of the dignity which is ascribed to the entity. Dignity which is ascribed is different on the one hand from species to species (it depends on their developmental stage in evolutionary chain), and as well between individuals from the same species (it depends on consequences of their actions) (Gluchman, 2009, p. 83).

Ethics of social consequences works with categories which might make the issue we are dealing with in this paper much clearer. It distinguishes between moral agent (subject) and moral object. Gluchman states that a moral agent is an agent of morality fulfilling required criteria: “he/she is able to recognize and understand the existing moral status of society and is competent of conscious and voluntary activity, for which he/she needs to take moral responsibility” (Gluchman, 1997, p. 22; Gluchman, 2018, p. xv). What is interesting in this definition is the fact that there is no condition to be a part of a specific biological species.<sup>20</sup> This helps it to overcome the speciesism argument which is present in those types of definitions. At the same time, the definition stays open to future discoveries of different life forms (extraterrestrial life or artificial intelligence). In addition to moral subject (agent), ethics of social consequences distinguishes moral object which is defined much more widely. All human beings, also animals to some extent, and even the entire universe can potentially be the object of our moral interest and actions, therefore – moral object (Gluchman, 2018, p. xv). Every moral agent (subject) is a moral object in this definition – and as such deserves the protection and respect of others. However, only few moral objects are sufficient to fulfill the requirements of becoming a moral agent (subject).<sup>21</sup> The definition of a moral agent used in ethics of social consequences is based on intellectual-cognitive assumptions. In this sense, it is close to McMahan’s ideas which are accepted by Singer.<sup>22</sup> However, a complex understanding of the issue is much more complicated, and it must be stated that Singer’s comprehension of moral agency is different (even with a few similarities) from its understanding in ethics of social consequences (Kalajtzis, 2017).

Ethics of social consequences comes from the standpoint that the death of a human being is an irreversible loss of what it is essentially to be a human (the intellectual-cognitive position). Ethics of social consequences assumes that set of functions controlled by the brain are more essential “than a mere pump and set of tubes through which blood flows” (Veatch & Ross, 2016, p. 6). Ethics of social consequences comes from the position that this definition of what

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<sup>19</sup> It is of course a matter of further discussion what it means to live. Gluchman writes that life is a “bin” which need to be filled up; that the existence of life is a base for the further ascribing of dignity. It is a value which deserves protection (Gluchman, 2008, p. 97). But it can only be assumed that the “existence of life as a base” means the same thing that I identified as “to be” and not “to exist”.

<sup>20</sup> Gluchman himself writes about moral agent using the term “person” as a synonym (Gluchman, 2008, p. 91), but never states that the definition of moral agent is reserved only for humans.

<sup>21</sup> Ethics of social consequences recognizes various types of moral agents, regarding several criteria. This taxonomy is not relevant for this paper. For those interested. see e.g. Kalajtzis (2017).

<sup>22</sup> Another approaches exist and are used. Haksars for example works with axiological criteria such as to act in accordance with minimal moral norms (Haksars, 1998, p. 499).

is essential to human existence is based not only on philosophical beliefs. It is based on contemporary medical knowledge, and in part on basic religious beliefs as well.

There is a clear difference between a moral agent (subject) and a moral object. This distinction can be identified by the presence of the consciousness, rationality and self-determination of the agent and their absence in the moral object. Those attributes are important because they are a prerequisite for the ability which distinguishes (qualitatively) a moral agent from any other being. The distinction is based on the ability of moral responsibility. Moral responsibility in ethics of social consequences is understood as the ability of an agent to take account for his/her actions or omissions. This competence is interconnected with the possibility to praise or blame him/her (reward or punish him/her). However, this understanding is not sufficient enough; additionally, the agent must be able not only to bear something (to take account), but also able to act. On the one hand the responsibility is understood as the ability to bear, on the other as the ability to act. It is important to acknowledge this aspect of responsibility; as a facility to assign duties to an agent. The agent must be able to act on behalf of something. If the agent is not capable of acting on behalf of something, it is impossible to refer to him/her as responsible and therefore as an agent. There is no purpose in assigning duties to somebody who is unable to be accountable for them. In this sense, responsibility is understood as an integral and central attribute of moral agency (Kalajtzidis, 2018).

There are three conditions which must be fulfilled when we want to ascribe moral responsibility to a moral agent and hold him/her responsible. The agent must be confronted with the situation which is morally relevant. He/she must face a morally significant choice involving the possibility of doing something good or bad (right or wrong).<sup>23</sup> The second condition is that he/she is able to judge the situation. The moral agent must be able to acquire relevant information to make a judgment. They must be in the position to see what is (was) at stake. The third condition is to be able to take charge of the way he/she shapes his/her judgment; he/she must be able to choose on the basis of judgment. The choice must be within the domain of the agent's will (control) (Kalajtzidis, 2018). It is clear that Jahi McMath from Singer's example was unable to fulfil those criteria, and as such she could not be labelled a moral agent. McMath and many other patients without a fully functional brain (without the functions of the higher brain)<sup>24</sup> cannot be considered moral agents. As such, they cannot relate to the notion of moral responsibility.

