

LIFE AND DEATH ISSUES IN BIOETHICS:  
ABORTION, PERSISTENT VEGETATIVE STATE, AND THE DEFINITION OF DEATH  
By

Ian Keith McDaniel

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Chairperson Dr. John Symons

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Co-Chairperson Dr. Donald Marquis

---

Dr. Dale Dorsey

---

Dr. Ben Eggleston

---

Dr. Erin Frykholm

---

Dr. Paul Scott

Date Defended: December 4, 2015

The Dissertation Committee for Ian Keith McDaniel  
certifies that this is the approved version of the following dissertation:

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Chairperson Dr. John Symons

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Co-Chairperson Dr. Donald Marquis

Date approved: December 8, 2015

## Abstract

This dissertation is comprised of three papers which consider prominent issues in bioethics. The three topics can be briefly stated as: 1) a refutation of the responsibility objection to abortion, 2) a rejection of the orthodox bioethical arguments attempting to justify removal of artificial nutrition and hydration from persistent vegetative state patients, and 3) a demand to revise the current orthodox criteria for determining death.

The Responsibility Objection to Abortion is a common and prominent objection to abortion in general. The objection claims that a woman is responsible for the fetus growing inside her body as a result of her willing participation in sexual activity. I argue that the Responsibility Objection to Abortion fails to establish that a woman must provide care to her unborn fetus. I do so by examining the various iterations in which the responsibility objection has been presented and then identifying the particular conception of responsibility that each iteration of the objection must be utilizing in order to ground the particular version of the objection. My contention is that once examined in this manner I am able to demonstrate that each iteration of the objection is unable to establish an obligation to provide care on the part of a pregnant woman to her unborn fetus. Thus, the responsibility objection ceases to be a serious objection to a woman's reproductive freedom.

The second paper in this work considers arguments within the orthodox bioethical framework which seek to justify the removal of life-saving medical treatment (LSMT), especially in the form of artificial nutrition and hydration (ANH), from patients in persistent vegetative states (PVS). I first outline the orthodox bioethical framework which seemingly requires the continued feeding of PVS patients. I then focus upon a prominent case of removing ANH from a

PVS patient, the case of Theresa Marie (Terri) Schiavo. Seven prominent arguments seeking to justify the removal of Terri's ANH are considered. I conclude that each of these arguments fails to justify removing Terri Schiavo's ANH within the established bioethical framework. Proponents of removing ANH from PVS patients such as Terri Schiavo will have to seek alternate approaches to defending their view which rejects the orthodox bioethical framework utilized throughout the discussion. In particular, so long as the right to life is based upon an individual being an innocent human being, removal of LSMT from PVS patients will remain unjustified.

The demand for revised criteria for determining death arises due to the inadequacy of the orthodox criteria currently used to determine death, which are reducible to whole brain death. I argue that whole brain death is an inadequate criterion for the death of a human being within the framework of orthodox bioethics. I first consider the conflict between whole brain death and the plausible definitions of death the criterion of whole brain death is intended to reflect. Second, I consider the possibility that whole brain death can be justified as a criterion for death without the need for a definition of death. Third, I consider arguments that whole brain death is analogous to decapitation (long recognized as the death of the decapitated individual). Each of these three arguments for the continued use of whole brain death as the criterion of death are shown to be flawed. Utilizing these arguments presented against whole brain death I suggest revised criteria for determining death that are able to overcome the failures of whole brain death.

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**THE RESPONSIBILITY OBJECTION TO ABORTION:  
REJECTING THE NOTION THAT THE RESPONSIBILITY OBJECTION  
SUCCESSFULLY REFUTES A WOMAN'S RIGHT TO CHOOSE**

**Abstract**

The Responsibility Objection to Abortion is a common and prominent objection to abortion in general and to Judith Jarvis Thomson's argument in particular. The objection claims that a woman is responsible for the fetus growing inside her body as a result of her willing participation in sexual activity. The objection aims to establish that a woman is obligated to provide assistance to the fetus growing inside her womb, despite what Thomson may say concerning one's obligations to ailing violinists. I argue that the Responsibility Objection to Abortion fails to establish that a woman must provide care to her unborn fetus. I do so by examining four distinct versions of the objection. I refer to these as the harm version, the care version, the negligence version and the tacit consent version respectively. I then identify the particular conception of responsibility that each iteration of the objection must be utilizing in order to ground the particular version of the objection. I contend that I am able to demonstrate that each iteration of the objection is unable to establish an obligation to provide care on the part of a pregnant woman to her unborn fetus. Thus, the responsibility objection ceases to be a serious objection to a woman's reproductive freedom.<sup>1</sup>

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<sup>1</sup> This work originally appears in the May 2015 issue of *Bioethics*. This work is largely unchanged from the work that appears in that publication. See I. McDaniel. The Responsibility Objection to Abortion: Rejecting the Notion that the Responsibility Objection Successfully Refutes a Woman's Right to Choose. *Bioethics*. May 2015; 29 (4): 291-299.

## I. INTRODUCTION

In response to Judith Jarvis Thomson's *A Defense of Abortion*, opponents of abortion often offer the so-called "Responsibility Objection"; the goal of which is to refute Thomson's original claim that abortion in the case of unwanted pregnancy is permissible.<sup>2</sup> This objection to the permissibility of abortion has been expressed in a variety of forms over the last forty years.<sup>3</sup> As such, it is more difficult than expected to present the objection in a manner that is both suitably succinct and encompasses the breadth of the objection. Generally, the *Responsibility Objection* holds that a woman is responsible for the fetus now growing inside her body as a result of her willing participation in sexual activity.<sup>4</sup> Three questions I will consider regarding this brief statement of the Responsibility Objection are:

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<sup>2</sup> Thomson's approach to defending reproductive choice is not the only view that is susceptible to the Responsibility Objection, but for the purposes of this paper I invoke Thomson in order to limit the scope of the argument to some degree. As Thomson limits her consideration to one's duty to render aid, the ensuing discussion will attempt to do likewise. See J.J. Thomson. *A Defense of Abortion*. *Philosophy & Public Affairs* 1971; 1 (1): 47-66.

<sup>3</sup> See M. Tooley. 1983 *Abortion and Infanticide*. Oxford: Clarendon Press: 45; M.A. Warren. 1985. On the Moral and Legal Status of Abortion. In *Today's Moral Problems 3<sup>rd</sup> Edition*. R. A. Wasserstrom, ed. New York, NY: MacMillan Publishing: 438-440; R. Werner. Abortion: The Moral Status of the Unborn. *Social Theory and Practice* 1974-75; 3: 211-214; L.S. Carrier. Abortion and the Right to Life. *Social Theory and Practice* 1974-75; 3: 398-399; H. Silverstein. A Woman's 'Responsibility' for the Fetus. *Social Theory and Practice* 1987; 13: 103-104; R. Langer. Silverstein and the 'Responsibility Objection'. *Social Theory and Practice* 1993; 13: 345; D. Boonin-Vail. A Defense of 'A Defense of Abortion': On the Responsibility Objection to Thomson's Argument. *Ethics* 1997; 107: 288-290; D. Boonin. 2003. *A Defense of Abortion*. Cambridge: Cambridge University Press: 167-188; J. McMahon. 2002. *The Ethics of Killing: Problems at the Margins of Life*. Oxford: Oxford UP: 362-98.

<sup>4</sup> Thus, this paper is only interested in examining a woman's obligation to render aid to her fetus. No other individuals are involved in this discussion. Expanding the notion of responsibility beyond a woman's responsibility

- 1) What is the nature of the responsibility?
- 2) What is the source from which the responsibility derives?
- 3) What is the requirement for future actions, if any, on behalf of the responsible party?

For the first two questions some answers include ideas about harm, demands for care, recognition of one's liability, claims about causality, proposals of one's consent, and finally, failures due to one's own negligence. For the third, the possible answers that some propose are familiar, ranging from the idea a woman is free to choose whether she wishes to continue the pregnancy to the idea the only acceptable action is one that preserves the life of the fetus, regardless of the cost associated with preserving the pregnancy.<sup>5</sup>

In this work I argue that the connection between different versions of the Responsibility Objection and the conception of responsibility that is supposed to ground each version of the objection fails to obtain. Therefore, the demands the Responsibility Objection attempts to place upon a woman to provide care for her unborn fetus until the fetus can survive without her are unsupported at best and potentially question begging at worst. To produce this conclusion I consider some conceptions of responsibility upon which the responsibility objection has been grounded, some of the various iterations of the Responsibility Objection (and attempt to clarify these iterations of the objection) and then demonstrate how each possible conception of

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to her fetus to include a responsibility to others may provide an avenue for opponents of abortion to continue to object to the practice as immoral, but the argument here contends that they cannot continue to do so based on the grounds that a woman has a responsibility *to her fetus*. Considerations of a woman's responsibility to render aid to her fetus based on a responsibility to society or a responsibility to the father or to some other entity are outside the scope of this argument.

<sup>5</sup> In this instance, the costs need not be strictly monetary, but can include demands that individual rights to self-determination be sacrificed, or even that the life of the mother (the right to self-preservation) must be sacrificed in order to preserve the life of the fetus.

responsibility fails as the principle foundation for a corresponding version of the Responsibility Objection.

## II. CONCEPTIONS OF RESPONSIBILITY

A serious issue within the debate over the Responsibility Objection concerns our understanding of, and use of, the term “responsibility”. Here I present four possible conceptions of responsibility.<sup>6</sup> Responsibility could present as either a *Liability Demand* or as a *Causal Responsibility*. Similarly, responsibility could present as either a *Harm Responsibility* or as a *Care Responsibility*.

1. *Liability Demand*: one is ascribed liability for an act under a set of rules or customs that demand further action in response to the resulting circumstances.<sup>7</sup>
2. *Causal Responsibility*: one is said to be responsible for those acts they perform, even if no further ascription of liability to further action exists.
3. *Harm Responsibility*: one is often said to be responsible for an act when their action results in a harm to another. Such responsibility usually attaches notions of *fault* or *blame* to the responsible party and often demands that the responsible party provide *care* to the harmed party.<sup>8</sup>
4. *Care Responsibility*: one could be responsible for providing care for another. Often such responsibility is the result of harm, though one could be responsible to care for another even if no harm is involved.<sup>9</sup>

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<sup>6</sup> For this discussion I ignore contentious issues among free will, determinism and problems for moral responsibility. Such difficult issues I leave for better minds than my own. I will simply assume that we do in fact have free will and thus can have responsibility for our actions in accordance with such a doctrine.

<sup>7</sup> See Langer, *op. cit.* 3, p. 354; J. Fienberg. 1970. Action and Responsibility. In *Doing and Deserving*. Princeton, NJ: Princeton University Press: 130-137.

<sup>8</sup> See Langer, *op. cit.* 3, p 354. See also H. Silverstein. Reply to Langer. *Social Theory and Practice* 1993; 19: 359; Fienberg, *op. cit.* 7, 130-37; F. J. Beckwith. Personal Bodily Rights, Abortion, and Unplugging the Violinist. *International Philosophical Quarterly* 1992; 32: 111-12; D. Marquis. Unpublished comments on Thomson’s Defense of Abortion, July 2011.

<sup>9</sup> See Langer, *op. cit.* 3, 354; Silverstein, *op cit.* 8, 363.

It is worthwhile to note that these conceptions of responsibility overlap with one another. For example, one can have a liability demand as a result of having harmed another or as a result of having consented to care for another. Alternatively, one might have a liability demand even without having consented to the current conditions or harmed another.

If what follows in this work is correct, pregnancy would be a case in which one has a liability demand. In other words, further action is required on the part of the pregnant woman, even though she did not consent to the pregnancy or harm another in bringing the pregnancy about. However, this liability demand need not (and I will argue does not) include a requirement that the future action entail a responsibility to provide care.<sup>10</sup>

Conversely, one may be responsible for an act in a strictly causal sense of responsibility. On this understanding of responsibility, one is the cause of the act, but no harm has resulted, no demand for care independent of any harm exists and there are no other rules or customs that apply a demand for further action on behalf of the individual. I take it that the vast majority of our daily actions are of this sort.<sup>11</sup>

The conceptions of responsibility that seem most prominent in discussions of the Responsibility Objection are harm responsibility and care responsibility. As noted above, harm responsibility and care responsibility attach themselves to a liability demand. Whenever we recognize an individual as having a harm responsibility or a care responsibility, we recognize a demand for further action on behalf of such individuals. Harm responsibility is often the sort of responsibility that most individuals have in mind when they think of responsibility more

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<sup>10</sup> This demand for further action would be the result of the biological facts of pregnancy, namely, that the pregnant woman is attached to the fetus and so must act *in some fashion* relative to the fetus.

<sup>11</sup> It is perhaps the ubiquity of this sort of responsibility that has resulted in it being largely omitted from previous discussions of the responsibility objection.

generally. However, harm responsibility is also likely the source of much confusion and opacity when it comes to understanding the Responsibility Objection. Given its connection to a demand for care, harm responsibility can also be confused with care responsibility. Similarly, given its connections to ideas about *fault* and *blame*, harm responsibility can be confused with a liability demand when one attaches a demand for future action on behalf of a responsible party to notions of fault or blame. Finally, since one cannot be responsible for a harm without causing said harm, harm responsibility can be confused with causal responsibility as well. It is therefore important to keep the conception of harm responsibility separate from the other sorts of responsibility.

Furthermore, as noted, one can be responsible for acts arising from issues other than harm. One can be responsible for another's care without having harmed anyone. This sort of responsibility can arise in cases when a parent has a responsibility to care for her [5 year old] child by providing for the child's basic needs.<sup>12</sup> The parent has not harmed the child, but we recognize a certain responsibility on the part of the parent to provide for the [post-birth] children under her care.

### **III. FOUR ITERATIONS OF THE RESPONSIBILITY OBJECTION**

The first two iterations of the Responsibility Objection I will refer to as the *Harm Version* (due to a reliance on instantiations of harm) and the *Care Version* (due to a reliance on a demand for care without harm). Under the Harm Version of the Responsibility Objection an individual is causally responsible for producing a harmful situation and the situation was produced via voluntary acts which one either knew (or should have known) might result in the harmful situation. Thus the responsible individual is now charged with acting in a way to repair the harm

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<sup>12</sup> Langer, *op. cit.* 3, 354.

done.<sup>13</sup> Similarly, the Care Version entails that (though you have not harmed another) you have an obligation to provide for another's welfare, even at great cost to yourself. One such example would be a parent whose young child is deathly ill and will die in a couple years unless the parent makes large personal sacrifices to save the child's life, in which case the child will live a long and healthy life.<sup>14</sup> The other two iterations of the Responsibility Objection to consider arise either because of the now pregnant woman's tacit consent to the consequence of pregnancy by engaging voluntarily in sexual intercourse (the *Tacit Consent Version*) or because of the negligence on the part of the now pregnant woman in failing to avoid the consequence of becoming pregnant (the *Negligence Version*).<sup>15</sup>

#### **IV. NEITHER HARM, NOR NEGLIGENCE, NOR TACIT CONSENT**

Harm responsibility is not a suitable conception of a pregnant woman's responsibility to her fetus because the woman has not harmed her fetus by bringing it into existence in a condition in which it is now dependent upon her for its continued survival. In the discussion of the harm and care versions of the Responsibility Objection, Harry Silverstein presents a series of cases which seek to demonstrate how a woman cannot be said to be responsible for the fetus as a result of harm. The two cases which are most important for this discussion are as follows. Imagine you are a doctor and Thomson's famous violinist is before you with a disease which, if left untreated, is fatal. The only treatment for the disease is a drug, D-super, that is known to have the side effect of Thomson's famous kidney ailment in five to ten years. Furthermore, you alone have the right blood type to help the violinist when he contracts the disease in five to ten years time. You

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<sup>13</sup> Silverstein, *op. cit.* 8, 359; Langer, *op. cit.* 3, 351.

<sup>14</sup> Silverstein, *op. cit.* 8, 363. Langer, *op. cit.* 3, 351-352.

<sup>15</sup> Boonin, *op. cit.* 3 (1997), 288.

treat the violinist, saving his life, and sure enough, six years later he contracts the kidney ailment. The alternative to this case is one in which everything is exactly the same except that there is also another drug, D-SuperPlus, which lacks the unfortunate side effect of Thomson's kidney ailment.<sup>16</sup>

Silverstein asks the reader to consider the following three scenarios, where  $t$  is the point in time in which the violinist contracts the kidney ailment six years after treatment with D-Super in the first case and does not contract the kidney ailment six years after treatment with D-SuperPlus in the second case<sup>17</sup>:

- (1) The violinist does not exist at time  $t$
- (2) The violinist exists at  $t$  but needs the use of your kidneys for nine months to survive beyond that time
- (3) The violinist exists at  $t$  and does not need the use of your kidneys to survive beyond that time.

The difference between the two cases lies in the fact that all three scenarios are possible in the case of D-SuperPlus, but not in the case of D-Super. In the case of D-SuperPlus, you as the physician can refrain from treating the violinist, resulting in (1); you can treat with D-Super, resulting in (2); or you can treat with D-SuperPlus, resulting in (3). In the case where only D-Super is available, as the treating physician you can only choose between (1) and (2).

We can now see the crucial difference between these two cases. One cannot properly say that the doctor in case D-Super has harmed the violinist by treating him with D-Super, as there was no alternative scenario in which the violinist would both exist at time  $t$  and exist in a state where he did not need the use of another's kidneys to prolong his existence. One can make the claim of a doctor in the case of D-SuperPlus who chooses (through laziness, carelessness, spite,

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<sup>16</sup> See Silverstein, *op. cit.* 3, 106-107; Silverstein, *op. cit.* 8, 360.

<sup>17</sup> Silverstein, *op. cit.* 8, 361.

etc.) to treat the violinist with D-Super rather than D-SuperPlus that the doctor has in fact harmed the violinist. We can say this because in case D-SuperPlus, there was alternative (3) in which the violinist would have both existed and been in a better condition had the doctor acted differently (by giving the superior drug with no side effect). The same cannot be said in the case of D-Super.<sup>18</sup>

Pregnancy is like the case of D-Super rather than D-SuperPlus. Early in pregnancy there is no alternative condition that a pregnant woman and her fetus can find themselves in that would equate to (3). Assume that you are a woman who is six weeks pregnant. There is no alternative condition that can be made manifest in order to achieve

(3\*) The fetus exists at  $t^*$  and does not need your body for continued survival (where  $t^*$  is the time you are six weeks pregnant).

Since there is no corresponding condition in which the fetus could both exist and could exist in a condition free of its dependence upon its mother's body, the case of pregnancy is like the case of D-Super.<sup>19</sup> In that case, the claim that the doctor has harmed the violinist by treating him with D-

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<sup>18</sup> See Ibid: 361.

<sup>19</sup> One might wish to raise the issue of ectogenesis at this stage. The suggestion being that if ectogenesis were to become available as an alternative for pregnant women, then there would exist a situation such that a fetus could exist and exist in a state that it is not dependent upon its mother's body for survival. In such a scenario, pregnancy would then be like the case of D-SuperPlus rather than D-Super. In the event that ectogenesis were to become widely available, the arguments made in this section would need to be reconsidered. Until such time, however, the prospect of ectogenesis cannot serve as a means of refuting the argument offered since there is still not a situation in which the pregnant woman's condition is like the case of D-SuperPlus. For her part, Thomson recognizes the distinction between securing the evacuation of the fetus and securing the death of the fetus and that, while a woman may detach the fetus from herself, she is not entitled to secure its death in the event the fetus were to survive. See Thomson, *op. cit.* 2, 66. The conclusion then, if ectogenesis were reality and widely available, might be that a

Super fails. As such, the claim that a pregnant woman is responsible to her fetus on the basis of having harmed it by bringing it into a condition of dependency upon her body also fails. From this discussion we can leave behind a consideration of harm as an appropriate understanding of the nature of a woman's responsibility to her fetus. Without a harm being imposed upon the fetus a woman cannot have a responsibility to her fetus based on having done it harm. Based upon this discussion, one can discard the Harm Version of the Responsibility Objection as an appropriate conception of the Responsibility Objection.

Like the Harm Version, the Negligence Version will fail as an appropriate conception of the Responsibility Objection on similar grounds. In introducing the Negligence Version, David Boonin makes reference to a driver who injures a pedestrian whilst driving.<sup>20</sup> Don Marquis makes use of a similar example, only the driver in his scenario is under the influence of alcohol

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pregnant woman would be allowed to detach herself from a fetus but would then be required to give over the unwanted fetus for ectogenesis. Then there arise questions concerning the woman's obligation to care for the resultant child. While answers to those questions may be beyond the scope of this argument, the ectogenesis objection raises concerns about the justification for the right to disconnect oneself from the violinist. Some suggest that the right to disconnect oneself from the violinist relies upon the inconvenience of the attachment to the violinist. An inconvenience approach to justifying the disconnection of the violinist reinforces a libertarian view of Thomson's analogy. The worry for this approach to justifying the disconnection of the violinist may be that the more minor the inconvenience imposed by the violinist, the less intuitively obvious the right to disconnect from the violinist. Given that the violinist will die as a result of the disconnection, if the inconvenience is a mere 9 minutes, or 9 seconds, rather than 9 months, the less obvious it is that one can justly disconnect from the violinist. These concerns seemingly indicate that Thomson may have to utilize a strong conception of bodily integrity (or privacy perhaps) rather than mere inconvenience to justify the right to disconnect from the violinist.

<sup>20</sup> Boonin, *op. cit.* 3 (1997), 288.

at the time of the injury.<sup>21</sup> The point both of these examples propose is that, if you are the driver of the car, you did not intend to injure anyone, nor did you consent to the injuring of another person when you got behind the wheel. Your intent was to get where you were trying to go without causing another person injury. However, due to your negligence, another person is now in need of assistance and to make the case suitably like pregnancy, only you can provide the required aid in the form of blood transfusions, kidney dialysis, etc. until the pedestrian has recovered from the injuries you inflicted upon her. Other examples one might point to of negligent behavior will have a similar element of carelessness on the part of the individual actor that result in the harming of another and hence a responsibility to render aid to the injured party.