In this sense, they cannot be held accountable and are not eligible for moral evaluation. Without this ability there is no point in reflecting on other aspects of responsibility such as the notion of duty<sup>25</sup> and notion of guarantee.<sup>26,27</sup>

### Conclusion

As stated earlier in the paper, McMahan, Johnston and Singer (among others) work with the assertion that we are not "essentially human organisms". This helps us to distinguish between the death of a person and the death of the organism. McMahan is a supporter of the

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<sup>23</sup> For better understanding of the issue see: (Gluchman, 2017).

<sup>24</sup> As a specific part of the of the brain responsible for a particular function.

<sup>25</sup> Connected in ethics of social consequences with the ability to make deliberate decisions and act on them. To act in compliance with fundamental moral values, such as human dignity and humanity.

<sup>26</sup> Connected in ethics of social consequences with the ability to bear consequences. To allow (for) the possibility to impute reward or punishment on a moral agent.

<sup>27</sup> It must be stated that the issues of moral responsibility and moral agency are inseparable. Without moral agency, there would be no moral responsibility. Without moral responsibility there would be no moral agency (notion of moral agent) as we know it. For better understanding of the notion of moral responsibility in ethics of social consequences, see Responsibility and justice: secondary values in ethics of social consequences (Kalajtzidis, 2018).

mind account of persistence mentioned above. It suggests that it is our mind that makes us who we are, that we are essentially minds. We persist as far as our minds remain intact. More precisely, McMahan believes that we persist just if the regions of our brains responsible for our capacity for consciousness remain undivided as well as functional enough to make consciousness possible. McMahan calls this account the embodied mind account (McMahan, 2002, pp. 66–69).

In the terminology of ethics of social consequences, we can use the terms moral agent and moral object in this sense. This distinction can be used to help in situations when it needs to be decided if organ harvesting is defensible or not. When a being has lost its ability to be a moral agent (as was explained in connection to moral responsibility), it dies as a person. However, the human being still exists and is labelled as a moral object. The person (moral agent) is dead, but the body survives (moral object). Luper is, in his book *Philosophy of death*, exploring the connection between ceasing to exist and dying. He asks if we may cease to exist deathlessly, or die without ceasing to exist (Luper, 2009, p. 39). McMahan's version of mind essentialism accepts the termination thesis which states that dying entails ceasing to exist. Mind is embodied and is annihilated when its embodiment dies. On the other hand, if the person ceases to exist (loses the ability to be a moral agent) then they can depart deathlessly in this sense. The moral agent ceases to exist without dying. The question which stands in front of us will be whether these living bodies (which ceased to exist without dying) that are no longer moral agents (persons) should be treated differently from normal living people? Ethics of social consequences would answer positively.

This type of reasoning is possible in ethics of social consequences in connection with its primary values: humanity and human dignity. Both values are understood in connection to the protection, support and development of human life.<sup>28</sup> Harvesting of organs from a moral object is a promotion of those values. It is a promotion of the protection, support and development of human life, at the expense of "life" in general. It is a demonstration of humanity. It is true that people naturally tend to protect and support life in any form. Ethics of social consequences states that one of the reasons for this protection and support is predominantly our compassion with suffering people and our need to help and protect and support life. But in the same sense it must be stated that people also naturally differentiate between life, and do not accept all its forms as naturally equal.<sup>29</sup>

Even if a being is born in a human like body, if it cannot fulfil the criteria to be understood as a moral agent, it only "is" and does not "exist" (in the already mentioned meaning). A being was born (as a body, as a moral object) but at the same time it was dead (as a person, as a moral subject/agent). The same applies for those who lost the ability to be a moral agent during their life as a result of any event. They can be labelled on the one hand as a living being (legally or medically) and still be labelled as dead (person / moral agent) in our meaning.<sup>30</sup>

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<sup>28</sup> As a result of the rapid growth in science and technology, realization of the importance of moral responsibility for the preservation of humankind is growing as well.

<sup>29</sup> In this context Katarina Komenská developed a concept of moral community which tries to explain the issue of the relationships between moral agents from the point of view of ethics of social consequences (Komenská, 2014).

<sup>30</sup> For some readers, those ideas might remind them of ideas which are closely connected to discussions on euthanasia and eugenic programs. Those were popular mostly at the beginning of the 20th century and even applied during Nazism in Germany. The idea of existence of "life unworthy of life" is closely connected with the poverty and starvation which appeared in contemporary Germany after the First World War. Most noted contributors to the spreading of the idea were Karl Binding and Alfred Hoche who published an influential tract *Permission for the Destruction of Life Unworthy of Life* (1920). Those ideas and ideas in the paper should not be confused and/or connected. The presented paper does not claim (for example) that there are lives which are not worthy of protection by law, does not commodify people, or does not claim that people might have a negative value, etc. For a deeper understanding of the former I suggest the book by Michael Burleigh *Death and*



There are two basic arguments for this position. The first is the already mentioned value structure of the theory which is connected to the protection and support of life. The second is the consequential attitude of ethics of social consequences. Moral objects have no ability to protect and support life,<sup>31</sup> and equally they do not cause consequences in a way a moral agent can. In other words, ethics of social consequences cannot evaluate the consequence of their actions, as they do not have the power to perform them (even if they might happen).<sup>32</sup> Ethics of social consequences states that the demand on the respect of dignity and humanity in relation to human beings must be permanently confirmed. This confirmation is possible only by actions by human beings, specifically by the character of their actions that should be in accordance with valid and acceptable moral norms. However, only moral agents can fulfil this requirement.

It is believed that it is morally unacceptable to remove vital organs from living human beings. However, it is very important how we define a living human being.<sup>33</sup> If by a living human being we mean a moral agent, then our argumentation can soften this issue. On the other hand, if by a living human being we mean every human-like body (even those which we labelled as moral objects), then the problem remains. At the same time this second understanding opens many other questions connected with this position, such as what is so special about beings that look like humans but have no abilities of a person (moral agent). Another problem which remains and should be considered as very important is the connection between moral death (as a person) and the legal definition of death. This is mostly important in connection to organ harvesting. Is it possible to legalize<sup>34</sup> organ harvesting from humans who lost the ability to be a moral agent? Is it feasible in humans who were born without this ability? Who is legally responsible for their consent? Those and many other questions will still stay in front of us until we find an acceptable definition of death. A definition which is not only up to date with contemporary medical research, but primarily in accordance with our moral understanding of the issue.

## References

- BURLEIGH, M. (1994): *Death and deliverance: Euthanasia in Germany 1900–1945*. Cambridge: Cambridge University Press.
- COLLINS-NAIR, M., GREEN, R. S. & SUTIN, A. R. (2015): Abandoning the dead donor rule? A national survey of public views on death and organ donations. In: *Journal of Medical Ethics*, 41(4), pp. 297–302.
- GLUCHMAN, M. & KALAJTZIDIS, J. (2014): Ethics of social consequences and issue of the principle of humanity in medical ethics. In: *2nd Eurasian multidisciplinary forum*. Tbilisi: ESI, pp. 235–243.
- GLUCHMAN, V. (1994): *Angažovanost', solidarita, zodpovednost'* [Involvement, solidarity, responsibility]. Prešov: Universum.
- GLUCHMAN, V. (1997): *Človek a morálka* [Person and morality]. Brno: Doplněk.

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*deliverance* (1994). A warning about how today's society might become focused on consumption values and commodify people can be found in a paper by Joanna Mysona Byrska (2015).

<sup>31</sup> I do not claim that without the ability to protect and support life, there are no other valuable attributes. I do claim on the other hand, that this ability is very important and can be used as an indicator for classification.

<sup>32</sup> It is very difficult to exactly identify for which consequences a moral agent can be accountable.

<sup>33</sup> The paper presents the idea that what makes us a person and not only a living body (even if human-like), is our ability to be moral agents (which is connected to moral responsibility).

<sup>34</sup> I do believe that the argumentation presented in the paper makes it morally defensible. The problem of legality, however, remains.

- GLUCHMAN, V. (1999): *Etika sociálnych dôsledkov v kontexte jej kritiky* [Ethics of social consequences in the context of its critique]. Prešov: L.I.M.
- GLUCHMAN, V. (2008): *Etika a reflexie morálky* [Ethics and a reflection of morality]. Prešov: FF PU.
- GLUCHMAN, V. (2009): Dignity and human dignity as a methodological basis of bioethics. In: V. Gluchman (ed.): *Bioethics in Central Europe: Methodology and education*. Prešov: FF PU, pp. 73–86.
- GLUCHMAN, V. (2017): G. E. Moore and the theory of moral/right action in ethics of social consequences. In: *Ethics & Bioethics (in Central Europe)*, 7(1–2), pp. 57–65.
- GLUCHMAN, V. (2018): Introduction: Ethics of social consequences – the past and the present. In: V. Gluchman (ed.): *Ethics of Social Consequences: Philosophical, Applied and Professional Challenges*. Newcastle upon Tyne: Cambridge Scholars Publishing, pp. viii–xxvii.
- HAKSAR, V. (1998): Moral Agents. In: E. Craig (ed.): *Routledge Encyclopedia of Philosophy*, vol. 6. London: Routledge, pp. 499–504.
- KALAJTZIDIS, J. (2013): Ethics of social consequences as a contemporary consequentialist theory. In: *Ethics & Bioethics (in Central Europe)*, 3(3–4), pp. 159–171.
- KALAJTZIDIS, J. (2017): Mravný subjekt v etike sociálnych dôsledkov a jeho komparácia v kontexte konzekvencializmu [Moral agent in the ethics of social consequences and its comparison in the context of consequentialism]. In: V. Gluchman (ed.): *Etické myslenie minulosti a súčasnosti (ETPP 2017/18): Človek v súčasnej etike* [Ethical thinking – past and present (ETPP 2017/18): Person in contemporary ethics]. Prešov: FF PU, pp. 37–49.
- KALAJTZIDIS, J. (2018): Responsibility and Justice: Secondary Values in Ethics of Social Consequences. In: V. Gluchman (ed.): *Ethics of social consequences: Philosophical, applied and professional challenges*. Newcastle upon Tyne: Cambridge Scholars Publishing, pp. 2–23.
- KOMENSKÁ, K. (2014): *Etika vzťahu k zvieratám (cez optiku etiky sociálnych dôsledkov)* [Ethics of relation to animals (in the optics of the ethics of social consequences)]. Prešov: VPU.
- LUPER, S. (2009): *The Philosophy of death*. New York: Cambridge University Press.
- MCMAHAN, J. (2002): *The ethics of killing: Problems at the margins of life*. Oxford: Oxford University Press.
- MYSONA BYRSKA, J. (2015): Values in consumption society: A comparison of consumption society in Poland and in Slovakia. In: *European Scientific Journal*, 11(special edition of July), pp. 110–117.
- POLOMSKÁ, J. (2018): Human dignity within ethics of social consequences. In: V. Gluchman (ed.): *Ethics of social consequences: Philosophical, applied and professional challenges*. Newcastle upon Tyne: Cambridge Scholars Publishing, pp. 137–183.
- SHEWMON, D. A. & MACHADO, C. (eds.) (2004): *Brain death and disorders of consciousness*. New York: Springer.
- SINGER, P. (2018): The challenge of brain death for the sanctity of life ethic. In: *Ethics & Bioethics (in Central Europe)*, 8(3–4), pp. 153–165.
- ŠVAŇA, L. (2016): On two modern hybrid forms of consequentialism. In: *Ethics & Bioethics (in Central Europe)*, 6(3–4), pp. 157–166.
- VEATCH, M. R. & ROSS, L. F. (2016): *Defining death: The case for choice*. Washington: Georgetown University Press.
- VEATCH, M. R. (2010): Transplanting Hearts after Death Measured by Cardiac Criteria: The Challenge to the Dead Donor Rule. In: *Journal of Medicine and Philosophy*, 35(3), pp. 313–329.