The problem that arises at this stage of the discussion is that any claim of responsibility which is the result of negligence hinges on the causation of harm to another. Generally, this harm must also occur within a scenario where we already agree people are not supposed to be treated in such a fashion. In the case of the injured pedestrians cited by Boonin and Marquis, we already agree that pedestrians have a right not to be hit by careless automobile drivers.<sup>22</sup> We already recognize that to harm another person in this way is unacceptable. But in such cases it is not so much the negligence that is producing the responsibility requirement, but the fact that the harm inflicted is one we already agree should not be inflicted at all. The fact that the responsibility demand on the Negligence Version hinges on the harm inflicted, not the negligence, means that the applicability of this version of the Responsibility Objection falls along with the failure of harm responsibility.

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<sup>21</sup> Marquis, *op. cit.* 8.

<sup>22</sup> Boonin makes this same claim as well. See Boonin, *op. cit.* 3 (1997), 301.

The rejection of the Tacit Consent Version relies upon an analogy Boonin draws between sexual activity and the social convention of tipping after a meal.<sup>23</sup> The result is that, according to Boonin, one can engage in an activity such as sexual intercourse, in full knowledge of the possible outcomes, such as pregnancy, without consenting to any particular outcome that may obtain. To support this conclusion, Boonin offers the scenario of two dinners, Bill and Ted. Bill sits down to a nice meal in a restaurant and, after finishing his meal, leaves a pile of bills on the table as he exits. Bill's leaving the money arose as a result of Bill voluntarily leaving the money behind. Ted's case, however, is suitably, and subtly, different. In Ted's case, the money is left behind because Ted placed the money on the table when he sat down (presumably because he didn't like the way it felt in his pocket). Upon finishing his meal Ted rose from the table and left, forgetting to place the money back in his pocket. According to Boonin this is different from Bill's action in that in Ted's case the leaving of the money itself is not voluntary, but arose as a foreseeable consequence of a different voluntary act.

The issue that arises is that according to the proponent of Tacit Consent three criteria are typically acknowledged and defended as necessary to establish consent: voluntariness, causality, and foreseeability.<sup>24</sup> The first criterion is that the act must be voluntary. One cannot properly be said to have consented to a state of affairs under force or duress. Second, the act must cause the state of affairs to which one is supposed to have consented. Third, the state of affairs must be foreseeable or there must exist a reasonable expectation that the state of affairs could have been foreseen prior to the act occurring.

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<sup>23</sup> I offer a brief account of Boonin's argument here. For a fuller discussion see Boonin, *op. cit.* 3 (1997), 290-300; Boonin, *op. cit.* 3 (2003), 148-166.

<sup>24</sup> See Boonin, *op. cit.* 3 (1997), 291-292; R. Langer. Abortion and the Right to Privacy. *Journal of Social Philosophy* 1992; 23: 23-51.

The problem is that these criteria, though seemingly met by both Bill and Ted, treat the two cases as being the same only as a result of confusing the distinction between (a) voluntarily bringing about a state of affairs S and (b) voluntarily doing an action foreseeing that this may bring about a state of affairs S.<sup>25</sup> Both Bill and Ted meet the broad criteria defended by the proponents of tacit consent, but only because the conception of voluntariness found within tacit consent does not recognize that one might bring about a state of affairs without consenting to that state of affairs. Ted's actions amounted to his consent for the money to be on the table while he ate, not consent for this money to be transferred to the waiter in the form of a tip. Thus, even though Ted voluntarily placed the money on the table, his placing the money caused the money to be left behind, and he could reasonably be expected to foresee such an outcome, Ted did not consent to the relinquishing of the money into the possession of the waiter.<sup>26</sup>

The case of a woman who has an unwanted pregnancy can be suitably compared to that of Ted rather than Bill. A woman in such a state of affairs did not consent to the state of affairs in which she is now pregnant. Rather, she consented to a state of affairs in which a man was having sex with her knowing that it could foreseeably lead to the state of affairs in which she now finds herself of being pregnant. As such, according to Boonin, arguments of tacit consent are insufficient to ground a responsibility demand upon a pregnant woman.<sup>27</sup> With Boonin's authoritative dismissal of the Tacit Consent Version available, the one remaining version of the Responsibility Objection is the Care Version.

## **V. REJECTING THE CARE VERSION OF THE RESPONSIBILITY OBJECTION**

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<sup>25</sup> Boonin, *op. cit.* 3 (1997), 291.

<sup>26</sup> Or any other particular employee of the restaurant, dishwasher, kitchen staff, hostess, etc.

<sup>27</sup> Boonin, *op. cit.* 3 (1997), 293-300.

Of the four versions on the Responsibility Objection previously stated, the one remaining version of the objection left to consider is the Care Version. To reiterate, on this version of the objection, one can have a responsibility to care for another and that this responsibility for care can arise without a corresponding harm to generate the responsibility. The case used as an exemplar of this sort of responsibility is one a parent has toward her [post birth] child to provide certain basics of care. The claim that the proponent of the Care Version of the Responsibility Objection then wishes to make is that a fetus is merely a very immature child. Therefore, just as one can have a responsibility to older children to provide care, one can also have an obligation to very immature children (i.e. fetuses) to provide care as well. In the case of a pregnant woman, she and she alone is in such a position to provide the care the fetus requires. As such, she is responsible for the care of that fetus until such time as the fetus can be cared for by others (or can survive on its own).

The problem with this argument is that the analogy between these two cases on behalf of the Care Version overlooks certain elements present in the case of parental obligations to care for [post birth] children that cannot be properly said to exist with fetuses without begging the question. The question that needs to be answered here is what motivation exists for the responsibility to provide care in each case? In the case of the [post birth] child, one possible answer seems to be consent.<sup>28</sup> In the case of the [post birth] child, we recognize in the actions of parents who take their children home from the hospital after they are born (or who adopt

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<sup>28</sup> If the demand for care were motivated by issues of harm, then this scenario would fall within the prevue of that conception of responsibility. Having already assessed the potential of that conception of responsibility and found it inapplicable to the case of abortion, the Care Version cannot be based on harm if it is to apply to abortion.

Furthermore, as the discussion shows, though consent may not be appropriate in the case of abortion that does not mean consent is not an appropriate conception of responsibility in other cases.

children) a level of consent to care for that child. This consent may be tacit or explicit depending upon the scenario.<sup>29</sup> We recognize that these elements of consent take place within a previously established social convention<sup>30</sup> that governs the recognition of our responsibilities as new parents to provide for the children under our supervision.<sup>31</sup> In such scenarios, our consent to the care of

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<sup>29</sup> Presumptively, parents who take their biological children home from the hospital at the very least tacitly consent to the care of their children. That said, one might argue that parents have explicitly consented to the care of their children. Like adoptive parents who must file formal documents with the state agreeing to take on the role and responsibility of parenting for a child, biological parents must file formal documents with the institutions that report the birth of infants to the state. In such instances, before leaving the hospital with their child, even biological parents could be said to have explicitly, not just tacitly agreed to the care of their infant by literally signing for the child. Whether or not this aside is correct, the main point is that parents of born children seem to have consented to the care of such children in some fashion. However, this sort of consent is not applicable to the case of pregnancy and abortion as evidenced by the work of Boonin discussed previously.

<sup>30</sup> Here, the term “social convention” is being used to reflect a societal understanding of expectations and habits that are recognized as reasonable expectations of acceptable behavior. The term is not intended to invoke the usage of legally binding international conventions from the United Nations (such as the Convention on the Rights of the Child). However, even if one wishes to include such conventions as part of the societal expectations and habits, it is unclear whether such legal conventions are intended to apply to fetuses or merely [post birth] children. Different countries that are signatories to the Convention on Human Rights and the Convention on the Rights of the Child have differing laws regarding abortion. Mere acceptance of the convention on child rights does not automatically entail the inclusion of “fetuses” in the category of covered “children”. Thus, whether one is thinking of conventions in either case (as either legally binding conventions like the Convention on the Rights of the Child, or as “social expectations and habits”) the point is that neither can be used to establish an obligation of care to fetuses as that is exactly what is at issue here.

<sup>31</sup> Home births and other less common practices regarding the entrance of children into industrialized society may require further argumentation on the aspect of one’s consent to care for a [post-birth] child. However, I think the

[post birth] children is like the case of Bill, who leaves the money on the table in accordance with a previously established social convention on tipping. But if the case of care for [post birth] children is like the case of Bill and the case of unwanted pregnancy is like the case of Ted, then the same problem that presented itself under the Tacit Consent Version has manifest again under the Care Version. If the responsibility to care for [post birth] children rests on consent, then the analogy of [post birth] children to fetuses is of no use to the Care Version of the Responsibility Objection given Boonin's dismissal of tacit consent as appropriate to ground a responsibility on the part of the pregnant woman to her fetus.<sup>32</sup>

Rather than consent, the proponent of the Responsibility Objection may wish to ground the Care Version on a conception of care responsibility (that exists without having consented to care for the fetus). However, even if the proponent of the Care Version can get around the problem of consent in the case of the [post birth] child, the care responsibility, as mentioned, exists within previously established social conventions on the matter. These social conventions on care for fetuses are exactly what are currently at issue.<sup>33</sup> Thus to demand that a mother care

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general point about consent post birth still applies. By keeping the child in one's home, one consents to the care of said child in accordance with our previously established social conventions on the matter.

<sup>32</sup> Explicit consent might still remain within the abortion debate and may present other interesting problems, but I leave such issues aside for the time being as I assume that the majority of people who explicitly consent to pregnancies desire to see the matter through. The only obvious problem I see being cases where an explicit consent pregnancy becomes life threatening for the mother. In such cases, I find self-defense suitably compelling to warrant termination (whether generated via Thomson's analogy or another argument).

<sup>33</sup> One may wish to ask how such social conventions are established and recognized, because we all have an understanding that over time social conventions seem to change. This is an important concern in that it suggests that if the rejection of a care responsibility hinges on the existence or lack thereof of a social convention, that a change in the convention would necessitate a change in the responsibility. As such, whether or not the responsibility exists will

for her unborn fetus as if the same social conventions that apply to [post birth] children apply to the fetus is to beg the question. As such, if the Care Version is grounded on a conception of consent the proponent of the Responsibility Objection who upholds the Care Version of the Responsibility Objection presents a demand for care from the pregnant woman that cannot be supported. Alternatively, if the Care Version is grounded on a conception of care responsibility the proponent of the Responsibility Objection who upholds the Care Version of the Responsibility Objection begs the question.

## **VI. CERTAIN OBJECTIONS AND REPLIES**

The first objection I will consider is in response to issues raised during the discussion of the Care Version of the Responsibility Objection. One might wish to object to the suggestion that the care responsibility arises as a result of consent (tacit or otherwise). One might argue that refusing to care for their [post-birth] child by refusing to take the child home post-birth is child neglect and that the law does not give parents the right to refuse to care for their children. The issue here is that the law, at least in some countries, seemingly allows parents to do exactly what the proponent of the Responsibility Objection wishes to deny. At least as far as the United States of America is concerned, the existence of “Safe Haven” laws seemingly allows parents to choose whether or not they wish to care for their newly born children or give up their

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have to be continually reevaluated. But then, the question of whether a woman has a responsibility to care for her fetus is ‘simply’: has the social convention on this matter changed [however we evaluate and recognize that change]? I take it that there is no established social convention on the obligation to care for fetuses, so I will not consider the matter further here. However, further discussion of how such social conventions are established may be a useful endeavor for proponents of the Responsibility Objection who wish to undercut my argument here. To do so, a proponent of the Responsibility Objection would need to provide the criteria which establish the existence of such a social convention on the obligation to care for fetuses.

rights/responsibility as parents to the state.<sup>34</sup> Safe Haven laws in general allow an individual to leave a newly born infant at designated public institutions (often hospitals, police and fire stations, and rescue squads). These designated institutions will then assume the responsibility to care for the child until such time as the child can be placed into the custody of the appropriate state agency.<sup>35</sup> In such situations the act of leaving the child with the state institution is usually treated as a surrendering of parental rights (adoption surrender) on the part of the parent. Provided the adult has acted in accordance with the edicts of the particular state statute, which usually have to do with the age of the child and the general physical condition of the infant at the time it is left with the state, the adult is no longer responsible for the care of the child and is not punished by the state for child abuse or neglect as a result of forfeiting his/her parental rights.

The second objection I will consider which one might try to raise to the argument as presented is that the discussion of Harm Responsibility and the Harm Version misrepresents the argument presented by proponents of the Responsibility Objection on the subject of harm. Rather than making the claim that the fetus has been harmed and thus is owed care, proponents of the Responsibility Objection could instead be attempting to argue that abortion intentionally harms the fetus, intentionally inflicting harm upon innocent persons is immoral and the fetus is an innocent person, thus an abortion cannot be performed. This version of the argument would

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<sup>34</sup> As of 2008, each US state had some version of a “Safe Haven” law.

The U.S Department of Health and Human Services. 2013. *Infant Safe Haven Laws*.

[https://www.childwelfare.gov/systemwide/laws\\_policies/statutes/safehaven.cfm](https://www.childwelfare.gov/systemwide/laws_policies/statutes/safehaven.cfm) [Accessed 28 Oct 2013].

<sup>35</sup> The agency in question is usually a state run department of Health and Human Services/department of Child Welfare.

utilize a negative duty to avoid harm to generate its opposition to abortion.<sup>36</sup> However, the purpose of this work was to explore the potential for the Responsibility Objection to generate a demand for care based on a duty or responsibility to render aid, not a responsibility to avoid future harm. As shown, the duty to render aid would only arise in situations where one has previously inflicted harm upon another. In response, one might attempt to argue that avoiding future harms is an important element of the obligation to render aid. Such an account would seemingly be obligated to invoke Peter Singer's account of one's obligation to render aid [that one is obligated to render aid in situations where doing so can be accomplished without sacrificing something of comparable moral worth] in order to generate opposition to abortion.<sup>37</sup> The concern that arises from such a move by the proponents of the Responsibility Objection is that the responsibility to render aid in the case of a mother and her fetus is only generated in this case at the cost of placing a demand for the supererogatory rendering of aid onto every individual.<sup>38</sup>

A further objection one might offer to the argument presented is the idea that abortion is not simply a case where one refrains from rendering care, but rather abortion is a case in which

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<sup>36</sup> I am perhaps sympathetic to the potential for such an approach [an obligation to prevent harm to others] as a viable alternative for proponents of the Responsibility Objection to demonstrate the immorality of abortion.

However, I maintain that such an approach is fundamentally different from the approach taken by the most common or prominent forms of the Responsibility Objection as presented here.

<sup>37</sup> See P. Singer. *Famine, Affluence and Morality*. *Philosophy & Public Affairs*. 1972; 1 (1): 229-243.

<sup>38</sup> There is a great deal of discussion of the issue of supererogation and Singer's original arguments in *Famine*. However, such discussions are well enough beyond the scope of this paper that I must leave those concerns aside for the time being.

an individual is actively engaged in the practice of killing another.<sup>39</sup> This objection claims that a woman is either actively killing her own child or (more likely) is asking healthcare professionals to do so on her behalf.<sup>40</sup> This objection to the argument presented therefore rests on a distinction between killing and letting die. In brief, the objector to the argument would maintain that it may be permissible to allow an innocent to die but it is never acceptable to intentionally kill an innocent.<sup>41</sup> Since the fetus is an innocent, it cannot be intentionally killed and because abortion is intentional killing (or so the objector claims) then an abortion cannot be performed.

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<sup>39</sup> This objection is not unique to the argument I have presented here, but is one that has been discussed at great length by many thinkers engaged in the debate on abortion. For a fuller account of the killing/letting die distinction see: B. Brody. Thomson on Abortion. *Philosophy & Public Affairs*. 1972; 1 (3): 335-340; J. Finnis. The Rights and Wrongs of Abortion: A Reply to Judith Thomson. *Philosophy & Public Affairs*. 1973; 2 (2): 117-145; J.J. Thomson. Rights and Death. *Philosophy & Public Affairs*. 1973; 2 (2): 146-159; P. Foot. 1985. Killing and Letting Die, In *Abortion: Moral and Legal Perspectives*. J. Garfield, ed. Amherst, MA: University of Massachusetts Press: 177-185; J.J. Thomson. Turning the Trolley. *Philosophy & Public Affairs*. 2003; 36 (4): 359-374; and Boonin, *op. cit.* 3 (2003), 188-211.

<sup>40</sup> The question of what obligations a mother has to her fetus is already complicated enough that I cannot address every aspect of the debate in this work. The issue of what obligations healthcare professionals have to a woman seeking an abortion (even assuming that a woman is morally permitted an abortion) is an issue complicated enough that I cannot adequately discuss it here. It may be the case that even though a woman can have or is entitled to have an abortion, a healthcare professional may not be obligated to provide one.

<sup>41</sup> This argument also assumes that the objector is willing to allow the individual in Thomson's famous violinist example to unplug herself from the violinist, even if unwilling (at this stage of the argument) to grant that one can likewise "unplug" oneself from a fetus. If the objector is unwilling to grant this assumption and instead claim that the individual in Thomson's argument cannot unplug herself from the ailing violinist, then I can only respond that the objector's conceptions of our responsibilities in this regard strike me as being stronger than those of our established social conventions and further argumentation along this line is rendered unfeasible.

The response to the objection that abortion is killing rather than letting die can take one of two forms. The first form is to deny the claim that there is a morally relevant distinction between killing and letting die. This is the choice that Thomson makes.<sup>42</sup> The second form is to accept the distinction and allow that killing is substantially worse than letting die, but that abortion can be justified. This is the approach I will consider more fully.

One approach to take in attempting to justify abortion in the face of the killing/letting die distinction is to find an abortion procedure that is letting die rather than killing.<sup>43</sup> One plausible abortion procedure which could be construed as letting die is the case of hysterotomy. In hysterotomy, the fetus is removed from the woman's uterus, whole and intact. The fetus then dies as a result of its own body's inability to sustain its life. This practice is akin to the case of Thomson's violinist in which you "unplug" yourself from the violinist. Assuming that in Thomson's example that when you unplug yourself from the violinist you let him die rather than kill him, then the same would hold in the case of hysterotomy.<sup>44</sup> Thus, even if one accepts the killing/letting die distinction, there is a plausible procedure that would allow for abortion on the grounds that it is not killing the fetus, but letting the fetus die.

At this point the objector may deny the conclusion that hysterotomy is letting die, but is instead killing. The concern now is what constitutes killing in a way that can justify the claim that hysterotomy is killing. Philippa Foot's account that the real concern with the killing/letting

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<sup>42</sup> Thomson argues that the distinction is not only false, but shown to be false by the story of you and the violinist. See Thomson, *op. cit.* 39 (1973), 156-157; Boonin, *op. cit.* 3 (2003), p. 190.

<sup>43</sup> Much of the following argument is a reflection of Boonin's account of the same problem, from which I drew much inspiration in dealing with this objection myself. I offer a greatly shortened version of that argument and focus on the most prominent aspects of this debate here. For a fuller discussion, see Boonin, *op. cit.* 3 (2003), 188-199.

<sup>44</sup> Boonin discusses the practice of hysterotomy as a plausible case of letting die. See *Ibid.*: 193-199.

die distinction is a concern over initiating a fatal sequence of events rather than allowing a fatal sequence of events to run its course is one option that could justify the view that hysterotomy is killing and not merely letting die.<sup>45</sup> On Foot's account, it is permissible to allow a fatal sequence of events to take its course, but it is not permissible to initiate a fatal sequence of events. The objector would have to claim that the problem with hysterotomy is that it is the initiation of a new fatal sequence of events and so is impermissible. Conversely, Thomson's violinist would then have to be a case in which the fatal sequence of events is allowed to run its course when the violinist is unplugged because he dies from his preexisting fatal kidney ailment.

The problem with this response by the objector that hysterotomy is actually killing and not merely letting die, is that it is unclear why it is that the case of abortion is different from the case of the violinist in regards to initiating a fatal sequence of events versus allowing a fatal sequence to run its course. Taking the view that hysterotomy is killing because it is the initiation of a fatal sequence, then the concern is that what constitutes the creation of a new fatal sequence is unclear. The argument that hysterotomy is the initiation of a fatal sequence seemingly rests on the idea that the fetus is not in any danger of imminent death from its underdeveloped condition which prevents it from being able to sustain its own life if it were removed from the womb so long as it remains attached and inside the womb. Furthermore, while in the womb, provided it is not interfered with, it will continue in that state. But then, so long as the violinist is connected to you and you remain connected to him and the violinist is not otherwise interfered with, then the violinist is also not in any danger of imminent death from his kidney ailment (which prevents him from being able to sustain his own life if he were disconnected from you). Thus, if hysterotomy is killing the fetus, then unplugging the violinist is killing the violinist. This result

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<sup>45</sup> See Foot, *op. cit* 39, 181.

seems difficult to accept. Similarly, if we accept that unplugging the violinist is letting the violinist die, we must do so on the basis that unplugging the violinist is allowing his preexisting kidney condition that renders the kidneys incapable of sustaining his life to run its course. However, this would also suggest that unplugging the fetus is allowing the fetus's preexisting condition of lungs that are incapable of sustaining its life to run its course and so we must also be letting the fetus die.<sup>46</sup> Similar attempts to clarify what constitutes initiating a fatal sequence as opposed to allowing a fatal sequence to continue seem equally problematic. As a result, the distinction the objector needs in order to maintain that hysterotomy is killing seems unlikely to obtain. Therefore, it seems there is at least one version of abortion procedure that should be acceptable on the grounds that it is not killing the fetus but merely allowing it to die and so the opponent of abortion cannot object to all abortion procedures on the grounds that abortion is killing the fetus.<sup>47</sup>

## VII. CONCLUSION

It seems at this stage that the only possible conceptions of responsibility that can ground the Responsibility Objection are the liability demand and causal responsibility. As initially

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<sup>46</sup> At this stage, I worry that perhaps Thomson's approach of simply denying the killing/letting die distinction may be the correct approach, though I am inclined to accept the view that there is in fact a morally relevant difference between killing and letting die, even if the distinction remains, as of yet, unclear.