*Philosophical essay*

**Axiology and the mortality of the human being**

**Mariusz Wojewoda<sup>1</sup>**

*Man is a being who has the ability to split: he establishes the difference between himself and the image of himself. Between what he does and what he could do. Between his present existence and the existence he hopes for. In other words, he is a depicting creature, he bears in his mind representations about himself and the world, which remain somewhat remote from reality, although he may want to match it to him (Delsol, 2011, p. 88)*

**Abstract**

Awareness of mortality is one of the key aspects of human existence. Death goes beyond the boundary of knowledge, mortality. However, it is actually experienced by man as something inevitable. Death is a fact – the end of life, and the experience of mortality is one of the borderline situations. In the essay, the author puts forward the thesis that the experience of mortality has a significant impact on the human understanding of values. Attitudes towards death be it fear, resignation, indifference, fascination, mourning, sadness, despair after the loss of a loved one, or the desire for death, indicate the wealth of the world of value of axiological experience. The attitude of the person towards death, in some sense, is a test of our humanity, the principal value to which we refer most often. The author of the essay adopts the position of axiological relationalism (or axiological structurism), it implies that values are independent of the subject, they form a network of relational connections, but they are in a significant way connected with culture. The study of these connections: 1) with the world of people, 2) world of things, 3) internal relations that take place between values, allows us to get to know the complex structure of the world of values. In the article, the author analyzes in what sense mortality influences human understanding of values.

**Keywords:** axiology, axiological structure, mortality, death in the media, death of values

The issue of death and mortality can be analyzed in many ways. In this article, the author wants to look at the issue from the axiological perspective. Death is a biological fact, in this sense it is inevitable for a human being. However, it is also something mysterious to us. Death is a mystery, a borderline aspect of human finitude, it cannot be directly presented to us, let alone indicate what happens to us after death. To express this helplessness, we often use the language of symbols and metaphorical approximations (Cichowicz, 1993, pp. 9–10).

Here we neither analyze the immortality of the human soul, nor the life of this soul after death. We are interested in death as a borderline experience, something that will happen for sure, but not yet. Considering biological life, we can influence the prolongation of lifespan through specific pharmacological, technical and genetic actions. Then the main problem is not the length of life, but the quality of life of an aging body. Some hopes for maintaining the quality of life are associated with biological and technical interference into the aging process

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and the decline of life's abilities. These types of futuristic visions are related to, *inter alia*, the transhumanism trend (Grabowski, 2015, p. 25).

Representatives of this trend postulate the use of science, technology, and now also neuroscience, biotechnology and nanotechnology to cross the boundaries imposed by biology. They postulate improvement in the quality of human life, and sometimes equipping it with some additional physical and intellectual skills (Kurzweil, 2013, pp. 23–45). When we reject the dependence between the human condition and death, we succumb to the civilizational illusion that the end of life is only accidental, and in the course of time, when we use appropriate technical means, we will live indefinitely, unless we decide to end our lives ourselves in the act of suicide. Nevertheless death is still a requisite for man, but it does not mean that one should not take care of the quality of the extended existence, life that brings satisfaction (Ziemiński, 2010, p. 418).

In this case, we deal with two aspects of the problem: 1) Do we undertake medico-technical activities to improve the individual well-being of specific people suffering from some dysfunction? 2) Do we have in mind interferences in the body related to the modification of human nature; then we assume a longer period of such impact. These are two different issues, although related to each other. It is easier for us to accept interventions in the individual life of a person with congenital defects, or a person who has lost “natural” abilities, than to accept activities that would permanently change the human condition.

In discussions on this subject, we return to the classic term “human nature”, which in this case is to set the boundaries of such interference, or indicate the duties that we have towards human nature, for example engagement in activities to defend people against civilizational threats, or ascertainment of their improvement. In both cases we deal with understanding of human life as a certain value. Then, on the one hand, we consider what is good or bad for our lives, and on the other hand we indicate what is better or worse for a human being. In the latter case, in the argument “from an inclined plane” we analyze how much a given kind of interference in the human body will bring more or less benefits or losses in the overall balance of the actions of medicine and technology. This, of course, is only a prediction that we cannot be absolutely sure about, but we are morally obligated to make such a reflection (Wojewoda, 2017, pp. 128–132).

### **Death and mortality**

The term “mortality” is derived from “death”, but it reveals to us a different scope of axiological references. Awareness of existence is associated with the awareness of the loss of goods that are in our possession at a given time and to which we are attached, and often we cannot imagine life without them. The loss of goods convinces us of their importance, and among these goods life is a basic value, it is difficult to realize any other values without it. The discovery of mortality reveals one of the basic questions for a human being, that is, the question of the sense of individual and collective existence. Human existence in the world is being-towards-death, being temporarily finite. To understand our own life, we have to rethink the question of our finitude (Heidegger, 1994, pp. 332–334).

The question about the meaning of life can mean different things, but it basically indicates the attitude of man to the structure of the world of values. This structure is the source point of reference for human choices; it is associated with a certain type of existential experience. The experience of mortality reveals to us further episodes of losing something important to us: health, impairment of cognition, loss of vitality, exhaustion of the potential of life activities, or “small deaths”, which ultimately bring us closer to the factual death.

In the philosophical view of man's death and mortality one can take a 1) nihilistic position – death ends our lives and there is no point in analyzing the fate of man after death, 2) idealistic – based on the belief that man is the composition of the body and soul, after death of

the body the soul takes on another body, or goes to a “different” world and maintains consciousness of being, 3) realistic – considers human mortality as a basic aspect of his functioning in the world, when the discovery of finitude allows man to become aware of the specificity and distinctiveness of his existence (Čáp & Palenčár, 2012, pp. 158–161). In realistic terms, mortality understood as a belief – “not yet”, is associated with the experience of contingency of existence of things, relationships with relatives and ourselves. Awareness of finitude may be associated with awareness of dying – the fact that my death or the death of a loved one is not distant in time, nevertheless, it is not a necessary relationship. This awareness may result from a metaphysical reflection on the evanescence of man (Glaser & Strauss, 2016, pp. 11–19).

The French philosopher Vladimir Jankélévitch wrote about three aspects of human mortality included in the context of reference to the subject: death in the first, second and third person. Death in the first person (the death of “I”) is the most absurd thing, going beyond the limits of understanding. We do not remember the moment when we did not live. The consciousness of our “I” is connected with life. Plato, who argued for the existence of the soul before its connection with the body, appealed to the metaphor of forgetting – the soul forgot the knowledge resulting from watching eternal ideas. Therefore, later you have to remind it (anamnesis), or undertake the task of consistent acquisition of knowledge of reality (Jankélévitch, 1993, pp. 64–75).

Unfortunately, we do not know if our “life after death” will also be associated with individual consciousness. Collective consciousness does not guarantee the separateness of our “I”. In this case, one can refer to the theological argument, based on the concept of separateness of persons in the Holy Trinity. The separation of God the Father, the Son and the Holy Spirit for human beings would also guarantee the separateness of existence after biological death (Wanldenfels, 1993, p. 86). At the level of philosophical reflection, Epicurus’ argument is best known, which, without referring to the concept of the immortal soul, claimed that when we live, death is gone, and when death comes, we are gone. Death enters the limits of the rational, only the fear of death remains. Here, philosophy is useful, the task of which is to make man happy despite the fear he feels (Epikur, 1984, p. 645). Epicurus’ argument is not applicable to the fear of loss of a loved one, but only to the aspect of death that concerns for us.

This indicates the second dimension of understanding death or the death of another person. Mourning after losing someone with whom the subject was emotionally bound makes us left with inner emptiness that cannot be filled with anything. It is grief and sadness that can last for a very long time, even till the end of the life of the person who has suffered such a loss. The death of someone close to us is comparable to our own death. At a given moment, it seems that nothing will restore the person we have lost forever. In contemporary philosophical and psychological discourse, a lot of attention is devoted to this aspect of mortality, mainly to suggest some form of therapy to people who have lost a loved one and cannot return to normal functioning.

Death in the third person is an abstract and anonymous death. It has a media character, we know that people are dying, but it does not affect the rhythm of our lives. Death in this case is an object that can be analyzed by distancing ourselves from it. It can be examined from the demographic, medical and cultural side. We are accustomed to this aspect of death, and the universality of media coverage makes us neutral towards it. Showing images of death in the media does not make us sympathetic; instead, it makes us voyeurs of someone’s misfortune. You cannot blame the media for it, but thanks to media “peeping” others, it ceases to be an individual phenomenon and becomes an element of entertainment. Paradoxically, waiting for more reports about an unfortunate accident, the consequences of a terrorist attack, may be similar to looking forward the next episode of an interesting series.

This, however, is not indifferent to what images of death we see, or what the premises for our cultural associations regarding dying are. Photographs, and to, a greater extent movies, subtract feelings from the description of events. Admittedly, photos exaggerate misfortune, but it is not associated with a feeling of greater threat from the viewers of the movie or information program. Photography can capture someone's death or show the moment shortly before it. This view of dying arouses great curiosity among the viewers which is why it is often shown in the media. In this sense, it teaches us a certain indifference to the misfortune of others. According to Susan Sontag, photography is a tool for depersonalization of our attitude to the world. We are afraid of death, but in the visual context it is intriguing and arouses curiosity. The misfortunes of others make our misfortunes more tolerable or more distant in time and space (Sontag, 2016, pp. 73–75).