<sup>47</sup> Boonin takes the argument further and attempts to argue that other types of abortion are permissible as well, even if they do constitute killing the fetus. I do not wish to engage such arguments here. However, it is worth noting that the success or failure of such arguments may necessitate certain changes in abortion procedures, making abortion a more dangerous prospect for women seeking to terminate unwanted pregnancies. For more on such arguments see Boonin, *op. cit.* 3 (2003), 199-204 and a response by A. Tupa. Killing, Letting Die and the Morality of Abortion. *Journal of Applied Philosophy*. 2009; 26 (1): 16-22.

presented, the liability demand could have included either a demand to provide care or a demand to rectify harm. However, given that neither of those conceptions of responsibility survived the previous discussion as suitably applicable to the case of abortion, all the liability demand can produce is a requirement on the part of the pregnant woman to do “something” about her pregnancy. That “something” can seemingly allow for the care of the fetus if the woman so chooses, but could equally allow for termination of the pregnancy, though particular abortion procedures may require further argumentation if they are to be deemed acceptable methods of abortion. Without previously established conventions on the matter, a requirement to further action can include a wide array of potential actions. In a similar fashion, being causally responsible for the fetus, but without any demand for particular further action leaves a pregnant woman with the same variety of options.

It is my contention that the only conceptions of responsibility that can ground the Responsibility Objection which have thus far been presented are either liability or causality. If the preceding discussion in this work is correct, then it is incumbent upon the proponent of the Responsibility Objection to either offer alternative conceptions of responsibility or alternative iterations of the Responsibility Objection such that these alternatives are suitably distinct from those considered here.<sup>48</sup> Furthermore, the proponent of the Responsibility Objection must also demonstrate how it is that these alternatives can succeed in grounding these alternative iterations of the Responsibility Objection in light of what has been said here. Without such an argument,

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<sup>48</sup> Arguments from vulnerability may be one such avenue. In general, an argument from vulnerability claims that because fetuses are vulnerable they are deserving of special levels of care and protection not afforded to other members of society. My concern here is that while this may be a way of salvaging the responsibility objection by presenting it in a new light, such an approach may simply be repackaging care responsibility with its associated problems under a different title.

and given that neither the liability demand nor causal responsibility can generate a demand for a woman to provide care for her fetus until such time as it can survive without her assistance, the charge that a pregnant woman has a responsibility to her fetus only generates a requirement to perform *some* action, which includes termination of the pregnancy. As such, the Responsibility Objection ceases to be a serious objection to a woman's reproductive freedom.

**AN ANALYSIS OF HOW ORTHODOX BIOETHICS FAILS TO ADEQUATELY  
JUSTIFY REMOVAL OF ARTIFICIAL NUTRITION AND HYDRATION FROM PVS  
PATIENTS.**

**Abstract**

**This work considers arguments within the orthodox bioethical framework which seek to justify the removal of life-saving medical treatments (LSMT) from patients in persistent vegetative states (PVS), in particular those concerned with the removal of artificial nutrition and hydration (ANH). To focus the discussion I consider an exemplar case involving PVS and the removal of ANH: the case of Theresa Marie (Terri) Schiavo. The orthodox bioethical framework requiring continued feeding of patients like Terri Schiavo relies upon three claims. First, the patient is a [innocent] human being. Second, all innocent human beings have the right to life. Third, competent individuals can waive their right to life via the refusal of LSMT. Unless a patient refuses LSMT, the administration of LSMT is required to preserve the life of the patient. With this framework in place I consider common or prominent arguments that have been advanced by proponents of removing LSMT from Terri Schiavo. These arguments claim: 1) Terri Schiavo is dead; 2) Terri has the right to refuse any and all treatment in her condition and have that treatment withdrawn; 3) ANH is medical care and as medical care it is not obligatory; 4) ANH is extraordinary care and so can be withdrawn or withheld; 5) Refusing to force-feed Terri Schiavo via ANH is analogous to refusing to force-feed terminal cancer patients; 6) Terri Schiavo's right to privacy is being violated by continuing to feed her, so the removal of her feeding tube is justified; and 7) No one would choose to be in a PVS. I conclude that each of these arguments fails to justify removing Terri Schiavo's ANH within the established bioethical framework. Proponents of removing ANH from PVS patients such as Terri**

**Schiavo will have to seek alternate approaches to defending their view which rejects the orthodox bioethical framework utilized throughout the discussion. So long as the right to life is based upon being an innocent human being and LSMT is required unless a patient clearly refuses the particular treatment, the removal of Terri Schiavo's ANH (and the ANH of similar PVS patients) will remain unjustified.**

## I. INTRODUCTION

This paper will consider arguments which are concerned with the treatment of patients in persistent vegetative states (PVS) specifically with regard to the attempts aimed at justifying the removal of artificial nutrition and hydration (ANH). The ensuing discussion will tend to focus upon a particular exemplar case of removing ANH from a PVS patient: the case of Theresa Marie (Terri) Schiavo. The arguments in this paper will show that the commonly encountered approaches used to justify removal of Ms. Schiavo's feeding tube are fatally flawed. Though the discussion will predominately deal with the Schiavo case, prominent cases involving PVS patients Nancy Cruzan and Karen Ann Quinlan set certain precedents concerning treatment of PVS patients and the removal of life-sustaining medical treatment. As such the discussion of the arguments surrounding the Schiavo case will at times require a consideration of the arguments applied to previous PVS cases as well. Furthermore, just as the cases of Cruzan and Quinlan set a precedent effect for Schiavo, so too has the Schiavo case set a certain precedent effect for the much less publicized cases of PVS that have surely occurred across the country in the years since Ms. Schiavo's death. So even though it has been more than 10 years since her passing, the case of Terri Schiavo and the arguments employed to justify removing her feeding tube remain as relevant to the discussion of medical ethics today as during the early months of 2005 when the controversy surrounding her case reached its zenith.

## II. THE CASE OF THERESA MARIE (TERRI) SCHIAVO

Terri Schiavo's case began following a sudden collapse and loss of consciousness on February 25, 1990.<sup>49</sup> Her breathing stopped long enough to produce sufficient brain damage to

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<sup>49</sup> Joshua Perry et. al. The Terri Schiavo Case: Legal, Ethical, and Medical Perspectives. *Annals of Internal Medicine*. 2005; (143): 744-748; University of Miami Ethics Program. 2014. *Terri Schiavo Case Resources*.

leave her in a persistent vegetative state. A PVS is characterized most prominently by a persistent absence of consciousness in the patient. This persistent lack of consciousness is the result of damage to the neocortex, which is usually the result of a prolonged lack of oxygen to the brain.<sup>50</sup> Severe trauma can also cause a PVS as well. Additional characteristics of a PVS include the PVS patient's ability to demonstrate sleep and wake cycles, movement of the eyes, and reflexive swallowing.<sup>51</sup> However, the PVS patient lacks purposeful movement and awareness. PVS patients often maintain functioning brain stems such that they are capable of breathing spontaneously without the need for respirators. In Terri Schiavo's case, Terri could breathe on her own but she could not otherwise care for herself. Her condition made feeding her by mouth difficult and dangerous to Terri's health. So Terri's doctors provided her with ANH in the form of food and fluids via a feeding tube. Terri survived in this state for many years. During

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<http://www.miami.edu/index.php/ethics/projects/schiavo/> [Accessed 21 April 2014]; C. Haberman. 2014. *From Private Ordeal to National Fight: The Case of Terri Schiavo*. [http://www.nytimes.com/2014/04/21/us/from-private-ordeal-to-national-fight-the-case-of-terri-schiavo.html?\\_r=0](http://www.nytimes.com/2014/04/21/us/from-private-ordeal-to-national-fight-the-case-of-terri-schiavo.html?_r=0) [Accessed 21 April 2014].

<sup>50</sup> Possible causes of PVS include, but are not limited to: infections (bacterial, viral, or fungal), tumor, abscess, hemorrhaging, stroke, hypoxic ischemia (hypotension, cardiac arrest), toxins (such as ethanol, lead, opiates, etc.), trauma, seizure, and sepsis.

<sup>51</sup> Brain death differs from PVS in that, when a patient has suffered brain death the entire brain (including the brain stem) has irreversibly ceased its function. PVS patients maintain some level of functioning in the brain and brain stem and so are not dead based on the orthodox definition of death. See President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. 1981. *Defining Death: Medical, Legal and Ethical Issues in the Determination of Death*.

[https://bioethicsarchive.georgetown.edu/pcbe/reports/past\\_commissions/defining\\_death.pdf](https://bioethicsarchive.georgetown.edu/pcbe/reports/past_commissions/defining_death.pdf) [Accessed 14 February 2014].

this time Terri's husband, Michael Schiavo, and Terri's family sought treatment for Terri's condition.

By January of 2000 however, Michael Schiavo had ceased in his earlier efforts to find a way to treat Terri's PVS and instead attempted to have his wife's feeding tube removed.<sup>52</sup> This change in Michael's approach to dealing with his wife's condition led to conflict with Terri's parents, Mary and Robert Schindler, who objected to Michael's attempt to remove Terri's feeding tube. Though the Schindlers fought Michael Schiavo's attempt to remove Terri's feeding tube in both the Florida courts and federal appellate courts, and unprecedented attempts by state and federal lawmakers were taken to intervene in the case,<sup>53</sup> eventually the courts (which had "consistently sided with the husband as a matter of law")<sup>54</sup> ruled that Terri's feeding tube could be removed. Terri Schiavo died on March 31, 2005 approximately two weeks after the removal of her feeding tube.

### III. FRAMING THE DEBATE

The legal question of whether Michael Schiavo could permissibly remove the feeding tube from his wife has long been decided in favor of allowing the removal of Terri's feeding

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<sup>52</sup> Mary and Robert Schindler, et. al. 2006. *A Life that Matters: The Legacy of Terri Schiavo – A Lesson for Us All*. Warner Books, New York: 9-66.

<sup>53</sup> An example of such unprecedented intervention is "Terri's Law", which was passed by the Florida legislature and signed into law by Florida's governor at the time, Governor Jeb Bush. "Terri's Law" allowed Governor Bush to intervene in the removal of Terri Schiavo's feeding tube. The law was later found unconstitutional by the Florida courts. See CNN.com. 2004. *Florida Court Strikes Down Terri's Law*.

[http://www.cnn.com/2004/LAW/09/23/schiavo/index.html?\\_s=PM:LAW](http://www.cnn.com/2004/LAW/09/23/schiavo/index.html?_s=PM:LAW) [Accessed 10 April 2014]; O. C. Snead. Dynamic Complementarity: Terri's Law and Separation of Powers Principles in End-of-Life Context. *Florida Law Review*. 2005; 57: 53-88.

<sup>54</sup> Haberman, *op. cit.* 49.

tube. However, there remains considerable debate over the moral question concerning whether it was permissible to remove Terri Schiavo's feeding tube. The debate over removing Terri's feeding tube utilizes certain principles common to orthodox bioethics and U.S. law. These include the following:

- Terri Schiavo is a [innocent] human being.
- All innocent human beings have the right to life.
- Competent individuals can waive their right to life as patients via the refusal of life-saving medical treatments (such as ventilators, blood transfusions, surgeries, etc.).

Given the view in orthodox bioethics that it is possible to waive the right to life, some discussion of the nature of rights and the waiving of the right to life is in order. "Rights are entitlements (not) to perform certain actions, or (not) to be in certain states; or entitlements that others (not) perform certain actions or (not) be in certain states."<sup>55</sup> Rights are also often separated into positive and negative rights. Positive rights would entail an obligation to act while negative rights would entail an obligation to refrain from action.

The right to life is viewed as both a positive and negative right; it imparts both obligations to act and obligations to refrain from acting. Possession of a right to life entails most prominently an obligation that others not [unjustly] kill the right holder. In this sense the right to life is a negative right. Furthermore, under certain conditions, the right to life also entails that

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<sup>55</sup> L. Wenar. 2015. Stanford Encyclopedia of Philosophy. *Rights*. <http://plato.stanford.edu/entries/rights/> [Accessed 10 Oct 2015]. For example, possession of a "right to vote" entails that the right holder is entitled to cast their vote in the relevant election. The possession of a right to vote entails that others not act to prevent the right holder from exercising this right. However, the right holder can waive her right to vote by refusing to cast a ballot in the relevant election. A voter need not waive all elements of this right at once. A voter could choose not to vote on a particular ballot measure (perhaps a referendum about which the voter is uninformed) whilst still casting their vote for a particular candidate (whom the voter has a strong preference toward seeing elected).

particular others are obligated to act in a way to preserve the life of the individual right holder.<sup>56</sup> In this sense the right to life is viewed as a positive right.

In the practice of medicine the obligation to respect another's right to life is often found in the recognition that medical professionals have an obligation to act to preserve the lives of patients where possible, often via the use of life-saving medical treatments.<sup>57</sup> However, the individual who holds a right to life can waive any part of that right. Most commonly, the waiver of the right to life involves only a partial waiver of the right. Individual patients can waive their right to a particular form of treatment, even if doing so results in the patient's death, without relinquishing their right to other forms of life-saving treatment (positive right) or the right not to be [unjustly] killed (negative right). For example, a Jehovah's Witness is likely to refuse a blood transfusion due to her religious convictions even if she will die without it. However, if the Jehovah's Witness is also in need of a respirator to maintain her breathing and she has not also refused the respirator, presumably her physician would be obligated to continue the respirator while the Jehovah's Witness died from cardiac arrest (due to sustained blood loss because she had refused the transfusion). The refusal of the blood transfusion entails a waiver of the right to life on the part of the patient for a particular life-sustaining treatment (blood transfusion), but not all possible life-sustaining treatments (respirator) or all other obligations under the right to life.

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<sup>56</sup> There is considerable debate over the extent to which the right to life entails positive obligations of aid on the part of others toward the right holder. The most prominent of which can be found in Judith Jarvis Thomson's *A Defense of Abortion*, wherein Thomson argues that even in some cases the clear possession of a right to life does not entail an obligation on the part of others to provide everything needed to sustain that right. Thomson argues that what is clearly obligated is that others refrain from unjustly killing the right holder. See Thomson, *op. cit.* 2.

<sup>57</sup> Such treatments may include medications (such as antibiotics to kill potentially fatal diseases) and procedures (such as cardio-pulmonary resuscitation or blood transfusions).

Some in favor of maintaining Terri's feeding tube have argued that the principles above place obligations upon Terri's caregivers to provide her with proper care. This obligation would deny the removal of Terri's feeding tube:

1. Terri Schiavo is in a nursing home.
2. The staff at the nursing home has an obligation to provide their patients with care.
3. Food and fluids are among the sorts of care that the nursing home staff is obligated to provide to all patients under their care.
4. Therefore, the nursing home staff is obligated to provide food and fluids to Terri Schiavo.

Initially this argument appears to be sound. Premise 1 was obviously true during the time in which Michael Schiavo sought the removal of his wife's feeding tube. Premise 2 also seems reasonable to accept as true. We would recognize a nursing home staff which neglected the needs of their patients regarding issues like proper medication, bathing of patients, and cleaning and sanitation of the facility to be failing in their moral duties. Premise 3 seems an important aspect of the obligations entailed by premise 2, and so also seems quite reasonable to accept as true. We would rightly condemn a nursing home which routinely starved all of its patients of behaving in a horrific and clearly immoral fashion. Thus, the conclusion seems like a reasonable conclusion to accept.<sup>58</sup>

The conflict in the Schiavo case arises because Michael Schiavo and his supporters, though they are likely to accept premises 1-3 of the above argument, wish to deny the conclusion. Michael Schiavo is claiming that Terri is a special case. While the above argument certainly applies to the vast majority of patients in nursing homes and many patients afflicted with Terri Schiavo's particular condition, Michael Schiavo is arguing that Terri is an exception.

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<sup>58</sup> One could presumably expand the responsibility to provide care beyond the nursing home. The obligations to provide care that are being placed upon the nursing home staff would seem to apply equally to a home nurse or Terri's family if Terri was living with either Michael Schiavo or any other family member.

The issue this paper will seek to address is to identify what arguments, if any, are capable of justifying the claim by Michael Schiavo that it is acceptable for him (and all others charged with his wife's care) to willingly starve his wife to death within the framework commonly recognized by orthodox bioethics.

Some dispute the removal of the feeding tube on the grounds that Terri's diagnosis and prognosis were uncertain.<sup>59</sup> PVS is a difficult condition to diagnose. In the Schiavo case, there is at least some evidence to suggest that Terri was misdiagnosed and was actually in a minimally conscious state rather than in a PVS. Furthermore, even if Terri was in a PVS, the prospect of frequent misdiagnosis has resulted in reported 'recoveries' from PVS. This further obscures the facts about the nature of the prognosis for a PVS patient over time. To avoid having to consider the implications of Terri Schiavo being misdiagnosed and the complications of an uncertain prognosis, I will assume that Terri was in an irreversible PVS. In so doing I aim to provide the arguments to be considered here their best possible foundation and preempt counter-arguments about the uncertainty of Terri's prognosis and the possibility of a future cure for her condition.

#### **IV. ARGUMENT 1: TERRI SCHIAVO IS DEAD**

One approach to arguing in favor of removing Terri's feeding tube would be to claim that Terri Schiavo has already died. If it were true that Terri was actually dead, that would seem to provide all that is necessary to justify the refusal of food and fluids. After all, we do not think there is any reason for us to continue to feed corpses.<sup>60</sup> The question that must be answered then

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<sup>59</sup> Schindler, et. al. *op. cit.* 52, Appendix B.

<sup>60</sup> Though some religions may involve offerings of food to deceased relatives, this sort of behavior is not the same as a demand to actually feed the dead. Furthermore, there is a significant moral difference between someone choosing not to follow a religious tradition of this sort versus choosing to not feed a living human being. Moral principles of

is if there is reason to accept that Terri Schiavo was dead at the time her feeding tube was removed. Some authors have argued that since a PET scan or brain scan had not been performed on Mrs. Schiavo, there was no concrete evidence in favor of the claim that Terri Schiavo was brain dead at the time her feeding tube was removed. As one author put the matter: “It seems cavalier and coarse to presume that Mrs. Schiavo was brain-dead without performing this basic and easily available medical procedure.”<sup>61</sup>

Though Terri Schiavo had suffered severe brain damage, she had not suffered *brain death*. Brain death involves the irreversible loss of function of the entire brain, including the brain stem. This had not happened in Terri’s case. Furthermore, Terri’s respiratory and circulatory function had not ceased irreversibly as Terri was able to breath on her own and maintained a spontaneous heartbeat. As such, Terri Schiavo was not dead according to the orthodox definition of death. The orthodox definition of death stipulates that “an individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead.”<sup>62</sup> Terri Schiavo did not meet either of these criteria and so was not legally dead according to the accepted definition of death.

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respect for autonomy and non-interference seem to demand acceptance of the former. Those same principles seem to demand that we reject the latter.

<sup>61</sup> S. Calabresi. The Terri Schiavo Case: In defense of the special law enacted by Congress and President Bush. *Northwestern University Law Review*. 2006; 100 (1): 154.

<sup>62</sup> There are some states, for example New Jersey and New York, which vary the language of this approach to determining death to some minor degree. However, this criteria has been nearly universally accepted in the U.S. It is notably the current language used to determine death in the state of Florida. See The President’s Commission, *op. cit.* 51, 2.

Individuals who advocate for the position that Terri Schiavo (or any other PVS patient) died when she entered into a PVS must hold a conception of Terri Schiavo that is incompatible with the assumptions made at the outset of this paper. If Terri Schiavo is a human being, a member of the species *Homo sapiens*, then the death of Terri Schiavo is understood according to the present legal definition of death already presented above which defines the deaths of human beings.<sup>63</sup> On this view, Terri Schiavo died March 31, 2005 when her respiration and circulation ceased irreversibly or her whole brain irreversibly ceased its function (whichever came first, unless they occurred simultaneously). Terri did not die in the early months of 1990 when she fell into a PVS. The onset of the PVS did not remove Terri Schiavo from the species *Homo sapiens*.

To hold that Terri Schiavo died at the onset of her PVS is to conceive of Terri Schiavo as something other than a human being and member of the species *Homo sapiens*. A view that would support the conclusion that Terri Schiavo died at the onset of her PVS is known as *mental essentialism*. Mental essentialism holds that a human person is essentially a mental entity.<sup>64</sup> However, mental essentialism entails that human persons (such as myself, or you dear reader) are not human beings; that is, we are not members of the species *Homo sapiens*.

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<sup>63</sup> This approach to defining the death of human beings applies to the United States of America. Other countries can and do have different standards. Great Britain for instance defines death of a human being in terms of the death of the brain stem, rather than the death of the whole brain. See National Health Services. 2015. *Brain Stem Death*. <http://www.nhs.uk/Conditions/Brain-death/Pages/Introduction.aspx> [Accessed 23 September 2015]; B. Smith. Brain death: time for an international consensus. *British Journal of Anaesthesia*. Year; 108(1): 6-9. Available at: [http://bja.oxfordjournals.org/content/108/suppl\\_1/i6.full](http://bja.oxfordjournals.org/content/108/suppl_1/i6.full) [Accessed 23 September 2015].

<sup>64</sup> J. McMahan. The Metaphysics of Brain Death. *Bioethics*. Apr 1995; 9(2): 91-126.

Jeff McMahan's brain transplant argument demonstrates why it is the case that adoption of mental essentialism entails that an individual is not a member of any particular species.<sup>65</sup> Imagine a scenario in which we remove the brain of one individual (call him Alan) and transplant that brain into the brainless body of another (call him Brian). All the memories, thoughts, beliefs, feelings, attitudes, preferences, etc. that existed in Alan prior to the transplant are preserved in the brain that now resides in Brian. According to the mental essentialist, the individual that now resides inside the body that looks like Brian is in fact Alan. Alan has survived the transplant and, though he looks different than he did prior to the operation, is still the same individual.<sup>66</sup> While reading this story of the brain transplant you probably pictured transplanting Alan's brain from one human body to another human body, likely both of them male. However, suppose that the brainless body Brian is not a human body at all, but is actually a brainless dog body. Alan would still survive the transplant and maintain his identity even though Alan no longer resides in a body belonging to the species *Homo sapiens*. Alan now resides inside a body belonging to the species *Canis familiaris*. In neither of these situations is Alan the same as either of these biological organisms according to mental essentialism. Alan is not the dog any

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<sup>65</sup> McMahan argues that although our mental entities are intimately connected to and associated with our bodies, our bodies being biological organisms and members of the species *Homo sapiens*, we are not identical to our bodies. McMahan, *op. cit.* 64, 97-101.

<sup>66</sup> This claim (and indeed mental essentialism itself) relies upon a conception of personal identity known as psychological continuity. Psychological continuity holds that an individual maintains her personal identity through time as a result of being psychologically connected from one time to another via particular mental states.

Psychological continuity views are popular options among personal identity theorists, though they are not without their detractors. See E.T. Olsen. 2015. Stanford Encyclopedia of Philosophy. *Personal Identity*.

<http://plato.stanford.edu/entries/identity-personal/#PsyApp> [Accessed 9 October 2015].

more than he is the human being. Alan is the mental entity that is being moved from one body to the other.

Mental essentialism would entail that Terri Schiavo died when she entered into a PVS because Terri Schiavo would be a mental entity, not the biological organism which is a member of the species *Homo sapiens*. The onset of the PVS would mark the point in time wherein Terri's mental functions that maintain her psychological continuity ceased. At that time, the mental entity that was Terri Schiavo ceased to be, so Terri died. Such a position is incompatible with the assumptions made by orthodox bioethics concerning the existence of Terri Schiavo and indeed, all other human beings.

Terri Schiavo was in a PVS. This was the recognized diagnosis accepted by her treating physicians and the courts. PVS is different from whole brain death, the latter of which can be diagnosed without the necessity of a PET scan.<sup>67</sup> Even if a PET scan had not been performed it would be possible to recognize that Ms. Schiavo had not suffered either whole brain death or cardiac/respiratory death. As such, any argument for removal of Terri's feeding tube which is based on the claim that Terri Schiavo was legally dead in accordance with the recognized determinations of death concerning human beings at the time of removal is erroneous and should be rejected.

## **V. ARGUMENT 2: TERRI SCHIAVO HAS THE RIGHT TO REFUSE ANY AND ALL TREATMENT IN HER CONDITION AND HAVE THAT TREATMENT WITHDRAWN**

One of the most fundamental rights afforded to any and all competent patients in the United States is the right to refuse care. This right is codified in U.S. law and the laws of every

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<sup>67</sup> A.K. Goila and M. Pawar. 2009. National Institutes of Health. *The diagnosis of brain death*.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2772257/> [accessed: 1 July 2015].

state. The works of J.S. Mill and Immanuel Kant offer two potential approaches to understanding the connection between personal autonomy and the right to refuse care.

Philosophical justification for the right to refuse care can be found in two prominent sources: J.S. Mill's *On Liberty* and Immanuel Kant's *Groundwork of the Metaphysics of Morals*. The principle of autonomy is "a central value in the Kantian tradition of moral philosophy [and] it is also given fundamental status in J.S. Mill's version of utilitarian liberalism."<sup>68</sup> Mill's approach requires that others refrain from interfering in our actions as autonomous agents provided that our actions do not threaten to do harm to others.<sup>69</sup> Patients who refuse care on this account of autonomy are presumed to do harm only to themselves. Kant's approach requires that autonomous moral agents always be treated as ends and never merely as means.<sup>70</sup> Patients who refuse care on this account of autonomy are treated as ends if the refusal of care is respected and as a mere means if the refusal of care is not respected.<sup>71</sup>

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<sup>68</sup> J. Christman. Stanford Encyclopedia of Philosophy. *Autonomy in Moral and Political Philosophy*.

<http://plato.stanford.edu/entries/autonomy-moral/#ConAut> [Accessed 9 September 2015].

<sup>69</sup> J.S. Mill. 2005. *On Liberty*. In *Classics of Moral and Political Theory*. M.L. Morgan, ed. Indianapolis, IN: Hackett Publishing: 940-941.

<sup>70</sup> Immanuel Kant. 1997. *Groundwork of the Metaphysics of Morals*. Mary Gregor, ed. Cambridge UP: 38.

<sup>71</sup> This short discussion of connections between autonomy and the right to refuse care is not intended to be exhaustive. Other methods of justifying the connection surely exist. For example, an alternative approach one could instead recognize is that the respect for individual patient autonomy which affords one the right of refusal is grounded within one's own bodily integrity and that no other has the right to violate that bodily integrity without the individual patient's permission. However, the concern with the Schiavo case in the ensuing discussion is less about how one justifies Ms. Schiavo's right to refuse care and instead is about whether or not Ms. Schiavo refused care at all.

The right of refusal is often the most prominent argument in the discussion of cases like Terri Schiavo. Proponents of removing Terri's feeding tube are likely to claim that Terri has refused the feeding tube; therefore the feeding tube must be removed. Yet there is a problem with making the argument in such a fashion. Terri Schiavo's lack of consciousness as a PVS patient presents a serious challenge to any claim that Terri Schiavo has actively refused any treatment option once she is in a PVS. The argument as presented suggests that Terri Schiavo is in a PVS and is somehow actively refusing the care in question. This is not possible if what the argument is claiming is that following the events of February 25, 1990 someone has asked Terri if she would like to have her feeding tube removed and Terri somehow responded in the affirmative. From February 25, 1990 until her death, Terri Schiavo is in an irreversible PVS. She lacks consciousness and the ability to communicate. We could ask her repeatedly whether she wants us to remove her feeding tube or not, but we would never receive a response from a patient in such a condition.<sup>72</sup>

The conclusion to take from this argument is that if Terri Schiavo has in some way refused treatment, she is not doing so actively while in a PVS. Rather, her refusal of care must take some other form. The question then becomes: can patients legitimately refuse treatment in some other fashion (besides an immediate response to the inquiry of a caregiver) and if so, what form would such refusals take? The answer to this question concerns the use in medical practice of advance care directives and proxy decision-makers.

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<sup>72</sup> Were we to receive a response from a patient which suggested the presence of consciousness and the ability to express oneself, such a response would entail that the patient was not actually in a PVS but had been misdiagnosed. In such a situation the arguments presented here concerning PVS would cease to apply and different arguments would need to be considered.

There are numerous conditions that may befall a person that will render said person unable to communicate her particular preferences concerning treatment. PVS is just one example of such a condition; advanced Alzheimer's disease is another. For the last several decades there has been increasing demand for patients and prospective patients to actively engage in the process of medical decision making prior to the onset of conditions which will render the patient unable to make decisions for herself. This campaign for increased awareness of patient preferences has resulted in two primary methods for representing patient preferences should the patient be unable to communicate in the future. The first, and perhaps most well-known of these methods is known as an advance care directive (sometimes referred to as a "living will"). An advance care directive is a written document that specifies patient preferences concerning various treatments and medical conditions. The alternative to the advance care directive is for individuals to designate a medical proxy via a durable power of attorney for medical decisions. Presumably, the individual then informs the chosen proxy of her preferences which the proxy is now charged with executing in the event the individual becomes ill and is unable to communicate her preferences directly.

The Schiavo case may have been easily resolvable had Terri Schiavo completed an advance care directive prior to falling into a PVS. In it, she could have specified her preferences to either continue to be treated or not in the event she was diagnosed with a PVS. Following the Schiavo case, thousands of individuals no doubt completed advance care directives specifying their preferences to either be fed or not be fed should they be diagnosed as being in a PVS. Those cases have surely been resolved without the controversy and national attention that occurred with the Schiavo case. However, because Terri Schiavo did not have an advance care directive, any

attempt to discern Terri Schiavo's preferences concerning her care must rely upon the use of proxy decision-makers instead.

Proxy decision-makers arise in a variety of fashions. As mentioned above, some proxies are specifically designated by the patient prior to the onset of illness. When such specifically designated proxies are unavailable (or the patient has not designated such a proxy), the proxy is determined via a generally recognized hierarchy. In Terri Schiavo's case, Terri had not designated a proxy, so the chosen proxy was her husband Michael Schiavo.<sup>73</sup> Terri had not specifically designated Michael to be her proxy, but for married patients the spouse is generally the first to be recognized as the proxy decision-maker. When a spouse is unavailable, parents (most commonly for younger patients such as Terri Schiavo, or adolescents and children) and either siblings or adult children (most commonly for older patients) are selected as proxy decision-makers instead. When none of these individuals are available, other family members can be chosen to fulfill the role of the proxy and if no family members can be found to stand as proxy for a patient, healthcare providers may turn to the courts to appoint an individual to act as guardian for the patient instead.

The justification for the use of the proxy arises because the proxy is viewed as an extension of the autonomy/integrity of the patient herself. When I designate a particular individual as my proxy, I am indicating my preference for this individual to act on my behalf.<sup>74</sup> The proxy (however determined) is charged with not only making decisions on behalf of the patient, but presumably and most importantly, the proxy is charged with making the decision that

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<sup>73</sup> The Schindlers, Terri's parents, signed over power of attorney to Michael in the early days of Terri's treatment. Schindler, *op. cit.* 52, 40-42.

<sup>74</sup> One might also suppose that if I were to refrain from choosing a particular proxy that I am opting for the generally recognized hierarchy noted above to be employed to determine a proxy instead.

the patient herself would have made were the patient able to decide for herself. Presumably, the reason I chose a particular individual as my proxy is because I expect that chosen individual to act in accordance with my own particular preferences. A proxy who is knowingly and willfully acting contrary to the wishes of the individual for whom they are designated as proxy does not seem to be acting in accordance with the onus placed upon them by the designation of 'medical proxy'. If I am aware of my chosen proxy's intention to act contrary to my preferences, I would surely act to either remove that individual as my proxy or to convince my chosen proxy that I would prefer they act in accordance with my expressed preferences. The purpose of the proxy is to act on the patient's behalf and to do so in light of the preferences of the patient. If proxies can consistently act in accordance with the preferences of those patients they represent, then the use of proxies may well be justified.

The problem for this method of reflecting a patient's right to refuse care is that proxy decision-makers are one of the more dubious aspects of orthodox medical ethics. The Schiavo case highlights some of the most serious concerns with the use of proxy decision-makers. As mentioned, a proxy decision-maker is charged with making the medical treatment choice that the patient, if competent, would have made.<sup>75</sup> Michael Schiavo claimed that Terri had expressed to him a preference not to be kept alive in the event of serious incapacitation (such as PVS). This claim by Michael Schiavo formed the foundation upon which the justification for removing Terri's feeding tube was based. Michael Schiavo's decision to disconnect Terri Schiavo from her

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<sup>75</sup> ProCon.org. 2008. *From a Legal Perspective, Should Terri Schiavo's Feeding Tube Have Been Removed?*

<http://euthanasia.procon.org/view.answers.php?questionID=000170> [Accessed 10 July 2015].

feeding tube was challenged by Terri's parents on the basis that Michael's decision did not reflect Terri's autonomy or her preferences.<sup>76</sup>

There may be several possible reasons for questioning whether or not a decision by a proxy truly reflects the autonomy of the patient. For example, surrogates are not necessarily well enough informed in regards to the patient's preferences. We can imagine endless scenarios in which a would-be proxy holds a belief about the preferences of a future patient that is contrary to the actual preferences of the patient. For example, a parent who is not a Jehovah's Witness may believe their adult child would prefer to have a blood transfusion when the adult child had undergone a religious conversion and would have actually refused the transfusion. A failure to communicate the change in preference though led to a conflict between the patient's preference and the proxy's belief about the patient's preference.

It may also be the case that proxies disagree about the preferences of a particular patient. Imagine the conflict that would arise in the event a wife expressed a preference to her new husband to have a feeding tube maintained in the event of PVS but did not also share this preference with her parents who believe that their daughter would prefer not to have the tube maintained. Though the proxy (in the form of the husband) would in fact be reflecting the expressed preferences of the patient in such a scenario, there would also be reason to question the decision based on the parent's beliefs about their daughter whom they have known for much longer than the new husband. Should this sort of conflict between individuals who have an interest in the treatment of a particular patient arise, the presence of such a disagreement at least suggests reason to be suspect of the proxy's choice (barring clear and convincing evidence from the patient herself).

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<sup>76</sup> Schindler, *op. cit.* 52, 67-84.

Proxies may also be uncertain of a particular patient's preferences concerning a given treatment. This uncertainty may be the result of a lack of communication between patient and proxy or a lack of knowledge on the part of the patient about a particular treatment or condition. However it arises, the proxy now finds herself in the position of trying to make the decision the patient would have made for herself but the proxy is trying to decide without specific guidance from the patient. In such a scenario, proxies can only guess at what they believe the patient would have wanted based on what the proxy knows about the patient. The problem with having to guess is that the accuracy of our guess will depend a great deal upon how well we know the patient, but even an educated guess is still just a guess.

A further concern is that many proxies may make decisions based upon their own preferences, which differ from those of the patient whose autonomy is supposed to be represented by the choices of the proxy. It may well be the case that the proxy would prefer not to be kept alive in a PVS while the patient would prefer to be kept alive. Additionally, proxies may make decisions based upon what would be best for the proxy rather than what would best represent the patient's preferences. In the case of Terri Schiavo, the motivation of her husband to remove the feeding tube from Terri was questioned in part because of Michael Schiavo's relationship that he began with another woman following the onset of Terri's PVS. Michael Schiavo had fathered children with another woman while his wife was still alive and in a PVS. The financial costs associated with maintaining a PVS patient often fall upon the family of the patient. The spouse in particular can face serious financial hardship as a result of maintaining a PVS patient. A proxy who is financially responsible for a patient's care may desire the end of the patient's care for reasons which have nothing to do with respect for the patient's autonomy. Financial benefit may be the true motivation for some proxy decisions to remove care. Proxies

are supposed to reflect the autonomy of the patient. A husband who is financially responsible for a wife in a PVS and a growing family with another woman seems suspect in his motivations to have his wife's feeding tube removed knowing that it would result in the end of the costly financial burden.<sup>77</sup>

Even when proxies are not compromised, studies have demonstrated that proxies are not as reliable in their assessment of patient preferences as the justification for their use would seemingly demand. In one study for example, physicians who believed they were reflecting the wishes of their patients did no better than if the physician was merely guessing at what a patient would want regarding the continuation of a treatment option. Family members were only slightly better than physicians in this regard, which is troubling since family members are the sort of proxies that are *supposed* to know what the patient wants. Furthermore, while patients believed that their proxies would accurately reflect their preferences, the results of the study did not suggest that this was in fact the case.<sup>78</sup> Results from studies such as this would suggest that if the justification for the use of a proxy is based upon the proxy acting as an extension of the patient's autonomy, then nearly half of all proxies are failing to fulfill their obligations as proxy. The decisions of nearly half of all proxies would therefore fail to be justified.

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<sup>77</sup> Terri Schiavo's family, the Schindlers, have claimed that they offered to assume all costs associated with caring for Terri. It is also worth noting that there did exist a trust to help pay for the cost of care for Terri Schiavo. However, in the event of her death, any money remaining in the trust would have passed to Michael Schiavo. This financial gain may have been part of the motivation for Michael Schiavo to insist upon the removal of Terri Schiavo's feeding tube rather than to allow Terri's family to assume the cost of caring for her.

<sup>78</sup> A. Seckler, et. al. Substituted Judgment: How Accurate are Proxy Predictions? *Annals of Internal Medicine*. 1991; 115: 95.

If we suppose that Michael Schiavo's motivations were pure and his intent truly was to reflect his wife's preferences, given the general inaccuracies of proxy decision-makers, there is reason to be suspect of the claim that Michael Schiavo's decisions truly were reflective of his wife's preferences. When you add in Terri's catholic background and the general stance of the Catholic Church against the removal of feeding tubes from PVS patients,<sup>79</sup> the claim that Michael Schiavo is reflecting his wife's wishes is further weakened. When one also recognizes the conflicted position that Michael Schiavo created for himself by fathering children with a woman who was not his wife while she was in a PVS, the incredulity of those who refuse to accept that Michael Schiavo is acting upon the expressed wishes of his wife becomes entirely understandable. Taken together there seems to be sufficient justification for rejecting the claim that removal of Terri Schiavo's feeding tube was morally justified based upon clear and convincing evidence provided by her proxy decision-maker Michael Schiavo.

## **VI. ARGUMENT 3: ANH IS MEDICAL CARE AND AS MEDICAL CARE IT IS NOT OBLIGATORY**

One approach utilized by some advocates of removing feeding tubes from PVS patients involves distinguishing between medical care and natural means of preserving life. Advocates of removing feeding tubes from PVS patients like Terri Schiavo will argue that medical care (or a medical act) can always be refused by a patient. According to such advocates for removing Terri's feeding tube: ANH is clearly medical care and so the feeding tube can be removed.

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<sup>79</sup> The Vatican. 2004. *Address of John Paul II to the participants of the international congress on "Life-Sustaining treatments and vegetative state: scientific advance and ethical dilemmas."* [http://w2.vatican.va/content/john-paul-ii/en/speeches/2004/march/documents/hf\\_jp-ii\\_spe\\_20040320\\_congress-fiamc.html](http://w2.vatican.va/content/john-paul-ii/en/speeches/2004/march/documents/hf_jp-ii_spe_20040320_congress-fiamc.html) [accessed 21 April 2014].

Proponents of this sort of argument are usually responding to comments made by the late Pope John Paul II regarding the withdrawal of ANH.

Pope John Paul II argued that “the administration of water and food, even when provided by artificial means, always represents a natural means of preserving life, not a medical act.”<sup>80</sup> Proponents of maintaining the feeding tube will argue that the feeding tube is an extension of the concept entailed by the cup and the spoon. A feeding tube is simply a means of delivering the food to the digestive system of the person being fed. In this regard the tube is just a means of conveyance. Presumably a doctor who is feeding his sick child soup via a spoon is not engaged in a medical act, though the doctor is providing care to the child. Neither the food itself nor the means of conveyance qualify as medical acts.

This argument by the late pope raises the question: why should we treat a feeding tube as anything more than a spoon which bypasses the mouth and delivers food directly to the stomach? Some have argued that “we must recognize that having a synthetic protein compound pumped directly into the intestine by skilled medical personnel is not the same as eating and drinking with friends. It is a qualitatively different act from feeding a patient with a cup and spoon.”<sup>81</sup> Those responding to the late pope will note two additional points: first, the placing of a gastrostomy tube is performed by a surgeon and no surgeon placing such a tube believes they are engaged in anything other than a medical act.<sup>82</sup> Second, the occurrence of complications, including infections and blocked/damaged tubing, are common amongst ANH recipients. These

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<sup>80</sup> Ibid.

<sup>81</sup> C. Cohen. 2005. The Episcopal Church. *Morality and Medicine: Church addresses end-of-life obligations*. <http://www.episcopalchurch.org/library/article/morality-and-medicine> [Accessed 20 July 2015].

<sup>82</sup> R. Fine. 2005. National Institutes of Health. *From Quinlan to Schiavo: medical, ethical and legal issues in severe brain injury*. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1255938/> [Accessed 27 April 2015].

complications will often require additional treatment and/or surgery.<sup>83</sup> Those who wish to argue against an obligation to maintain a feeding tube will respond to the late pope's view that taken together these points entail that ANH is indeed a medical treatment and not merely a natural means of preserving life.

The distinction being drawn by those who wish to recognize feeding tubes as medical treatment potentially have a case that feeding tubes are in fact medical treatment. An individual who uses a spoon to feed her sick child is not engaged in 'doctoring' and so is not engaged in a medical act. The care in this case is not medical care. Rather, she is engaged in some other type of care which we might denote as 'parental care' or 'child care' perhaps. The individual who is placing a gastrostomy tube is engaged in an act of doctoring and so is engaged in a medical act and is providing 'medical care'. The same individual could perform both of these acts and would presumably be engaged in a medical act toward her patient when placing the feeding tube and a non-medical act toward her child when providing soup with a spoon. Therefore, if viewed from such a perspective, feeding tubes would indeed qualify as medical treatment.

While there may be good reason to accept that the placing and continual upkeep of the various tubes that are required in order to provide food and fluids to PVS patients constitute unique medical acts performed by individuals engaged in the practice of doctoring [or nursing, etc.], this fact alone does not seem to justify the removal of the feeding tubes from PVS patients. Rather, to justify the removal of the feeding tube, the advocate of removing the tube would seemingly need to demonstrate either that Terri is suffering due to her continued feeding or that

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<sup>83</sup> D. Zientek. Artificial Nutrition and Hydration in Catholic Healthcare: Balancing Tradition, Recent Teaching, and Law. *HEC Forum*. 2013; 25: 154 and P. Clark. Tube Feedings and Persistent Vegetative State Patients: Ordinary or Extraordinary Means? *Christian Bioethics*. 2006; 12: 56.