The feeling that the misfortune viewed in the media does not concern the viewer is fueling interest in images of the suffering of other people who are anonymous to us. As a consequence, watching images of death blurs the boundary between the report from events and film or television fiction. Therefore viewing death image can please the average media recipient; allow them to become part of the evening entertainment. However, victims of persecution immortalized in photographs accuse us of our indifference. Images that we watch about death leave us indifferent, affect our axiological sensitivity, make us more or less sensitive to death. Sometimes they cause embarrassment in the viewer and sometimes unhealthy curiosity. They can also cause fear that the threat to life becomes something real.

In the opinion of the French philosopher and sociologist Jean Baudrillard, the sight of unhappiness can lead to attitudes and behaviors opposite to those described earlier. They might be based on solidarity and kindness towards the victims. In this sense, good may be the result of a human reaction to social evil or evil resulting from the circumstances of the destructive action of the forces of nature. It can also teach greater caution in making decisions that pose a threat to our security (Baudrillard, 2009, pp. 98–101).

### **Axiology of mortality**

All human choices are related to the world of values, there are no axiologically indifferent activities. What, then, is the world of values? This is not the place to consider the dispute over the existence of values. However, fundamental decisions regarding this dispute refer to two positions: objectivism or axiological subjectivism. The third position is also possible, according to which, values are useless cultural fiction. I will not consider this view because no axiology can be based on it. As part of the assumption of axiological objectivity, values are independent of the subject, while according to the second position, values are created by an individual entity or by a cultural group. The author of the article is a proponent of the moderate version of objectivism, which he describes as axiological structure or axiological relationalism. According to it, values are independent of the subject; people, things, events are carriers of values. Man learns values; it takes place through internal experience and through intellectual reflection. We know nothing about the non-human experience of the world of values. Values are a kind of filter through which we make self-reflection, we refer to other people and objects from our environment.

Values are associated with a specific cultural context, but this connection does not concern the question of existence, but the specificity of their reading. This means that values can be read differently in a historical, cultural and social context, but also in relation to certain types of existential experiences. Values are not objects, but a certain type of relationship, the intensity of experiencing them depends on their comparison with other values. For example, the value of freedom, which is particularly valued by modern culture, will be interpreted in a different way depending whether we link it with independence from oppressive political power or whether we associate freedom with responsibility. In a sense, the position of

relationism was represented in German philosophy by Nicolai Hartmann, and Roman Ingarden, Władysław Tatarkiewicz and Tadeusz Czeżowski in Polish philosophy (Wiśniewski, 2013, pp. 34–35).

Values constitute a certain relationship, impossible to calculate, it is impossible to create a closed table of values and a measurable number of references, in this sense they do not fit into any system. Using the term “values system” we only talk about the cultural ordering of values, there are many ways of ordering it, they depend on the historical, cultural, religious and institutional context, for example in this way we speak about liberal and Christian values. The values structure is the basis of the communication code we use when exchanging information, interpersonal dialogue between interlocutors, models of description and ordering of reality. Dialogue concerns many situations, but if we are eager to reach an agreement and cooperation, we do it by referring to similarly understood values. Relationships between values have a network character, and there are a lot of possible configurations within the general axiological structure. The metaphor of the “communication network” works well here because the world of values is a multidimensional and diverse system of connections that we can consider on many ontic levels.

The intensity of axiological experiences depends on the situation in which the subject is located. One of these situations is related to the boundary experience of the inevitability of death. You can check in what sense you are aware of your mortality, suffering, guilt, fight – “borderline situations” (Jaspers, 1973, pp. 201–210). In Karl Jaspers’ concept, these situations are connected with the process of becoming human existence – we become ourselves when we encounter borderline situations. The author of the article assumes that borderline situations affect the experience of meeting the world of values.

Awareness of mortality is waiting for a specific point in time, but ignorance concerning this moment can become a general premise of fear of death. It may be the loss of a loved one. We are witnesses of the deaths of people who accompanied us – grandparents, parents, spouses, children, friends, people with whom we had bonds of love and friendship. As a rule, this is related to the experience of suffering, a sense of irreversible loss, regret, depression. We lose an important part of ourselves with them, the part that was associated with deceased people (Wieczorek, 2004, pp. 20–21). Suffering resulting from the awareness of the end of existence is associated with sadness, but in principle it can become an important pretext to discover the sense of existence. The question about sense in a borderline situation has an indispensable axiological dimension, from the perspective of death we ask about the value of life and its dimensions, which used to seem and still seem important, or lose their validity. When we talk about axiology of mortality, we can point to two aspects of this issue: negative and positive. The former is connected with the state of weakening or undermining the will to live. Human experience in this respect is diverse, it concerns:

Realization of the impermanence of existence in the biological and social dimension – especially when we think about our own life and our relationships with our relatives. From the perspective of the impermanence of existence, we see the value of our life, the value of family relationships, friendly relationships and commitment to typical life activities, participation in forms of community life in a different light. They appear to us as something particularly valuable, which should be cherished.