Terri has somehow refused the continuation of the feeding tube. The feeding tube is necessary to keep Terri alive. Removing the feeding tube in this instance would entail killing Terri. Killing Terri might be acceptable if Terri was suffering and there was no other way to alleviate her suffering. We can posit myriad examples wherein we recognize that individuals in extreme pain whose suffering cannot be prevented except by death can justifiably be killed to alleviate their suffering. But the irreversible lack of consciousness in PVS patients entails that the PVS patients cannot experience suffering. Terri Schiavo cannot experience pain or hardship because she cannot experience anything at all while in a PVS. Killing Terri by removing her feeding tube might also be acceptable if it was clear that Terri had refused medical treatment. Respecting Terri's autonomy and/or bodily integrity are two different approaches previously discussed that would seemingly justify such a refusal and obligate the removal of the refused medical treatment. But as previously argued there is reason to doubt that Terri has refused her feeding tube.

Removing Terri's feeding tube amounts to killing an individual who is not suffering without her permission. Such an act is generally recognized as an immoral killing. The fact that we are killing her via the removal of her medical treatment does not make our action moral. If all that was required to make killing an individual moral was the killing to involve removing medical treatment from the individual killed, then it would be acceptable for someone to remove the required respirator from a patient in order to asphyxiate the patient. When performed in accordance with a clear refusal by the patient, we accept such killings as morally justified. For someone to do so without the patient's clear refusal would be to commit homicide. Thus, even if the feeding tube is medical treatment, that alone does not justify its removal and the killing of Terri Schiavo.

Furthermore, our recognition of the difference between placing/maintaining a feeding tube and providing food to a sick individual points to a problem with the claim that providing food via feeding tube constitutes a medical act. Our previous considerations suggested that feeding a sick child would not constitute a medical act, while placing a feeding tube would. But consider now the actual use of the tube, the act of providing nourishment via the feeding tube, not the placing of the tube itself. Does this constitute a medical act? I submit that it does not.

Consider the following varied case: I blend all of my food for consumption. Perhaps I do so because I find it more convenient to drink my meals. Perhaps I enjoy the sensation. Perhaps I have a medical condition that prevents me from chewing and swallowing food, forcing me to drink my meals in liquid form. Is the use of the blender in this instance a medical act? I would argue that it is clearly not a medical act. Suppose that part of my condition involves two broken arms so that I require assistance in the blending of my meals. If my wife were to prepare my meals for me in such a fashion, would it now constitute medicine simply because the act was performed by someone other than me and I have a condition that prevents me from doing so myself? Again, I submit that this is still not a medical act (though she is providing care of some sort). Suppose my wife were a doctor. Does her profession entail that when she makes my meal for me in such a fashion that she is now performing a medical act? Once more, it does not seem to be the case that she is engaged in a medical act. So she pours the liquefied meal into my mouth via a funnel. Now is it medicine? No, it does not seem to be medicine. What if the funnel was not placed in my mouth but instead was placed into my throat or directly to the stomach? Now is it medicine? It does not seem that the placement of where the food enters the digestive system changes a non-medical act of providing care into a medical act of providing care. Is it different from eating with a spoon in some qualitative way? Yes, it does seem to be different in

some fashion. Is that difference sufficient to change a non-medical act into a medical one? I submit that it does not. Either the feeding was always a medical act or none of the acts described here constitute a medical act. I submit that the latter is correct. The fact that a child could conceivably keep me alive with a funnel and a blender suggests that while it is not the same as eating with a cup and spoon, having sustenance poured directly into one's stomach [or intestines] is still not a medical act.

There is a dichotomy between the medical act of inserting and maintaining the feeding tube and the non-medical act of providing food to individuals who require feeding. This dichotomy has surely produced much of the debate over whether it is acceptable to cease feeding patients like Terri Schiavo. However, arguments which seek to distinguish between medical and non-medical care and then place ANH into the medical distinction still require the patient to refuse treatment in order to justify removal of the feeding tube. Without the refusal of the patient, removal of the feeding tube does not seem to be justified even if the placement and maintenance [but not use] of the feeding tubes is medical care.

#### **VII. ARGUMENT 4: ANH IS EXTRAORDINARY CARE AND SO CAN BE WITHDRAWN OR WITHHELD**

Some have advanced an argument that Terri's feeding tube can be removed because her feeding tube is extraordinary care. In order to justify the removal of the feeding tube in this fashion the notion of 'extraordinary care' must be considered. There are two possible interpretations of 'extraordinary' which would justify the removal or withholding of a treatment from a patient: either the treatment is burdensome for the patient or the treatment is futile.

There are individuals who have decried the continued feeding of Terri Schiavo as burdensome: "Fifteen years of maintaining a woman [on a feeding tube] I'd say is

disproportionately burdensome, yes.”<sup>84</sup> This claim raises questions about what is meant by a burdensome treatment. A burdensome treatment would be one in which the benefits of the treatment to the patient are outweighed by the burdens of the treatment to the patient. It is the patient’s experience of the treatment which makes the treatment ordinary or extraordinary in this regard.<sup>85</sup> An ‘extraordinary’ treatment in this regard would therefore be one that caused some form of pain or suffering to the patient without a corresponding equivalent benefit to the patient. There are consequentialist justifications for avoiding the infliction of pain and suffering upon individuals without at least an equivalent corresponding benefit. As such, if indeed Terri’s feeding tube is burdensome in this fashion, there would seem sufficient justification for removing Terri’s feeding tube. In the case of a PVS patient, the irreversible lack of consciousness in the patient entails that the PVS patient cannot experience benefits and burdens. Terri Schiavo cannot experience pain or hardship because she cannot experience anything at all while in a PVS. Thus, Terri’s continued feeding cannot be burdensome to her. As such, Terri’s continued feeding cannot be extraordinary if ‘extraordinary’ means ‘burdensome’.

Alternatively, ‘extraordinary’ could be defined as ‘futile’. A futile treatment would be one that would be incapable of achieving its intended purpose. There is no justification for requiring a treatment that is known to be futile. Thus, if feeding Terri Schiavo were indeed a

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<sup>84</sup> B. Braiker. 2005. Newsweek. *No Moral Sense*. <http://www.newsweek.com/no-moral-sense-114701> [Accessed 7 May 2015]. David Fletcher characterizes a general position amongst some Christians as holding the view “... that AN&H are a medical intervention ... are burdensome and costly treatments that offer no real benefit to permanently unconscious patients.” See D. Fletcher. *The Terri Schiavo Case*. <http://www.wheaton.edu/~media/Files/Centers-and-Institutes/CACE/articles/TerriSchiavo.pdf> [Accessed 20 July 2015].

<sup>85</sup> J. Drane. Stopping Nutrition and Hydration Technologies: A Conflict Between Traditional Catholic Ethics and Church Authority. *Christian Bioethics*. 2006; 12(11): 18.

futile treatment, then feeding Terri would not be required. However, in determining if feeding Terri is futile, one must first determine the purpose of feeding Terri. If the purpose of feeding Terri Schiavo is to cure her PVS, then feeding Terri would certainly be futile. Feeding Terri will not cure her PVS. However, feeding Terri is not intended to cure her PVS. The intent of feeding Terri Schiavo is keeping her alive.<sup>86</sup> Providing Terri with food and fluids will certainly achieve this end. Feeding a patient would be futile if the patient lacked the physical ability to digest the food being provided.<sup>87</sup> But Terri has the physical ability to digest food and fluids provided to her. Continuing to provide Terri with food and fluids will clearly keep Terri alive. As such, feeding Terri is not futile and so is not extraordinary care if ‘extraordinary’ means ‘futile’.

It may be worth noting that these discussions do not entail that the use of feeding tubes is always obligatory and that feeding tubes can never be either burdensome or futile.

There will be circumstances and situations where tube feeding may become *extraordinary or disproportionate*, as when it is no longer effective (the food is not absorbed), when it causes extreme discomfort, pain or serious infection, or when it causes other grave difficulties such as repetitive aspiration (vomiting and breathing the vomit into the lungs, often resulting in pneumonia).<sup>88</sup>

If tube feeding can be shown to be either futile or burdensome in these or other similar situations, then the tube feeding would be extraordinary care and so could be justly withdrawn or

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<sup>86</sup> T. Pacholcayk. 2012. National Catholic Bioethics Center. *Feeding Our Loved Ones: The Modern Anathema of Living with Brain Damage*. <http://www.ncbcenter.org/page.aspx?pid=303> [Accessed 20 July 2015].

<sup>87</sup> R.E. Cranston. 2001. The Center for Bioethics and Human Dignity, Trinity International University. *Withholding or Withdrawing of Artificial Nutrition and Hydration*. <https://cbhd.org/content/withholding-or-withdrawing-artificial-nutrition-and-hydration> [Accessed 20 July 2015].

<sup>88</sup> Pacholcayk, *op. cit.* 86.

withheld.<sup>89</sup> Otherwise, tube feeding would generally be ordinary care and so could not be withdrawn or withheld from patients who require it based upon a distinction between ordinary and extraordinary care.

Since PVS patients lack the ability to suffer, one might argue that without the ability to suffer it would not be wrong to refuse to feed a PVS patient. For this argument, the wrongness of refusing to feed a patient hinges on the suffering that such a refusal to feed would cause. If one were to refuse to feed a conscious patient, or a child, or an elderly parent, the pain and suffering that such a refusal to feed would cause could be considered sufficient grounds for the condemnation of such refusals to feed. But for an irreversibly unconscious patient in a PVS, there is no pain and suffering to ground the condemnation of the refusal to feed the patient. The conclusion such an argument seeks is that it would therefore not be wrong to refuse to feed Terri Schiavo because Terri will not suffer.

While it is true that because the PVS patient is irreversibly unconscious the PVS patient cannot suffer the same way that a conscious and otherwise healthy person suffers from lack of food and fluids, this alone does not necessarily entail that one can refuse to feed a PVS patient simply on the grounds she will not suffer physical pain as a result. For example, there is a rare condition known as congenital insensitivity to pain (CIP) which renders its victims unable to experience pain even though they are fully conscious. Such a patient would not experience pain from lack of food and fluids just as a PVS patient would not experience such pain either. Yet it is presumably impermissible for me to deny the CIP patient food and fluids. The fact the CIP patient will not experience pain from the lack of food and fluids does not justify withholding

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<sup>89</sup> T. Pacholcayk. 2012. National Catholic Bioethics Center. *Towards "Passive Euthanasia."*

<http://www.ncbcenter.org/page.aspx?pid=1055> [Accessed 20 July 2015].

such things from the CIP patient. So if there is reason to withhold such things from a PVS patient, it must be something other than the lack of physical pain and the inability of the PVS patient to suffer.<sup>90</sup>

### **VIII. ARGUMENT 5: REFUSING TO FORCE-FEED TERRI SCHIAVO VIA ANH IS ANALOGOUS TO REFUSING TO FORCE-FEED TERMINAL CANCER PATIENTS**

Some have equated refusing to feed Terri Schiavo to our willingness to refuse to feed other individuals whom we believe it would be wrong to force-feed. The specific example invoked by Michael Schiavo and his attorney George Felos is our acceptance that it would be wrong to force-feed individuals who are dying of terminal cancer. This argument in favor of removing Terri Schiavo's feeding tube argues that a case of PVS is in some way analogous to a case of terminal cancer:

1. Cancer patients refuse to eat for two or three weeks, resulting in death by starvation/dehydration.
2. We do not force cancer patients to eat or drink in such cases.
3. Therefore, we should not force patients such as Terri Schiavo to eat or drink either.

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<sup>90</sup> Some advocates of maintaining Terri Schiavo's feeding tube mistakenly equate refusing to feed Terri to refusing to feed conscious individuals. The argument in this case claims that it would be agonizing if you or I (as conscious individuals) were starved to death, why think that it is different for PVS patients like Terri? The answer to such a question would be that without consciousness, such individuals could not suffer at all, let alone the way a conscious individual would suffer under such circumstances. Without consciousness there is no suffering. As such, arguments aimed at maintaining the feeding tubes of PVS patients based on the suffering of the PVS patient are deeply flawed and should be rejected just as any argument seeking to remove Schiavo's feeding tube based on her suffering would also be deeply flawed. See W.J. Smith. 2003. *The Weekly Standard*. A "Painless" Death?

<http://www.weeklystandard.com/Content/Public/Articles/000/000/003/370oqiwy.asp> [Accessed 14 September 2015].

Schiavo and Felos utilized this argument to defend Michael Schiavo's decision to remove Terri's feeding tube during an interview with Larry King on October 27, 2003.<sup>91</sup>

This argument by analogy fails because the analogy between cancer patients and PVS patients regarding the reason for acceptable refusals of care fails to obtain. We recognize that cancer patients can refuse to eat or drink because such refusals are based upon the patient's recognition that the intake of food and fluids in such situations causes pain and suffering.<sup>92</sup> We can recognize that when the burdens associated with a treatment outweigh the benefits of that treatment, it is appropriate for a patient to refuse such treatments. In the case of a cancer patient refusing food and fluids we accept that the refusal is the result of the cancer patient's recognition that the pain and suffering associated with the intake of food and fluids is greater than the resulting benefits. Furthermore, in such instances we have a conscious patient who is intimately aware of the benefits and burdens associated with either accepting or refusing the offered care who is actively making the refusal. In the case of a PVS patient, the irreversible lack of consciousness entails that the PVS patient is not actively refusing food and fluids like the cancer patient.<sup>93</sup> Furthermore, due to Terri Schiavo's irreversible loss of consciousness, she lacks the ability to suffer. Terri cannot experience pain or hardship because she cannot experience anything while in a PVS. Therefore, Terri cannot suffer. As a result, it is neither the case that the

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<sup>91</sup> Ibid.

<sup>92</sup> Such patients are most commonly those suffering from stomach or throat cancer, though some treatments for cancer such as radiation and chemotherapy can cause some patients to suffer side effects including pain when eating or drinking.

<sup>93</sup> Any refusals must be performed by proxy or via the patient's ACD. But as discussed: Terri lacks an ACD, the efficacy of proxies is dubious even under the best of circumstances, and there is reason to be suspect of the legitimacy of decisions of Terri's proxy as representative of her preferences.

PVS patient can refuse food and fluids on the grounds that the intake of food and fluids is causing the PVS patient to suffer, nor could we refuse to feed a PVS patient on the grounds that we would be causing the PVS patient to suffer by force-feeding the patient.

There are those who have argued that removing Terri Schiavo's feeding tube is justified because people who are dying actively refuse food and water and we accept that respecting such refusals is morally permissible (perhaps even obligatory).<sup>94</sup> Though this argument might appear different from the previous analogy of PVS patients and cancer patients, there are several problems with this more general analogy of PVS patients to dying individuals. The first problem is that if the argument is based on the grounds that dying patients can actively refuse treatment by expressing their immediate preferences not to be fed, then the argument does not apply to Terri Schiavo since she cannot express to us her immediate preferences while in PVS.

The second problem with this argument is that dying patients presumably refuse food and fluids because in such cases the intake of food and fluids is painful. We can accept that patients may refuse care when they deem it more burdensome than beneficial to themselves. Dying patients then refuse food and fluids because it is less painful to be without food and fluids than it is to ingest them. But this would not apply in Terri's case because she is incapable of suffering while in her PVS as already mentioned above.

The last problem I will note for the argument comparing PVS patients to dying individuals is that if the motive force behind the argument here is that the patient is dying and thus can refuse food and fluids [presumably in an effort to avoid prolonging the dying process] then this argument is fatally flawed when applied to PVS cases. Terri Schiavo is not, under any

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<sup>94</sup> ProCon.org. 2008. *From a Medical Perspective, Should Terri Schiavo's Feeding Tube Have Been Removed?*

<http://euthanasia.procon.org/view.answers.php?questionID=000169> [Accessed 10 July 2015].

normal understanding of the term, “dying”. As her doctors explained to her family when she was first diagnosed, PVS is not a fatal condition and so would not kill Terri. At the time her feeding tube was removed, Terri was not known to be suffering from any other fatal ailments. Indeed, the only truly life threatening ailment in Terri’s life was her husband’s insistence on removing her feeding tube and starving her to death. To claim that her life was threatened and so removal of the feeding tube was justified based on Terri’s imminent death would beg the question. Terri was not dying and could, quite possibly, still be alive today if her feeding tube had not been removed. Thus, this argument does not in any way justify removing Terri Schiavo’s feeding tube.

**IX. ARGUMENT 6: TERRI SCHIAVO’S RIGHT TO PRIVACY IS BEING VIOLATED BY CONTINUING TO FEED HER, SO THE REMOVAL OF HER FEEDING TUBE IS JUSTIFIED**

Some have argued that Terri Schiavo’s right to privacy is violated by having her feeding tube maintained. Legal precedent established during the case of Karen Ann Quinlan recognizes a patient’s right to privacy under the U.S. Constitution to terminate unwanted treatment.<sup>95</sup> There are three possible ways in which one could interpret the concept of the right to privacy, none of which will be sufficient to justify the withdrawal of Terri’s feeding tube.

The first interpretation of privacy that I will consider is the one employed by Michael Schiavo and his attorneys in their brief to the Florida Supreme Court. Michael Schiavo and his attorneys argued that Terri’s right to privacy was being violated by continued use of the feeding tube.

Under Article I, Section 23 of the Florida Constitution, '[e]very natural person has the right to be let alone and free from governmental intrusion into the person's

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<sup>95</sup> In Re Quinlan. 70 N.J. 10. 1976; 355 A.2d 647: 38-42 and Nancy Beth Cruzan v. Director, Missouri Department of Health. *The United States Law Week*. 1990; 58: 4918.

private life.'... This constitutional right of privacy, which exceeds analogous protections under federal constitutional law, includes the right to self-determination with respect to medical treatment, that is, to decide for oneself whether or not to receive such treatment...<sup>96</sup>

Michael Schiavo and his attorney's further argue that

Under *Browning*, a competent individual has the constitutional right to refuse medical treatment regardless of his or her medical condition. Therefore, one need not be terminally ill or beyond recovery, or in any other particular physical or mental condition to exercise that right; the right is one of self-determination that cannot be diminished by the condition of the patient. Further, the right to choose or refuse medical treatment extends to all decisions concerning one's health, major or minor, ordinary or extraordinary, life-prolonging, life-maintaining, life-sustaining or otherwise, and specifically includes the right to choose or refuse the supplying of food and water through a feeding tube.<sup>97</sup>

Based upon these statements, one interpretation of the 'privacy argument' can be understood as the following:

- 1) Terri Schiavo has a right to privacy.
- 2) The right to privacy includes the right to refuse medical treatments.
- 3) Food and fluids are a medical treatment.
- 4) Terri Schiavo has refused food and fluids.
- 5) Therefore, to continue to feed Terri Schiavo violates her right to privacy.

Many of the issues raised by this argument have been addressed in the preceding discussions. One such issue involves the claim that food and fluids are medical treatment. An earlier argument addressed this claim and found it to be unsupported. Food and fluids themselves are not medical treatment. Yet one could refine the privacy argument to focus upon the feeding tube itself as medical care rather than the food and fluids as medical care. Even if one were to refine the privacy argument in this fashion, the problem of obtaining the patient's refusal persists in cases like Terri Schiavo's. Whether it is the food and fluids or the feeding tube itself that is

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<sup>96</sup> M. Schiavo et. al. 2003. *Petitioner's Brief*. <https://www.aclu.org/files/FilesPDFs/schiavo.pdf> [Accessed 2 August 2015].

<sup>97</sup> *Ibid*.

being refused, no clear refusal has been given on the part of Terri Schiavo. The only refusal of care that has been given is a proxy refusal on the part of Michael Schiavo and a preceding discussion has addressed the problems with removing the feeding tube on the basis of this particular type of refusal. Thus, this interpretation of the privacy argument fails because it depends upon multiple other unsuccessful arguments already considered.

The second interpretation of the right to privacy I will consider defines privacy in terms of one's right to keep information about oneself unknown to others. This conception of the right to privacy can be found in the 4<sup>th</sup> Amendment to the U.S. Constitution and additional federal statutes like the Health Insurance Portability and Accountability Act (HIPAA) of 1996.<sup>98</sup> Though this conception of the right to privacy surely exists within U.S. law, this conception of privacy is unable to justify the removal of a feeding tube from a PVS patient. The problem with this approach to understanding the right to privacy as the right to keep personal information about oneself unknown to others is that the removal of a feeding tube has nothing to do with keeping information about oneself away from others. So if this is the extent of the right to privacy, then removal of the feeding tube is not justified.

A third interpretation of the right to privacy which seeks to justify removal of Terri's feeding tube may be found if one delves more deeply into the concept of the protections offered by the 4<sup>th</sup> amendment to the U.S. Constitution. Commonly cited as a source for the right to privacy, the 4<sup>th</sup> amendment protects individuals from unreasonable searches and seizures by the

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<sup>98</sup> Legal Information Institute, Cornell University Law School. *Fourth Amendment*.

[https://www.law.cornell.edu/wex/Fourth\\_amendment](https://www.law.cornell.edu/wex/Fourth_amendment) [Accessed 14 September 2015] and U.S. Department of Health and Human Service, *Health Information Privacy*. <http://www.hhs.gov/ocr/privacy/index.html> [Accessed 14 September 2015].

state.<sup>99</sup> This protection has been understood to apply not only to one's home, but also to one's own body as well.<sup>100</sup> Proponents of the argument that Terri Schiavo's right to privacy is being violated by the continued use of the feeding tube could have in mind that the continued presence of the feeding tube in Terri Schiavo's body constitutes an unreasonable intrusion into Terri's body. Thus, the feeding tube is a violation of Terri's right to privacy just as an unjustified search by a police officer of Terri's body would violate her right to privacy. In this case, the right to privacy is revealed as being less about keeping information about oneself unknown to others and instead is about an individual's bodily integrity as protected under the 4<sup>th</sup> Amendment to the U.S. Constitution.