This may lead to an axiological error – a special concentration on vital and hedonistic values, marginalization of the value of another axiological area (level), for example those that indicate the dimension of spiritual life – moral, aesthetic. It is expressed in the disagreement and non-accepting attitude to the biological aspects of aging, and as a consequence, the creation of medical and cultural forms of denial of old age – plastic surgery, or consolation – “your age is determined by how you feel”.

Impermanence indicates the transitory character of civilizational, political and scientific theories. Thus with a certain intensity, we look at the value of truth in the historical context, credibility of scientific theories, or the value of power in relation to the freedom of citizens. The dominance of instrumental and pragmatic values over those resulting from the attitude of selflessness and generosity is customarily suggested then.

Discoveries of body and mind limitations affect the belief that the subject is not able to get to know everything; he cannot acquire many physical and intellectual skills he wants. To avoid frustration, he must master the art of enjoying small successes and minor pleasures. A man who discovers this type of his own “impotence” is prone to resentment in the sense in which this concept was used by Max Scheler that is, undermining the sense of realizing those values that the subject cannot materialize. For example, when he cannot acquire knowledge on a given topic, he undermines the value of education in this area. The liberating factor in this case would be the ability to show respect for those who realize values the subject cannot realize (Scheler, 1977, pp. 65–68).

Mortality is the discovery of impermanence of human memory. On the one hand, it is based on awareness that the memory of the deceased does not last long. A lot depends on the type and intensity of emotional relationships that connect the deceased to his loved ones, and the length of his and their lives. On the other hand, the subject may consider the dilemma of Homeric Achilles, whether to choose a short and famous life, or long and anonymous one. Life that is biologically short but full of glory can be a reason for the descendants to remember, even after the three thousand years that have passed since the Trojan War, thanks to Homer, we still remember Achilles. The persistence of memory in this case is primarily due to the fact that Greek literature has been a canonical element of an educated European for many centuries.

The passing of things and people also affects the world of values. Impermanence (mortality of things and people) solidifies the belief about the relativity of all aspects of life, including the relativity of values themselves. This argument is also used by axiological subjectivists, considering that the establishment and convention determine the constitutive features of the existence of values. They depend on factors such as culture, biology or collective will – social contract.

In a positive aspect, when we associate mortality as an expression of finitude with the world of values, then other aspects of understanding values emerge: Awareness of mortality leads to a re-evaluation of values, for example, the discovery of the validity of those values that had been neglected until now, or treated as secondary. Specifically, the “revaluing of values” has been adopted through the philosophy of Friedrich Nietzsche, but fits well with the axiological context in question. Changing the validity in this case may be a crucial aspect of internal development – transitions from the development model related to the acquisition of new competences, the accumulation of intellectual and physical skills to the model understood as work on broadening subjective consciousness – metaphorically referred to as “the path into yourself” or expanding the range of responsibility for a new scope of affairs or for those around us. This type of attitude stems from concern about what will remain after me. We have in mind the influence on bringing up children, or creating something that will be remembered.

Awareness of mortality can change lifestyle, nutrition, and time management strategies, for example when it comes to establishing new proportions between commitment to family life and work. Awareness of mortality may lead to greater care for the efficiency of the body, brisk functioning of the mind, maintaining the “quality of life” at a satisfactory level, care for the satisfying relationship with loved ones.

An important consequence of recognizing your own mortality may be the need to appreciate the importance of mindfulness. Life in a “hurry” makes us insensitive to some kind of axiological experience. The validity (value) of certain things and activities is revealed



when we are watching reality at a slower pace (for example the value of working on ourselves), or when we are able to see a given thing from another, unconventional side (for example the value of harmony and order in nature). Exercise in mindfulness is, in a sense, an exercise of the mind, axiological sensitivity associated with moral or aesthetic competence, but also will, or courage in making difficult decisions. Lack of such sensitivity makes our experiences superficial, and meeting other people becomes hasty in its character and based on empty “talk”.

Death understood as “pushing” man into nothingness reveals to us the problem of memory – both individual and collective. The memory of our past can be recorded on the carrier of immortal soul, in social memory, material artifacts – in the products of human work, and now it can become a digital record placed in the resources of the network. The question of who I am is not only a question about self-determination, but also about the value of my own “I” – for me, my relatives, the people with whom I work, whom we identify with the supernatural power for the protection of the world (God). The conviction about the value of life is the conviction of its reasonableness; volitional and intellectual movement within the structure of the world of values determines the horizon of meaning and the proportions of involvement in various forms of life activities.

Finally, you can consider the topic of the death of values themselves, that is, life in a world where values have been forgotten. This, however, seems impossible, because it would be a life of total indeterminacy, equating all things, human choices and events with each other. It would also mean the death of the symbolic space for information exchange. We would become consumers of things that do not matter to us, events that we cannot understand. We get lost in various contexts of self-creation. By adopting the illusory conviction that each entity is the creator of a separate structure of values – the consequences of the axiological subjectivist position, we get a completely useless communication tool, such as creating private mathematics.

In order to negotiate the ways of interpreting the world of values, we must assume that the negotiation itself and the value of the agreement connected with it constitute a universal value. Diagnoses announcing the death of values in the space of symbolic exchange, however, seem to be exaggerated. This kind of critical evaluation of modern axiology of reversed meanings can be read, among others, in statements by Jean Baudrillard who, when describing the state of modern globalized culture, wrote that we are now dealing with a specific perversity of meanings – “reversibility of gift in the counter gift, reversibility of exchange in sacrifice, reversibility of time within a cycle, reversibility of production in destruction, reversibility of life in death, reversibility of every language rule and linguistic value” (Baudrillard, 2007, p. 12).