The issue with attempting to justify the removal of Terri Schiavo's feeding tube on this conception of privacy grounded in the 4<sup>th</sup> amendment is that the intrusion into the home or person of an individual can be justified by certain competing interests. The 4<sup>th</sup> amendment does not prevent any and all intrusions, only the unreasonable ones. The question then becomes "is the intrusion into Terri Schiavo's body unreasonable?" A precedent in this matter was set during the case of *Cruzan vs. Director, Missouri Department of Health* in 1990. In *Cruzan*, the justices recognized that Nancy Cruzan, who like Terri Schiavo was recognized as being in a PVS, had interests protected under the 4<sup>th</sup> and 14<sup>th</sup> amendments to refuse treatment. The issue with this approach to defending the removal of Terri's feeding tube is that the court in *Cruzan* also recognized that the state of Missouri was justified in seeking to safeguard the personal element of the choice to refuse treatment via the imposition of a "clear and convincing evidence" standard of the patient's desire to have nutrition and hydration withdrawn. Furthermore, the

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<sup>99</sup> Legal Information Institute, *op. cit* 98.

<sup>100</sup> "The right of the people to be secure in their persons..." Ibid.

*Cruzan* court recognized that the substituted judgment of others, including close family members, would not “necessarily be the same as the patient’s would have been had she been confronted with the prospect of her situation while competent.”<sup>101</sup> As such, the *Cruzan* decision rests the determination of how the patient would decide to be treated upon the patient herself and not the preferences of another. In the case of Terri Schiavo, clear and convincing evidence of Terri’s refusal does not seem to obtain and the refusal by Michael Schiavo on behalf of his wife does not clearly reflect his wife’s preferences. Without a clear and convincing refusal from Terri Schiavo, a competing state (or societal) interest in preserving the lives of its citizens (members) or ensuring that the personal autonomy of the individual is respected plausibly entail that the continued use and maintenance of Terri’s feeding tube does not constitute an unreasonable intrusion into her bodily integrity.

A similar protection to that offered by the ‘search and seizure’ clause of the 4<sup>th</sup> amendment exists within the common law of battery. The common law of battery protects individuals from unwanted voluntary touching on the part of others.<sup>102</sup> The common law of battery could plausibly justify the removal of Terri Schiavo’s feeding tube, but only on the condition that the particular touching of Terri Schiavo is known to be unwanted. If it were known that Terri Schiavo did not want her caregivers to touch her with a feeding tube then battery law would prohibit the continued maintenance of the unwanted feeding tube. This approach to understanding privacy fails to justify removal of Terri’s feeding tube due to the fact

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<sup>101</sup> Nancy Beth Cruzan v. Director, Missouri Department of Health. *The United States Law Week*. 1990; 58: 4922.

<sup>102</sup> Legal Information Institute, Cornell University Law School. *Battery*. <https://www.law.cornell.edu/wex/battery>

[Accessed 14 September 2015].

that it is not clearly known that Terri does not want to be touched by her caregivers via a feeding tube.

The right to privacy is often associated with the right to one's liberty and the right to one's bodily integrity. Each of these rights is itself commonly associated with the principle of autonomy.<sup>103</sup> Therefore, the right to privacy presumably derives its force from a principled demand for the respect of the individual. The difficulty in such a situation is that if our duty to act is based on respecting the individual and the wishes of the individual, we must discern the individual's wishes in order to proceed. Yet we are without *clear and convincing* guidance as to the wishes of Terri Schiavo and so any attempt to respect her autonomy, liberty, privacy, or bodily integrity via the withdrawal of her feeding tube ultimately seems forever in doubt.

#### **X. ARGUMENT 7: NO ONE WOULD CHOOSE TO BE IN A PVS.**

Since there were no clear instructions or preferences left by Terri Schiavo concerning how to proceed in the event of her being diagnosed with a PVS, some have suggested that guidance could be obtained from considering the preferences of the rest of society. One media poll asked if people would choose to live in a PVS.<sup>104</sup> The overwhelming response to this question was that the vast majority of individuals would not choose to live in a PVS. The inference that some supporters of removing Terri's feeding tube took from this is that since [almost] no one else would choose to live in a PVS, clearly Terri would not choose such a life either. Therefore, Terri's feeding tube could be withdrawn because Terri would not want to be kept alive in such a condition.

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<sup>103</sup> Recall the discussion at the opening of "Argument 2: Terri has the right to refuse any and all treatment in her condition and have that treatment withdrawn."

<sup>104</sup> ProCon.org. 2008. *From a Moral Perspective, Should Terri Schiavo's Feeding Tube Have Been Removed?* <http://euthanasia.procon.org/view.answers.php?questionID=000168> [Accessed 10 July 2015].

The first issue with this argument that I will address is the potential ambiguity in the presentation of the survey question. One interpretation of the question “would you choose to live in a PVS?” presents the respondent with two options: either continue life in their present condition as a conscious being or live as a being in a PVS. The alternative interpretation of the same question would involve inquiring whether an individual who is currently not in a PVS would either prefer that she be kept alive if she ever were in a PVS or if she would prefer that she not be kept alive if she ever were in a PVS. Depending upon how the survey question is phrased and how the respondents understand the question, there are different issues with this argument that require clarification. Yet neither interpretation of the argument presented will be sufficient to justify removing Terri Schiavo’s feeding tube on the grounds that “no one would choose to live in a PVS.”

Consider the first interpretation of the question “would you choose to live in a PVS?” Of course no one would *choose* to be in a PVS if the survey respondents were being presented with a choice between their current existence as conscious beings and one in a PVS. An individual respondent’s preference for a life of conscious experience over an irreversibly unconscious one only informs us that given the choice such an individual would rather remain conscious. The preferences of the respondents to such a survey only informs us that human beings seem to prefer a life of conscious experience over one devoid of conscious experience. What such a survey does not convey is whether we are morally justified in killing individuals who are irreversibly devoid of consciousness like those in a PVS.

Consider the second interpretation of the question “would you choose to live in a PVS?” In such a scenario, we can recognize that some respondents to the survey were in favor of being kept alive (even if that meant remaining in a PVS indefinitely). The lack of universality in the

response to such a survey presents a problem for removing the feeding tube from any patient in a PVS. If there were true universal agreement then removing the tube could be justified on the grounds that we have reason to believe that Terri Schiavo would refuse to have the tube continued in her condition (just like everyone else).<sup>105</sup> But we do not have universal agreement. Most would refuse the feeding tube, others would not. The issue at hand is that we do not universally subjugate the preferences of the minority to the preferences of the majority in the practice of medicine. While most prefer to receive blood transfusions when required, Jehovah's Witnesses actively refuse blood transfusions. Such refusals by competent adults are respected. Vital organs are an important resource and the supply is never enough to meet the demand. While it is likely that most would choose to donate if given the opportunity, we respect the wishes of those who choose not to do so.<sup>106</sup> Thus, even if there is a clear majority preference toward not continuing to receive food and fluids while in a PVS, the fact that Terri Schiavo may be a member of the minority who would prefer to continue to be fed<sup>107</sup> suggests that we should be hesitant to remove her feeding tube just because it is something most other people would want.

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<sup>105</sup> Admittedly, if this were indeed the case we probably would never have heard of Terri Schiavo or engage in much discussion of how to treat PVS patients in the first place. If there was such universal agreement we'd likely pull the feeding tube without much further consideration.

<sup>106</sup> And such refusals are respected based on any of the previously considered justifications such as autonomy, bodily integrity, liberty, etc.

<sup>107</sup> Terri Schiavo's catholic upbringing and the testimony of her family and friends regarding her faith serve as evidence that she would likely be someone who would fall within the minority preference for continued feeding as required by catholic tradition.

Now, some might suggest that we do subjugate the preferences of those with minority preferences in favor of the majority preference at times. The Jehovah's Witnesses can serve as a paradigm example in this context. It happens that a Jehovah's Witness will come into a medical facility unconscious and require a blood transfusion. The patient will die soon if not provided with blood and the treating physician does not know that the patient is a Jehovah's Witness. In such instances, the physician transfuses such patients because if the physician waited to confirm whether or not the patient would or would not want the transfusion, the patient would already have died. This means that some patients receive care they would otherwise have refused. Thus, in some cases a physician violates the [unknown] preferences of the patient and errs on the side of what the majority would prefer. Yet in such a case the physician errs on the side of what the majority wants not because it is what the majority wants, but because the treatment will prolong the life of the patient and can be withdrawn at a later time should the physician discover that the treatment is unwanted. Given the finality of death that would result from failing to treat patients in scenarios where the patient will die without treatment, when patient preferences are unknown it seems reasonable to have physicians treat patients until such time as the physicians know the treatment is unwanted. Such an approach balances the importance of preserving the lives of patients against the importance of respecting patient autonomy.

Let us now apply the same justification for violating the preferences of the Jehovah's Witnesses in cases of blood transfusions when patient preferences are unknown to the cases of PVS patients when patient preferences toward continued feeding are unknown. The suggested outcome points toward continued feeding as the appropriate course of action. The finality of refusing to treat such patients in both cases suggests that if what matters is respecting patient wishes, physicians should endeavor to preserve the lives of patients until the patients'

preferences can be ascertained. This would suggest that we should actually continue to feed Terri Schiavo until her actual preferences concerning continuation of feeding while in PVS can be determined, rather than simply assuming the majority preference is what Terri would have wanted.<sup>108</sup> The difficulty in ascertaining Terri's preferences in this regard have already been discussed at length, leaving this attempt at justifying the removal of Terri's feeding tube without the critical component required to justify removing the feeding tube.

## **XI. CONCLUSION**

The arguments in this work are based upon the view that all innocent human beings have the right to life. As an innocent human being, Terri Schiavo would have that right under this framework. Orthodox bioethics and U.S. law accept that this right can be waived by competent patients via the refusal of life-saving or life-sustaining medical treatment. The question this work considered was whether or not a patient in a PVS like that of Terri Schiavo could have her feeding tube removed without violating her assumed right to life. The arguments presented demonstrate that without a clear refusal of care Terri has not waived her right to life. Furthermore, none of the arguments presented have been successful in their ability to defend the removal of Terri's feeding tube without her clear consent to its removal. Thus, within the framework presented, the removal of Terri Schiavo's feeding tube was unjustified. Proponents of removing feeding tubes from PVS patients such as Terri Schiavo will have to seek alternative approaches to defending their view which rejects the basic framework utilized in this

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<sup>108</sup> And as previously mentioned, Terri's background as a devout catholic suggests that she is more likely than most to be in the minority group which would insist on continued feeding during PVS.

discussion.<sup>109</sup> So long as the right to life is based upon being an innocent human being, the removal of Terri Schiavo's feeding tube will remain unjustified.

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<sup>109</sup> Some alternative frameworks one might consider for justifying the right to life include (but are not necessarily limited to) 1) having a future of value, 2) being a person, 3) having a desire to continue to live, 4) having a basic natural capacity for higher mental function. As each of these alternatives represents a different basic framework from that utilized in the original discussion of Terri Schiavo and other PVS cases, I leave consideration of such alternative frameworks for another time.

**DETERMINING DEATH:  
ANOTHER ARGUMENT ON THE NEED TO ABANDON WHOLE BRAIN DEATH  
AND ADOPT ALTERNATE CRITERIA WHICH MORE ACCURATELY IDENTIFY  
WHEN A HUMAN ORGANISM HAS DIED**

**Abstract:**

The orthodox criteria currently used to determine death are reducible to whole brain death. I argue that whole brain death is an inadequate criterion for the death of a human being within the framework of orthodox bioethics. I first consider the conflict between whole brain death and the plausible definition(s) of death the criterion is intended to reflect. I next consider the possibility that whole brain death can be justified as a criterion for death without the need for a definition of death. Then I consider arguments that whole brain death is analogous to decapitation (long recognized as the death of the decapitated individual). Each argument for the continued use of whole brain death as the criterion of death is shown to be flawed. Utilizing these arguments presented against whole brain death I suggest revised criteria for determining death. The new criteria require the irreversible loss of consciousness combined with the irreversible loss of cardiac and respiratory function. The revised criteria are able to overcome the failures of whole brain death whilst reflecting important elements of the current orthodox criteria of death.

## I. INTRODUCTION

There are a myriad of actions that an individual may acceptably perform once another has died that would not be morally permitted if that same other were still alive. For example, one is allowed to marry a second time without first receiving either a divorce or annulment if their spouse has died. That same individual would not be permitted to do so if her spouse were still living.<sup>110</sup> Similarly, it is understood that one can drain the blood from a person who has died for the purpose of burial preparation, but that this same action [usually] constitutes an immoral act of killing when performed on a living individual. Since the same action can be judged as either moral or immoral depending upon whether the relevant other is either alive or dead, a precise understanding of when an individual is alive and when that same individual has died [or is dead] seems critically important.

The medical community at large remains committed to certain principles that seemingly must rely upon having a precise understanding of death to distinguish those who have died from those who are still alive. One example of such a principle is the so-called “dead donor rule” (DDR). The DDR applies to the practice of organ retrieval and transplantation and stipulates that no unpaired vital organs (or both of a pair of vital organs) can be harvested from a living donor for transplant into a recipient. If an individual is to receive a vital organ transplant, it must come from a donor who is already dead (so-called “cadaver organ donors”). If organs can only be taken from those who have already died, then it seems essential that a precise understanding of when a prospective donor has died is required and that the prospective donor has in fact died prior to the harvesting of the donor’s organs.

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<sup>110</sup> Assuming one resides in a society that does not permit polygamy.

This paper will argue that the current approach used to establish death in the United States, which I will demonstrate is fundamentally concerned with the death of the whole brain, is philosophically flawed and should be abandoned. Though it has been widely adopted, whole brain death should not be recognized as the criterion for establishing the death of an individual. I will first discuss the present criteria used to establish death and the definitions-criteria-tests (DCT) model associated with the present criteria. Under the DCT model, whole brain death is supposed to be an acceptable criterion which can be used to establish that an individual has met an accepted definition of death. I will argue that whole brain death fails to provide such a criterion for any of the plausible definitions of death that have been proposed. I will then consider an alternate approach to defending whole brain death as a suitable criterion for death outside the bounds of the DCT model. I will argue that this attempt to defend whole brain death as death also fails. I will then discuss a further attempt to defend whole brain death by considering whole brain death as a form of decapitation. This argument will also be shown insufficient to sustain whole brain death as death. The result of these considerations will be that whole brain death alone is not an adequate criterion for establishing the death of an individual. I will then suggest alternate criteria for establishing death arising from these discussions and conclude with some remarks suggesting future considerations arising from the results of this work.

## **II. WHOLE BRAIN DEATH UNDER THE DEFINITIONS-CRITERIA-TESTS MODEL:**

### **THE UDDA**

Most approaches to understanding death begin with the premise that death is an event in the existence of biological organisms. In brief, a biological organism is alive and then something

in the organism changes and the organism ceases to be alive any longer; the organism dies.<sup>111</sup> Death, then, is the moment which separates an organism which is alive from one which is dead.<sup>112</sup> Therefore, death is something that happens to a biological organism and the question that needs to be answered is: under what condition(s) is it true that the death of the biological organism has occurred? Furthermore, since death is something that happens to all biological organisms regardless of the complexity of their nature, the answer to this question seemingly should apply to all biological organisms regardless of the organism's complexity.

Arguably the most influential work in the discussion of death in bioethics was undertaken by James Bernat, Charles Culver, and Bernard Gert. These influential thinkers promoted a structured three phase approach to solving the problem of defining death which has been described by some as the "Definitions-Criteria-Tests Model".<sup>113</sup> According to Bernat, the first phase is a philosophical task, wherein the explicit *definition* of death is established based upon our implicit understanding of the traditional conception of death. The second phase requires the philosophical work to join with the medical task of identifying the exact *criterion* of death. Here the goal is to establish the necessary and sufficient conditions for death which will satisfy the established definition of death. The final phase is the purely medical task of identifying the

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<sup>111</sup> One of the difficulties in talking about death is that there can be a great deal of confusion about the various terms used. For example, the term 'dies' can be used as it is utilized here to identify 'experiencing the event/moment of death', but 'dies' can also be used to identify one as undergoing the process of 'dying'.

<sup>112</sup> For many philosophers the thought of describing a subject as "being dead", in which 'being dead' is existing in a state of non-existence, is illogical and an obvious contradiction. Such a difficulty is likely of great interest to the metaphysician and the linguistic philosopher. For the purposes of this work, such problems are not the important concern and so I do not spend any further space discussing these issues here.

<sup>113</sup> W. Chiong. Brain Death without Definitions. *The Hastings Center Report*. Nov/Dec 2005; 35(6): 21.

requisite *tests* needed to empirically establish that the criteria of death have been fulfilled and the patient has indeed died.<sup>114</sup>

First offered in 1981 and subsequently accepted by nearly all fifty U.S. States,<sup>115</sup> the Uniform Determination of Death Act (UDDA) is generally recognized by the American public and both the legal and medical communities across the United States as the “definition” of death. The UDDA defines death as the following:

An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead.<sup>116</sup>

This method of determining death created two potential methods of identifying death. The first recognized and followed the traditional method of determining death based on respiration and circulation, the loss of both being sufficient for death. The second recognized death as synonymous with the cessation of the functioning of the whole brain. In this way the UDDA suggests that individuals who are now commonly known as “brain dead” have met a sufficient condition for death and so are dead.

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<sup>114</sup> J.L. Bernat. How Much of the Brain Must Die in Brain Death? *Journal of Clinical Ethics*.1992; 3: 21-22. See also Chiong, *op. cit.* 113, 21.

<sup>115</sup> There are some states, for example New Jersey and New York, which vary the language of the UDDA to some minor degree. However, the acceptance of the UDDA has been nearly universal in the U.S.

<sup>116</sup> President’s Commission for the Study of Ethical Problems in Medicine and Biomeidcal and Behavioral Research. *Defining Death: Medical, Legal and Ethical Issues in the Determination of Death*, 1981, p. 2. Available at: [https://bioethicsarchive.georgetown.edu/pcbe/reports/past\\_commissions/defining\\_death.pdf](https://bioethicsarchive.georgetown.edu/pcbe/reports/past_commissions/defining_death.pdf) [Accessed 20 December 2014].

There are two potential issues with the UDDA. The first issue with the UDDA is that it is not defining death, but rather is providing criteria for recognizing when an individual has met a definition of death. Yet the UDDA is not directly connected with a particular definition of death. Thus the UDDA seeks to establish criteria for death without first having established a definition of death. The second issue concerns redundancy within the criteria.

The issue with redundancy in the criteria of the UDDA arises from the role of breathing and respiration in maintaining the brain and the brain stem and the role of the brain stem in maintaining spontaneous respiration and circulation. If respiration and circulation cease then the brain and brain stem will shortly and inevitably cease to function unless resupplied with oxygenated blood. Presumably, resupplying the brain and brain stem with oxygenated blood would require respiration and circulation to resume. So, if respiration and circulation have ceased irreversibly, the brain and brain stem will also cease to function irreversibly. Furthermore, if the brain stem has ceased to function irreversibly, then spontaneous respiration and circulation will also cease to function, though respiration and circulation could alternatively be maintained via mechanical ventilation. Presumably then, if an individual lacks respiration and/or circulation and the loss is recognized as irreversible, one could also establish that the brain and brain stem are also no longer functioning.<sup>117</sup> The individual in this condition would have effectively met the second criterion of death in the UDDA. Likewise, if an individual is maintained on mechanical ventilation, one could establish that the brain and brain stem are no longer functioning and that

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<sup>117</sup> There may be a time delay between the irreversible loss of cardiac and/or respiratory function and the irreversible loss of all brain function. This time delay is likely no more than a matter of minutes as the brain will quickly utilize whatever oxygenated blood it has available to itself prior to the loss of cardiac/respiratory function. Thus, without some form of external intervention (such as CPR) the irreversible loss of cardiac and respiratory function will quickly entail the irreversible loss of brain function as the brain cells become anoxic.

the loss of these functions is irreversible. This would also establish death according to the second criterion of the UDDA. In either case, criterion (1) of the UDDA would seem to be redundant.

The other issue with the UDDA is that it is providing the criteria<sup>118</sup> by which an individual can be recognized as dead without having first established the definition of death. Many critics of the UDDA (and later attempts to revise the UDDA) argue that brain death is not a sufficient condition for death and that merely brain dead donors are not dead. According to these critics of the UDDA the criteria established by the UDDA regarding the brain do not accord with any recognizable definition of death. Since criterion (1) is redundant under the UDDA, the primary concern would seemingly be whether or not the irreversible loss of function of the whole brain (including the brain stem) meets an appropriate definition of death. The difficulty for proponents of whole brain death in this regard is that no recognized definition of death coincides with whole brain death as a criterion of death.

### **III. WHOLE BRAIN DEATH UNDER THE DEFINITIONS-CRITERIA-TESTS**

#### **MODEL: BERNAT ET. AL. VS. SHEWMON ON THE DEFINITION AND CRITERIA OF [BRAIN] DEATH**

The earliest and perhaps most influential attempt to defend the UDDA and the adoption of whole brain death as the appropriate criterion for death throughout the U.S. was espoused by Bernat, Culver, and Gert.<sup>119</sup> Bernat et. al. defined death as “the cessation of the integrated functioning of the organism as a whole” and argued that the brain is the central integrator of the organism as a whole. Without the brain, the rest of the body would lose its integrator. The

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<sup>118</sup> Namely, the criteria the bedside tests should seek in order to establish that the patient has died or is in fact not yet dead.

<sup>119</sup> J. Bernat et. al. On the Definition and Criterion of Death. *Annals of Internal Medicine*. 1981; 94: 389-394.

irreversible cessation of all functioning of the brain (including the brain stem) would result in the loss of integration of the organism as a whole. Therefore, the irreversible cessation of functioning of the entire brain would entail the death of the organism as a whole according to Bernat and so whole brain death is death.

The problem with this attempt to defend whole brain death as death by Bernat is that the irreversible cessation of whole brain function is not a sufficient condition for the loss of integrated function of the organism as a whole. Alan Shewmon's criticism of Bernat's approach to defending whole brain death has been the most influential criticism of this aspect of the debate.<sup>120</sup> Shewmon notes that there are a host of integrated functions that persist in wholly brain dead individuals. Included among these functions that can occur (and have occurred) in wholly brain dead individuals are:<sup>121</sup>

- The homeostatic functioning of liver, kidney, cardiovascular and endocrine systems and a host of other systems
- Elimination and detoxification of waste
- Wound healing
- Reactions to presence of infection and mobilization of the body's defense systems to fight infection

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<sup>120</sup> D.A. Shewmon. Is "Brain Death" Actually Death? An Autobiographical Conceptual Itinerary. *Aletheia: An International Journal of Philosophy*. 1997; 7: 287-320 and D.A. Shewmon. The Brain and Somatic Integration: Insights Into the Standard Biological Rationale for Equating "Brain Death" with Death. *Journal of Medicine and Philosophy*. 2001; 26 (5): 457-478.

<sup>121</sup> This is an abbreviated list, for more integrated functions of brain dead individuals see Shewmon, *op. cit.* 120 (2001); 467-468. See also Shewmon, *op. cit.* 120 (1997), 287-320 for examples of such functions occurring in actual brain dead patients.

- Successful gestation of fetuses
- Sexual maturation and proportional growth of brain dead children

These functions which Shewmon notes as occurring within wholly brain dead individuals undermines the claim that the brain is the central integrator of the body, without which the body loses its integrative functioning. The sorts of processes that have been noted here (and elsewhere) as occurring within wholly brain dead individuals are the sort of integrated processes associated with living organisms, not corpses. As such, if the loss of integrative functioning is the definition of death, then the loss of even the entire brain is not a sufficient criterion for death.

In response to such criticisms, Bernat altered his defense of whole brain death and the definition of death. The revised definition Bernat offered was that death occurred with “the permanent cessation of the *critical* functions of the organism as a whole.”<sup>122</sup> Bernat then presents three distinct and complimentary categories which define the critical functions of the organism as a whole. These are as follows:

1. Vital functions of spontaneous breathing and autonomic control of circulation.
2. Integrating functions that assure homeostasis of the organism, including the appropriate physiologic responses to baroreceptors, chemoreceptors, neuroendocrine feedback loops and similar control systems.
3. Consciousness, which is required for the organism to respond to the requirements for hydration, nutrition, and protection, among other needs.

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<sup>122</sup> J. Bernat. A Defense of the Whole-Brain Concept of Death. *Hastings Center Report*. 1998; 28 (2): 17 (emphasis in original).

According to Bernat, the functions in all three categories must be permanently lost for the organism to be dead, while the presence of only one category serves as evidence that the organism is alive.<sup>123</sup>

One problem with this move by Bernat is that while his inclusion of ‘criticality’ may be reasonable, his list of ‘critical’ functions seems *ad hoc*.<sup>124</sup> Bernat thinks that the critical functions are those “the function of [which to] the organism as a whole is necessary for the maintenance of life, health, and unity of the organism.”<sup>125</sup> He dismisses the occurrence in many brain dead patients of hypothalamic secretions of antidiuretic hormone sufficient to prevent diabetes insipidus because “patients without such secretion can survive for long periods without treatment.”<sup>126</sup> Though the function is evidence of integration of the organism as a whole, it is not evidence of a *critical function* of the organism as a whole for Bernat. And yet, if these living patients whose hypothalamus is not secreting the required hormone do indeed survive long enough without treatment, they will eventually die of diabetes insipidus. Such a result would surely be equivalent to the loss of integrating function described in Bernat’s second criterion above (and at the time of death would be accompanied by the loss of criteria 1 and 3 as well). The fact that the patient will die from the condition, unless provided with treatment to correct the condition, seems like the lost function should count among those functions necessary for the maintenance of life, health, and unity of the organism. And so surely an individual who possesses such a function possesses an integrating function that is necessary for the maintenance

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<sup>123</sup> Ibid: 17.

<sup>124</sup> M. Potts. A Requiem for Whole Brain Death: A Response to D. Alan Shewmon’s “The Brain and Somatic Integration”. *Journal of Medicine and Philosophy*. 2001; 26 (5): 482.

<sup>125</sup> Bernat, *op. cit.* 123.

<sup>126</sup> Ibid: 17.

of life, health, and unity of the organism as a whole. Yet Bernat dismisses the presence of such a function (and others like it) as insignificant to the determination of the life or death of the individual. The charge against Bernat that his choice of critical functions is ad hoc seems warranted.

A further objection to Bernat's revised attempt to defend whole brain death as death based on critical functions was raised by Shewmon who noted that there are integrative functions that are mediated by the spinal cord.<sup>127</sup> Included among the integrative functions mediated by the spinal cord are stress responses to surgical incision, as well as spontaneous movements associated with attempts to breathe and the so-called "Lazarus sign". Such movements themselves may not be essential to the survival of the individual, but such movements do reflect the presence of the spinal cord's ability to maintain autonomic transsegmental integrative functions. "In a collection of brain dead patients with survivals of one week or more, those with spontaneous movements had particularly long survivals, [with] both features (length of survival and movements) implying relative integrity of the cord."<sup>128</sup> In the absence of the brain certain critical integrating functions of the body can be mediated by the spinal cord and so would presumably preserve the life of the individual even though the individual has suffered whole brain death. Such individuals may be severely injured and their prognosis for recovery may ultimately be nonexistent, but they are not yet dead.

In 2008, the President's Council on Bioethics (PCBE) presented their report *Controversies in the Determination of Death*. This white paper accepted Shewmon's critique of

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<sup>127</sup> Shewmon, *op. cit.* 120 (2001), 469-471. See also J. Bernat. Revisiting the Definition and Criterion of Death. *APA Newsletter*. Spr 2013; 12 (2): 28.

<sup>128</sup> Shewmon, *op. cit.* 120 (2001), 470-471.

the previous defenses of whole brain death advocated for by Bernat and attempted to offer a revised defense of whole brain death as death.<sup>129</sup> The PCBE recognized that the failures of the previous defenses of whole brain death were undermined by cases in which wholly brain dead individuals exhibited integrated functioning (i.e. wound healing, infection fighting, and temperature regulation). However, the PCBE ascribed this failure to the account of the ‘wholeness’ of the organism. Therefore, the PCBE claimed that the determination of whether an organism is a whole “depends on recognizing the persistence or cessation of the fundamental vital *work* of a living organism—the work of self-preservation, achieved through the organism’s need driven commerce with the surrounding world.”<sup>130</sup> On this understanding of wholeness, brain death would be equated with death because the organism would be unable to conduct its vital work of self-preservation.<sup>131</sup>

Shewmon’s attack on the defense of brain death by the PCBE is multifaceted. He first notes that the concept of ‘wholeness’ is never defined by the PCBE. This omission leads Shewmon to wonder why it is that ‘wholeness’ of the organism is defined exclusively in terms of externally directed work.<sup>132</sup> Furthermore, Shewmon challenges the PCBE’s undefended assumption that “the *only* kind of ‘fundamental vital work of a living organism’ is ‘the work of self-preservation, achieved through the organism’s need-driven commerce with the surrounding

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<sup>129</sup> President’s Council on Bioethics. 2008. *Controversies in the Determination of Death*. 59-65. Available online at: <https://bioethicsarchive.georgetown.edu/pcbe/reports/death/>. [Accessed 11 July 2014]. (emphasis in original). See also Bernat, *op. cit.* 127.

<sup>130</sup> President’s Council, *op. cit.* 129, 60.

<sup>131</sup> Ibid: 60-65. See also D.A. Shewmon. Brain Death: Can it be Resuscitated? *Hastings Center Report*. 2009; 39 (2): 20 and Bernat, *op. cit.* 127.

<sup>132</sup> Shewmon, *op.cit.* 131.

world.”<sup>133</sup> As Shewmon points out, why cannot other forms of work, perhaps that are undertaken on a holistic (but internal) level, not also qualify as vital work of the organism? Surely the work undertaken by a developing embryo or the orderly functioning of the cells of the organism should also qualify as the vital work of the organism, for without these things, the organism would fall into entropy and decay (i.e. it would be dead). Furthermore, the PCBE conflates the physical necessity of *staying* alive with the logical necessity for *being* alive.<sup>134</sup> The interactions one might take of seeking sustenance from food or avoiding dangerous predators are vital work for an organism to remain alive may well be correct, but though one may have ceased to perform these activities does not mean that one has immediately died. The fact that an individual may die soon (for one reason or another) is not the same as that individual being dead. As mentioned, Shewmon’s criticism of the PCBE white paper is multifaceted, and though there are further critiques leveled by Shewmon at the attempt by the PCBE to defend whole brain death, piling on further reasons to reject the PCBE attempt to defend brain death seems unnecessary at this stage.<sup>135</sup> As such, I leave the remainder of this discussion of the flaws in the PCBE white paper aside and turn now to a more recent attempt to defend the conception of whole brain death as death.

In response to Shewmon’s challenge to the PCBE white paper that the concept of ‘wholeness’ (and thus the associated idea of the ‘organism as a whole’) was not clearly defined,

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<sup>133</sup> Ibid: 20. (emphasis in original).

<sup>134</sup> Ibid: 20. (emphasis in original).

<sup>135</sup> In addition to the further criticisms of Shewmon, others have supported Shewmon’s attack on the reasoning of the PCBE white paper as well. See E.C. Brugger. D. Alan Shewmon and the PCBE’s White Paper on Brain Death: Are Brain-Dead Patients Dead? *Journal of Medicine and Philosophy*. 2013; 38: 205-218.

Bernat offered a discussion attempting to clarify the concept of an organism as a whole.<sup>136</sup> A key component in defining Bernat's conception of an organism as a whole is the concept of emergent functions. For Bernat, life is an emergent function that arises once the subsystems of an organism are properly organized. Living cells give rise to living tissue, tissue creates organs, and organs create organ systems. These systems are then arrayed to create a complex, "integrated, coordinated, unified whole"<sup>137</sup> that is the organism itself "whose life is a result of the functioning of all its living component subsystems."<sup>138</sup> Bernat further argues that "the 'organism as a whole' refers not to the whole organism ... but rather to the emergent functions of the organism that are the consequence of, but greater than, the mere sum of its component parts."<sup>139</sup> As such, an organism can lose some of its parts and continue to function as a whole provided that "the interrelatedness of the component parts and ensembles produces emergent functions that create the coherent unity of the organism."<sup>140</sup>

Now, according to Bernat, the loss of one's brain would equate to a loss of the emergent functions that create the coherent unity of the organism as a whole, whereas the loss of a leg or kidney would not equate with the loss of coherent unity of the organism as a whole. Yet at this stage it is unclear why it is that the loss of the brain represents the loss of the emergent functions of the organism as a whole in a way that the loss of other organs does not. In short, why is the brain special? Bernat relies upon the work of Raphael Bonelli to justify his view that the brain holds special primacy in the concept of the organism as a whole.

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<sup>136</sup> Bernat, *op. cit.* 127 (2013), 28-31.

<sup>137</sup> *Ibid.*: 29.

<sup>138</sup> *Ibid.*: 29.

<sup>139</sup> *Ibid.*: 29.

<sup>140</sup> *Ibid.*: 29.

Bonelli and colleagues offered four criteria that make a life form integrated, unified, and a whole organism:<sup>141</sup>

1. completion
2. indivisibility
3. self-reference or auto-finality
4. identity

Completion requires that an organism not be a component part of another living entity. Indivisibility requires that no organism can be divided into more than one living organism (and in the event of such a division, the completed organism must reside in one of the divided parts). Self-reference requires that the functioning of the component parts exist for the preservation of the whole, even at the expense of the particular component part. Identity requires that in the event of loss of component parts the living being remains one and the same throughout life.<sup>142</sup> Using these criteria, Bernat relies on Bonelli's work to attempt to defend whole brain death as the death of the organism as a whole. Bernat argues that the merely whole brain dead organism has lost immanency because its life processes no longer spring from itself, but result from external intensive care procedures; it lacks auto-finality and self-reference since its component parts are now directed at the level of maintaining the functioning parts rather than the function of the whole; and it has lost identity since its separate component parts and subsystems no longer belong to each other and no longer constitute a whole.<sup>143</sup>

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<sup>141</sup> Ibid: 29.

<sup>142</sup> Ibid: 29.

<sup>143</sup> Ibid: 30.

There are multiple problems with this defense of whole brain death as death by Bernat. To begin, Bernat claims that the loss of the brain equals a loss of immanency based on a lack of internally originating life processes. This claim overlooks the various life processes that persist within wholly brain dead individuals which are not externally directed and would seemingly arise from internally directed processes. For example, the lungs will exchange oxygen for carbon dioxide in merely wholly brain dead patients. This function is directed at the cellular level. The fact that the muscles of the diaphragm may no longer be functioning to bring air in and out of the lungs doesn't change the fact that the lungs themselves are still functional. Other systems too are functioning at a similar level. One system may require external direction, but other systems that maintain life processes are themselves functioning without external direction. The digestive system for instance is still able to extract nutrients and the renal system is able to eliminate waste from the body. The individual may require feeding via gastronomy or nasal-gastric tube as the direction required to ingest food may be lacking. However, the systems needed to process the ingested material for nutrition and excrete waste are still functioning and their function is directed by internal forces.

Furthermore, the functioning of the parts and systems considered above is not carried out for the parts and systems themselves. The lungs do not extract oxygen and excrete carbon dioxide only for themselves, but for the rest of the body as well (however much of it is continuing to function); so too for the kidneys and digestive system with their functions. The activity of such organs and organ systems is directed at the preservation of the organism as a whole (regardless of how much of the organism is still functioning).

To claim that the activity of such organs and organ systems is directed only at the preservation of the subsystems is to presuppose that the organism as a whole is already lost.

Indeed, it seems that Bernat has continued to treat the persistence of certain functions in an *ad hoc* manner in order to maintain his commitment to whole brain death as death. Previously Bernat treated continuing functions in wholly brain dead individuals as being non-critical to the persistence of the organism. Here, Bernat instead treats these functions as being merely elements of the organism's subsystems rather than continuing functions of a whole organism. On this matter Bernat seems to be mistaken. Contra Bernat, such continuing functions within wholly brain dead organisms remain as functions of an admittedly severely injured organism, but a whole organism nevertheless.

At this point in the discussion it seems that the attempts to establish death based upon the death of the whole brain have failed within the bounds of the DCT model. However, this result alone may not necessarily entail that whole brain death is an inappropriate criterion for death. At least one author has attempted to defend whole brain death as an appropriate criterion of death without following the DCT model and I turn now to an assessment of this attempt by Winston Chiong to defend whole brain death as death.

#### **IV. WHOLE BRAIN DEATH OUTSIDE THE DCT MODEL: CHIONG'S ARGUMENT**

The definitions-criteria-tests model proposed by Bernat et. al. has shaped much of the discussion concerning the definition of death. However, the model itself has not received as much criticism as the various definitions of death (and the resulting criteria and tests) that the model has produced. At least one author has argued that the problem with understanding death resides not with one particular definition of death or another, but rather with the very model that has shaped so much of the debate. In his 2005 article *Brain Death without Definitions*, Winston Chiong argues that it is not a particular criterion of death that must be abandoned (as the debate between Bernat and Shewmon might suggest), but rather the definitions-criteria-tests model itself

that must be abandoned.<sup>144</sup> According to Chiong, there is no single, general feature that defines death. Accordingly, there is no single general feature such that if one is in possession of this feature then that individual is alive and if one were to lack this same feature, that individual is dead. Therefore, according to Chiong, the exercise of seeking a particular definition of death based on a single characteristic which can then be used to separate the living from the dead is an exercise in futility.

Chiong's argument that the DCT model cannot result in a successful definition relies upon a consideration of two paradigm cases. The claim is that these two cases pick out two individuals who are clearly (determinately) alive. However, there is no characteristic that is shared by these two individuals in virtue of which they are both recognized as being alive rather than dead. These two cases are 1) a victim of a sudden heart attack and 2) an individual in a persistent [irreversible] vegetative state (PVS). Chiong's argument against the DCT model can be stated as follows:

1. If the definitions-criteria-tests model is correct, then all determinately alive individuals are alive in virtue of having a single characteristic in common.
2. The PVS patient and the sudden heart attack victim are determinately alive.
3. There is no single characteristic in common between the sudden-heart attack victim and the PVS patient in virtue of which they are both determinately alive.
4. Therefore, the definitions-criteria-tests model should be rejected.

The case of the sudden heart attack victim is intended by Chiong to undermine arguments advanced by advocates of cardio-pulmonary based definitions of death. Advocates of cardio-

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<sup>144</sup> Chiong, *op. cit.* 113, 20-30.

pulmonary definitions of death generally hold to the view that the death of an organism occurs when the organism experiences an *irreversible* loss of cardiac function. Chiong asks his reader to consider an individual who has suffered a sudden heart attack. Furthermore, Chiong stipulates that this heart attack is *irreversible* the instant it occurred. Since the heart attack victim in Chiong's example has irreversibly lost cardiac function, by the cardio-pulmonary definition of death this individual *is dead*.<sup>145</sup> However, if some individual in such a state were to remain conscious for a brief period of time after the onset of such a heart attack, then surely we would not take the utterances of such an individual for assistance (assuming they could manage to speak) to be the utterances of a corpse. Similarly, if such a person was unable to speak but was able to make other purposeful movements<sup>146</sup> in response to the activities of others, surely we would not say that a corpse was responsible for such movements either.

In this case, the fact that the victim maintained a level of consciousness is deemed by Chiong to be sufficient to establish that this individual is not dead, but rather is determinately alive. It is also worth noting that even if the individual in question could not respond to the questions of those attempting to render aid in this imagined scenario, the mere presence of consciousness should be sufficient to maintain our intuition that this patient is still (at least for the moment) alive. The fact that any onlookers and those attempting to aid the heart-attack victim may not be able to determine whether or not the victim is still alive is a problem

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<sup>145</sup> Bernat's definition of death stipulates that an individual is dead whenever that individual irreversibly loses the ability to function as an integrated unity. The cardiac victim has irreversibly lost the ability to function as an integrated unity. So it also seems to be the case that according to Bernat's definition of death this individual *is dead*.

<sup>146</sup> Imagine the person being asked to blink in response to questions asked by those attempting to render aid. Furthermore, the ability to blink one's eyes in this context would not result in the individual maintaining the ability to function as an integrated unity on the level of the organism as a whole.

associated with being able to *test* for the occurrence of death. The sudden heart-attack victim is still alive, however briefly, despite the fact we may not be able to determine that she is in the final few moments prior to her death. Having established that consciousness alone seems sufficient to maintain that an individual is still alive, Chiong shifts his discussion to the case of an individual who clearly lacks consciousness but is also determinately alive: the case of a PVS patient.

The case of the PVS patient is intended by Chiong to demonstrate that one need not have consciousness to be alive. The PVS patient lacks the one characteristic present in the sudden heart attack victim above that seemed responsible for our willingness to assent to the claim that the sudden heart attack victim was alive. However, the PVS patient maintains a host of functions that the sudden heart attack victim lacked in terms of integrated functioning of the organism as a whole. The PVS patient possesses many functions that Shewmon has argued clearly demonstrate integrated functioning in brain dead individuals. Among these features will be growth, wound healing, temperature regulation, digestion and waste excretion and (perhaps most prominently) sexual maturation in the prepubescent and the ability to gestate a fetus in pubescent women. Just as we would not ascribe speech acts to a corpse in the case of the heart attack victim above, surely we would not ascribe the ability to gestate a living fetus to a corpse either. Therefore, the PVS patient is also determinately alive, but for none of the reasons that the heart-attack victim above was recognized as being alive.

The result of these two cases is two determinately alive individuals who share no common characteristic by which they are recognized as being alive. On the surface, Chiong's case for the non-existence of a *single* necessary and sufficient condition for life or death seems justified.

Chiong combines his attack upon the definitions-criteria-tests model and the resulting conclusion that there is no necessary condition for an individual to be alive with a discussion of Wittgensteinian language games and Putnam's comments on operational definitions to argue that ultimately being alive is a matter of having a cluster of characteristics.<sup>147</sup> Chiong offers a list of seven such characteristics: consciousness, spontaneous vital functions, behavior, integrated and coordinated functioning of multiple subsystems, the ability to resist decay and putrefaction, the capacity to reproduce, and the capacity to grow via the assimilation of nutrients. Chiong then argues that possession of only one characteristic may be sufficient to establish an individual as determinately alive in some cases<sup>148</sup> while at other times even having multiple such characteristics is not sufficient to establish an individual as determinately alive.<sup>149</sup> Presumably, those who lack all of Chiong's proposed characteristics would be determinately dead. However, one may legitimately question whether or not an entity which possesses only one or two of Chiong's proposed characteristics is alive or dead. Viruses for example possess the ability to reproduce, yet Chiong suggests that viruses are neither determinately alive nor determinately dead.

Without endorsing Chiong's argument, the important result for our consideration is that according to Chiong there will be borderline cases wherein we are uncertain if an individual is alive or dead. There will now be an indeterminate boundary between cases that are clearly identified as being alive (determinately alive) and those that are clearly identified as being dead

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<sup>147</sup> Chiong, *op. cit.* 113, 23-26.