According to the author of the article, the diagnosis of the death of values is exaggerated, because the structure of the world of values as such cannot be destroyed. One can, at most, talk about the crisis of a certain model of understanding values, for example, Christian values or the value of the liberal culture of the West, in some sense it can be assumed that Islamic culture is also experiencing some crisis. In essence, values are relationships that are something accompanying an individual subject, something that is before the subject even starts to think of or wants to destroy. The relationship to death is a test of our humanity. When referring to one’s own and the mortality of others, we can check to what extent we are on the side of those values whose implementation requires from us personal courage, such as honesty, justice, openness, or the ability to work uncompromisingly, in situations posing a threat to other people’s life or health.

## References

- BAUDRILLARD, J. (2007): *Wymiana symboliczna i śmierć* [Symbolic exchange and death]. Warszawa: Wydawnictwo Sic!
- BAUDRILLARD, J. (2009): *Przejrzystość zła. Esej o zjawiskach skrajnych* [Transparency of Evil: Essay on Extreme Phenomena]. Warszawa: Wydawnictwo Sic!
- ČÁP, J. & PALENČÁR, M. (2012): *Smrt' a vedomie smrteľnosti* [Death and awareness of mortality]. Bratislava: Iris.
- CICHOWICZ, S. (1993): Śmierć: gwałt na idei lub reakcja życia. Wstęp [Death: violence on the idea or reaction of life]. In: S. Cichowicz (ed.): *Antropologia śmierci. Myśl francuska* [Anthropology of death: French thought]. Warszawa: PWN, pp. 5–23.
- EPIKUR (1984): List do Menojkeusa [Letter to Menoeceus]. In: Diogenes Laertius: *Żywoty i poglądy słynnych filozofów* [Lives and views of famous philosophers]. Warszawa: PWN, pp. 643–658.
- DELSOL, Ch. (2011): *Czym jest człowiek? Kurs antropologii dla niewtajemniczonych* [What is a human being? Anthropology course for the uninitiated]. Kraków: Znak.
- GRABOWSKI, M. (2015): Transhumanizm. Geneza – założenia – krytyka [Transhumanism: Genesis – Assumptions – Criticism]. In: „Ethos”, 3(111), pp. 23–41.
- GLASER G. B. & STRAUSS A. L. (2016): *Świadomość umierania* [Awareness of dying]. Kraków: Zakład Wydawniczy „Nomos”.
- HEIDEGGER, M. (1994): *Bycie i czas* [Being and time]. Warszawa: PWN.
- JANKÉLÉVITCH, V. (1993): Tajemnica śmierci i zjawisko śmierci [Mystery of death and the phenomenon of death]. In: S. Cichowicz & J. M. Godzimirski (eds.): *Antropologia śmierci. Myśl francuska* [Anthropology of death: French thought]. Warszawa: PWN, pp. 43–76.
- JASPERS, K. (1973): *Philosophie, vol. 3*. Berlin, Heidelberg & New York: Springer.
- KURZWAIL, R. (2013): *Nadchodzi osobliwość. Kiedy człowiek przekroczy granice biologii* [The singularity is near]. Warszawa: Kurhaus Publishing.
- SCHELER, M. (1977): *Resentiment i moralność* [Resentment and morality]. Warszawa: Fundacja Aletheia.
- SONTAG, S. (2016): *Widok cudzego cierpienia* [Regarding the pain of others]. Kraków: Wydawnictwo Karakter.
- WIECZOREK, K. (2004): Bogowie mają wieczność, ale nie mają teraźniejszości. Glosa do Achillesa [Gods have eternity, but they haven't present: Gloss to Achille]. In: J. Kolbuszewski (ed.): *Problemy współczesnej tanatologii* [Problems of the contemporary tanatology], vol. VIII. Wrocław: Wydawnictwo Wrocławskie Towarzystwo Naukowe, pp. 17–25.
- WIŚNIEWSKI, R. (2013): *Dobro: moralność, szczęście i piękno. Studium aksjologii Władysława Tatarkiewicza* [Good: Morality, happiness and beauty. Study of the axiology of Władysław Tatarkiewicz]. Bydgoszcz: Oficyna Wydawnicza Epigram.
- WALDENFELS, H. (1993): *O Bogu, Jezusie Chrystusie i Kościele dzisiaj. Teologia fundamentalna w kontekście czasów obecnych* [God, Jesus Christ and the church today: Fundamental theology in the context of present times]. Katowice: Wydawnictwo św. Jacka.
- WOJEWODA, M. (2017): Natura ludzka w dobie cybertechnologii – problem etyczny [Human nature in the era of cybertechnology – an ethical problem]. In: M. Sikora, L. Godek & T. Buksiński (eds.): *Z problemów współczesnej filozofii* [From the problems of the modern philosophy], vol. VI: *Człowiek i maszyna* [Man and machine]. Bydgoszcz: Oficyna Wydawnicza Epigram, pp. 125–138.
- ZIEMIŃSKI, I. (2010): *Metafizyka śmierci* [Metaphysics of death]. Kraków: Wydawnictwo WAM.