<sup>148</sup> i.e. consciousness

<sup>149</sup> Robots for example would have several features (but not all features) that appear on Chiong's list. "Behavior" and "integrated and coordinated functioning of multiple subsystems" being the most obvious candidates. However, Chiong does not consider robots to be determinately alive.

(determinately dead). Individuals who are indeterminate in their status will have some number of the cluster characteristics, but will have neither too few to make them determinately dead nor will they possess a sufficient number to mark them as determinately alive. According to Chiong this boundary of indeterminacy will include, among possible others, individuals who are undergoing systematic organ failure wherein one organ system is failing after another. At one point this person is determinately alive (prior to the onset of systemic organ failure). At another point the same individual is determinately dead (perhaps only after all organ systems have failed). However, in between those points it may be unclear whether such a person is alive or dead.

To solve the problem of indeterminacy created by his attack on the definitions-criteria-tests model, Chiong argues that whole brain death is a suitable boundary for determinacy within the indeterminate area between determinately alive and determinately dead. Whole brain death will act as a discontinuous boundary separating individuals who are otherwise indeterminate in their status into either determinately alive or determinately dead. Those who have not yet suffered whole brain death, but would otherwise be indeterminate in their status, are to be considered determinately alive under Chiong's approach. Individuals who have suffered whole brain death would be considered determinately dead.

Chiong's approach to solving the problem of indeterminacy in death via the use of whole brain death would work in much the same way that many societies recognize a particular age as the determinate boundary between childhood and adulthood. There are certain ages at which individuals should clearly be regarded as adults (Chiong cites 30 years as an example). There are certain ages at which individuals should clearly be regarded as children (Chiong cites 7 years as such an example). Yet between these determinate extremes will lie a period of indeterminacy. An

argument can be made that individuals that have reached 17 years of age are just as deserving of the rights afforded to 18 year olds in the U.S. as those who have already reached the 18 year threshold. Similarly, one might argue that a general recognition of adulthood at 18 years is too soon for a variety of reasons (most likely having to do with mental and emotional development). Regardless of how each individual perceives such matters a threshold or boundary is required to clearly separate adults from children. As such, a more or less agreeable threshold is chosen to separate those who are now determinately adults (18 years of age and older) from those who are now determinately children (less than 18 years of age). According to Chiong, whole brain death should be viewed the same way when it comes to separating those who are determinately alive from those who are determinately dead. If one has met the current criteria for whole brain death, then such an individual is now treated as determinately dead while those who have not met the current criteria are determinately alive.

Chiong seeks to defend the current conception of whole brain death against the attacks of individuals like Shewmon and preserve the current practice of vital organ transplantation based upon the dead donor rule. Shewmon's cases of individuals who are 'alive' even though they are wholly brain dead were the source of many problems for individuals attempting to defend whole brain death under the traditional definitions-criteria-tests model. Shewmon's cases would initially present as indeterminate in Chiong's view and then be reclassified as determinately dead once the whole brain death boundary for determinacy is adopted. Such individuals would be considered dead despite the functions the bodies of such wholly brain dead individuals are able to perform that seemed to suggest such individuals were alive. Furthermore, by classifying such individuals as determinately dead, Chiong would be able to maintain the status quo regarding organ transplantation and the dead donor rule.

## V. WHOLE BRAIN DEATH OUTSIDE THE DCT MODEL: REJECTING CHIONG'S DEFENSE OF WHOLE BRAIN DEATH

There is a potential problem for Chiong's proposed boundary for dividing indeterminate cases into determinately alive and determinately dead based on whole brain death. By making whole brain death the boundary separating determinately alive from determinately dead, Chiong has placed at least one group of individuals whom I will argue are determinately alive into the category of determinately dead. Chiong was quite clear that the boundary chosen to divide indeterminate cases cannot disagree with the results of determinate cases.<sup>150</sup> Therefore, if Chiong's boundary entails that a determinately alive individual were to be classified as determinately dead, then the boundary proposed would be unacceptable.

The type of individual which I will argue is in fact determinately alive and conflicts with Chiong's ascription of whole brain death as an appropriate boundary of determinacy is the case of a wholly brain dead pregnant woman. Chiong would argue that such an individual is in fact indeterminate in her status vis-à-vis alive or dead. In order to explicate why it is that a wholly brain dead pregnant woman should be considered alive I will need to explore certain aspects of Chiong's paradigm cases: the sudden heart attack victim and the PVS patient.

In Chiong's two paradigm cases, neither individual has suffered whole brain death. This is an important aspect of these two cases given Chiong's solution to his problem of indeterminacy. Since whole brain death is Chiong's threshold for dividing individuals whose status is indeterminate, neither the sudden heart attack victim nor the PVS patient can have suffered *whole* brain death. However, Chiong can maintain that neither the PVS patient nor the sudden heart attack victim shares a common characteristic so long as he stipulates that whatever

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<sup>150</sup> Chiong, *op. cit.* 113, 27.

part of the brain the PVS patient has which still functions is not shared by the sudden heart attack victim. Given what Chiong has stipulated about these two cases, it is clear that the sudden heart attack victim must still have functioning cerebra in order to maintain consciousness, while the PVS patient must have a functioning brain stem in order to maintain spontaneous respiration and breathing. The rest of the brain could be functioning or not functioning in either patient presumably without altering Chiong's view on the determinately alive status of each individual, provided the rest of the brain, if it is functioning in one case, is not also functioning in the other.

Focus now upon the PVS patient and consider what it is about this individual that induces the belief that such an individual is clearly alive. The most prominent answer seems to be something to do with the respiratory and circulatory functions of the individual. Yet, those functions alone do not seem to be all that is having a profound influence upon our willingness to assent to the claim that the PVS patient is alive. Not only is the individual breathing and circulating oxygenated blood, but other parts of the body are also functioning as well. Many of those functions that Shewmon pointed to in brain dead bodies as evidence of continued integration are present in the PVS patient before us. The difference between the PVS patient and the wholly brain dead patient is the lack of a functioning brain stem (and possibly functioning cerebellum). Yet if we were to reduce the PVS patient to *only* a functioning brain stem and cerebellum, the PVS patient no longer seems determinately alive. If anything, such an individual seems to be determinately dead. If reduced to only the brain stem and cerebellum, it seems that it is only these two particular parts of the brain which remain alive, not the individual patient. It seems that the functioning body played the more prominent role in our willingness to assent to the determinately alive status of the PVS patient. Hence, the body itself and its integrated status

must be an important aspect of our willingness to recognize the PVS patient as determinately alive.

Chiong might note the presence of artificial mechanisms necessary to maintain the respiration and circulation of the wholly brain dead pregnant woman and argue that this is an important difference between the PVS patient and the merely wholly brain dead pregnant woman. Chiong might claim we are willing to grant that the PVS patient is determinately alive because the PVS patient does not need artificial support to breath on her own. The merely wholly brain dead pregnant woman does. The lack of artificial support is perhaps an important distinction in our willingness to grant determinate status to the PVS patient; the presence of artificial maintenance of respiratory and circulatory function a possible reason to consider the merely wholly brain dead pregnant woman's status to be indeterminate.

To respond to the possible objection by Chiong I would suggest a slight modification to his other paradigm case of determinacy. I will maintain that the sudden heart attack victim's condition is such that his cardiac function and respiration are irreversibly lost. However, suppose that the means were available to immediately start the sudden heart attack victim on a form of artificial maintenance.<sup>151</sup> Rather than oxygenated blood circulating throughout the body, only the cerebra receive the oxygen they require (possibly through some medium besides blood). Additional nutrients that the cerebra require and the corresponding removal of cellular waste can also be carried out by this artificial maintenance. In this way we are able to artificially maintain the consciousness of the sudden heart attack victim indefinitely.

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<sup>151</sup> Think of this as a modified form of extracorporeal membrane oxygenation (ECMO) which is a system used during open heart surgery to provide oxygenated blood to the body while the heart is stopped and the surgery performed. Without ECMO, many such procedures would not be possible as the patient would die during the operation.

Given what Chiong has said about consciousness as sufficient on its own for the ascription of determinately alive status in his original sudden heart attack victim case, a consciousness that is maintained artificially in the modified case does not seem any less deserving of determinately alive status merely because it is being artificially maintained. Since it would be inappropriate to deny the artificially maintained consciousness determinately alive status<sup>152</sup> it does not seem any more appropriate to deny the wholly brain dead pregnant woman determinately alive status solely on the grounds that the functioning of her body (i.e. respiration, circulation, nutrition, etc.) is being maintained artificially.

If the preceding discussion concerning artificial maintenance of the wholly brain dead woman is correct, then it would seem that an individual in such a condition has as much claim to the status of ‘determinately alive’ as the PVS patient. Much of our willingness to grant determinately alive status to the PVS patient, even in the face of a permanent or irreversible loss of consciousness, must arise from the integrated functioning of the various systems of the PVS patient’s body. One should certainly recognize the integrated functioning of similar systems as necessary for the gestation of a developing fetus. Thus, our willingness to assent to the status of the PVS patient as determinately alive should also extend to the wholly brain dead pregnant

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<sup>152</sup> It would similarly seem inappropriate to deny the PVS patient determinately alive status in the event such a patient needed some level of artificial maintenance, such as a gastrostomy or nasal-gastric tube for instance. The high profile case of Terri Schiavo (and others like her) points to the acceptance of the concept that individuals who are in a PVS and maintained via artificial nutrition and hydration are not dead. If Schiavo was already dead, the removal of the tube should not have been an issue since we have no obligation to feed a corpse. The attempts by Schiavo’s husband to remove the feeding tube resulted in a prolonged legal battle and serious moral debate. This fact indicates acceptance of the view that Schiavo was not dead prior to the removal of the feeding tube.

woman as well.<sup>153</sup> Therefore, if the preceding discussion is correct, Chiong's boundary for determinacy based on whole brain death is flawed and should be rejected.

## **VI. AN ALTERNATE DEFENSE OF WHOLE BRAIN DEATH: THE DECAPITATION GAMBIT**

One last argument supporting whole brain death that I will discuss attempts to equate whole brain death with an individual who has been decapitated. For most, the image of a decapitated body evokes a clear conception of an individual who has died. Some proponents of whole brain death then argue that a merely wholly brain dead body has been *internally* decapitated. Then the defender of whole brain death argues that just as decapitation is the severing of the brain from the body, whole brain death is essentially the severing of the brain from the rest of the body. Though the head of the merely wholly brain dead body is still connected to the body by skin and muscle, the internal connections that brought the brain and the rest of the body together have been severed. Presumably the defender of whole brain death would then argue that if the severing of the whole head from the body produces death, then surely the severing of the most important aspect of the head (the brain) from the body must also produce death. Thus, if we consider decapitated bodies to be dead due to the loss of the

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<sup>153</sup> A similar argument could be applied to wholly brain dead individuals who are prepubescent but survive long enough to undergo puberty (either in part or in full). I personally believe that the ability to grow and mature into a being capable of reproduction is similar to the ability of a pubescent woman to develop a fetus to the point of viability; both are evidence of a living biological organism and so individuals displaying such characteristics should be regarded as determinately alive.

connection between brain and body, we should also consider whole brain dead bodies to be dead as well.<sup>154</sup>

Decapitated bodies share some similarities with merely wholly brain dead bodies. Merely wholly brain dead bodies still breathe and have functioning circulatory systems. Decapitated bodies also continue to breathe and have functioning circulatory systems immediately following decapitation. The functioning of the circulatory system is the primary reason why the decapitation of a human being generally involves copious amounts of bloodshed and is considered so gory and gruesome to witnesses. In a short time following decapitation, the loss of blood coupled with the loss of respiratory and circulatory function<sup>155</sup> entails the demise of the remaining systems of the body and the eventual death of the decapitated individual. Given the nature of decapitation this process likely takes only a few seconds so that death appears instantaneous.

However, it may be possible to intervene in the death of a recently decapitated individual. This process would be much the same as it is when one intervenes in the death of a merely wholly brain dead individual. In the case of the merely wholly brain dead individual, tubes and machines are used to maintain the functions of the respiratory and/or circulatory systems (and any additional system/subsystem as needed). This in turn preserves the functioning of the organism as previously discussed. In the case of the recently decapitated individual, the now

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<sup>154</sup> See J. Lizza. Where's Waldo? The "decapitation gambit" and the definition of death. *Journal of Medical Ethics*. 2011; 37: 743-746; J. Lizza. Commentary on "The Incoherence of Determining Death by Neurological Criteria." *Kennedy Institute of Ethics Journal*. 2010; 19 (4): 393-395.

<sup>155</sup> The respiratory and circulatory systems may continue to function very briefly following decapitation, but since decapitation will involve the destruction of the brain stem these systems will very shortly cease operation unless artificially maintained.

headless body and the now bodiless head could both be artificially maintained via appropriate tubes and machines. In the case of the headless body, this would likely entail preventing the massive blood loss that generally accompanies decapitation and then connecting the usual respirators needed to maintain breathing in the body. For the bodiless head, a modified form of extracorporeal membrane oxygenation (ECMO) could be employed to stave off the death of the bodiless head.<sup>156</sup> This process would involve oxygenating blood in a machine and then pumping that blood into the head. Thus it is theoretically possible to preserve both the headless body and bodiless head following a decapitation.<sup>157</sup>

Assume that an individual, call her Jean, has been decapitated. Further assume that it is possible to artificially maintain either or both of Jean's bodiless head and headless body. This creates three possible decapitation cases:

- 1) only Jean's headless body is maintained.
- 2) only Jean's bodiless head is maintained.
- 3) both Jean's bodiless head and headless body are maintained separately.

Many are no doubt drawn to ask the question: "Is 'Jean' still alive?" in each of these three cases. This question is incredibly difficult to answer since this question involves two of the most complex and difficult issues in philosophical discourse: *personhood* and *personal identity*. For the purposes of this work, the concern is not whether the bodiless head or the headless body is

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<sup>156</sup> Though not specifically intended to keep decapitated heads alive separate from their bodies, ECMO could be adapted to such a purpose or serve as the basis for a system that is designed to maintain decapitated heads.

<sup>157</sup> Additionally, the headless body and bodiless head would have to be nourished in some way. The bodiless head could be fed the same as any wholly brain dead individual via gastrostomy tube. The bodiless head would need to be nourished in some other fashion, possibly via parenteral nutrition which is a method currently in use to feed individuals which bypasses the ingestion and digestion processes.

still 'Jean'. The concern is whether or not either the headless body or bodiless head is still alive and then what reason we have for accepting that the headless body or bodiless head is still alive in each case.

Assume that upon decapitation the first case occurs, Jean's headless body is artificially maintained and her bodiless head is not artificially maintained. In this instance, Jean's body continues to function much as it did before. Respiration and circulation have been preserved, food and fluids placed into the digestive system via gastrostomy tube are processed and the nutrients distributed throughout the body. The resultant waste produced during digestion is excreted. All of the various functions previously discussed which supported the view that a merely wholly brain dead body is not dead continue to apply to Jean's headless body. Therefore, Jean's headless body is not dead. The situation of the headless body is supposed to be analogous to the case in which a body has suffered whole brain death. Yet the body does not die merely as a result of having the brain disconnected from the body, no matter how that disconnection may be achieved. If the artificially maintained headless body is not dead, the merely wholly brain dead body is not dead either. Therefore, whole brain death is not sufficient for death.

## **VII. AN ALTERNATIVE TO WHOLE BRAIN DEATH: NEW CRITERIA WHICH BETTER REFLECT THE BIOLOGICAL REALITY OF DEATH**

Whatever 'death' is, it is a biological phenomenon in the existence of biological organisms. Though the preceding discussions have concluded that whole brain death is unacceptable as the sole criterion for the determination of death, the brain is still an important entity in the determination of death. It also seems that respiratory function and circulatory function are also important entities in the determination of death. The problem that persists then

is to determine what exactly defines the death of a biological organism and what criteria, if any, exist for use in identifying when such an individual has died.

Reconsider for a moment the definitions offered by Bernat et. al. under the DCT model. The argument there focused on the failure of whole brain death to adequately reflect the definition of death. It may well be that one of the proposed definitions of death, such as “the loss of integration of the organism as a whole,” is in fact an appropriate definition of death. The problem was that the proposed criterion, whole brain death, failed to act as a sufficient condition for the definition.

Alternatively, if one were to accept Chiong’s approach to solving the problem of determining death, the failure of whole brain death to act as an appropriate boundary of determinacy for indeterminate cases suggests that an alternate boundary should be sought. The cases considered previously can act as a useful starting point in our search for such an alternate boundary of determinacy. Chiong’s two paradigm cases of determinacy suggest that while there may be no *single* necessary and sufficient condition for life or death, there are certainly some characteristics that are themselves sufficient conditions for the ascription of life. Furthermore, if a characteristic is a sufficient condition for life, then the corresponding loss of that same characteristic must be a necessary condition for death, even if the loss of that characteristic alone is not also sufficient for death.<sup>158</sup> In what follows of this work I will argue that alternate criteria for identifying death will involve *both*:

I. Irreversible loss of consciousness.

-AND-

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<sup>158</sup> Chiong recognizes certain results his cases entail for necessary and sufficient conditions concerning death. See Chiong, *op. cit.* 113, 27.

- II. Irreversible loss of respiratory and circulatory functions such that these functions are neither spontaneously nor artificially maintained.

This approach to determining death appears to satisfy the requirements for appropriate criteria for death, whether attached to a particular definition of death or used as a boundary of determinacy in indeterminate cases. I will first discuss how the cases of decapitation support this approach to determining death before briefly discussing why the proposed criteria are acceptable if one were to adopt Chiong's approach and then considering why the proposed criteria seem acceptable relative to the previously considered definitions of death.

Assume the second decapitation case were to occur. Only Jean's bodiless head is maintained following decapitation. Jean is conscious and is able to communicate with her doctors or other visitors.<sup>159</sup> Clearly Jean's bodiless head is alive. Assuming no additional damage was done to the head during removal<sup>160</sup> all of its features continue to function. The eyes and ears continue to provide the brain with their usual sense data. The mouth is able to move and the tongue taste. The head is unable to speak due to a lack of lung connection to the vocal chords, but demonstrations of the presence of consciousness and communication with the brain could be possible in other ways; the functioning eyes and ears of Jean's bodiless head likely providing the necessary means of communication. The presence of such consciousness in Jean's bodiless head is sufficient to demonstrate the continued life of Jean's bodiless head. Furthermore, if we assume the third decapitation case where Jean has been decapitated and had both her headless body and

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<sup>159</sup> This is similar to Chiong's sudden heart attack victim except Jean's bodiless head will be able to remain conscious far longer than Chiong's sudden heart attack victim.

<sup>160</sup> We could assume a clean severing occurred via a device such as the guillotine.

bodiless head preserved separately, both the bodiless head and headless body would continue to live for all the same reasons already mentioned in each of the two previous decapitation cases.

These decapitation cases suggest that even if the head is entirely severed from the body, this act alone is not a sufficient condition to pronounce the death of the organism. The organism may be severely and irrevocably injured, but it is not dead based solely on the loss of connection between the brain and the body. Decapitation may be the sort of injury that is so traumatic, and the onset of death so swift following the injury, that we may not be able to intervene in the deaths of decapitated individuals. But our present inability to intervene in the deaths of decapitated individuals does not in itself entail that the loss of the brain is a sufficient condition for death. The loss of the whole brain, even the entire head, is not sufficient on its own to decide the death of the body unless the body also suffers an irreversible loss of respiratory and circulatory function.<sup>161</sup> Similarly, the loss of respiratory and circulatory function is not sufficient on its own to determine the death of the head unless the head loses consciousness irreversibly.<sup>162</sup> The suggestion from these considerations is that, in order to be dead the organism must

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<sup>161</sup> We might imagine that Jean's status as an organ donor is uncertain and so the doctors are preserving Jean's headless body while awaiting a decision from Jean's family about organ donation. During this time Jean's headless body suffers cardiac arrest and so loses cardiac and respiratory function temporarily. We would not consider Jean's headless body to be dead even under such circumstances if the doctors were able to restart the heart of Jean's headless body and restore respiratory and circulatory function.

<sup>162</sup> We might assume Jean's bodiless head loses consciousness due to the onset of a condition such as coma but retains the capacity for consciousness. At some time later, Jean's bodiless head regains consciousness. We should not say that Jean's bodiless head died and then returned to life any more than we should say the same about actual coma patients who regain consciousness. Rather, it seems that so long as the capacity for consciousness remains the individual remains alive (however injured she might be and however poor her prognosis for recovery).

irreversibly lose *both* respiratory and circulatory function on the one hand and consciousness on the other.

One concern that arises from these cases involves questioning the nature of “respiratory and circulatory function”. In the case of the headless body, respiration may be viewed in terms of the movement of the diaphragm to draw air into the lungs and circulation may be viewed in terms of the pumping motion of the heart to move blood throughout the body. If this is what we mean by ‘respiratory and circulatory function’, then clearly the bodiless head lacks respiratory and circulatory function (and so too Chiong’s sudden heart attack victim). Yet we should question whether this “bellows and pump” conception of respiratory and circulatory function is itself a sufficient condition for life.

Imagine a body wherein the heart beats and the diaphragm moves drawing air into the lungs, yet the lungs do not exchange oxygen for carbon dioxide in the blood. So when the heart beats, all it is doing is pumping blood laden with carbon dioxide throughout the body. The individual cells throughout the body, unable to obtain the oxygen they need from the blood, die. The respiratory system in this case is not functioning.<sup>163</sup>

Now imagine a body where the air brought into the lungs carries oxygen which is absorbed into the blood and exchanged for any carbon dioxide present in the blood, which is in turn expelled by the lungs. So far so good, the respiratory function seems to be working appropriately. When the heart beats, that oxygenated blood remains in the lungs. This body does not have respiratory and circulatory function because the circulatory system is not functioning.

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<sup>163</sup> Here there is an assumption that by ‘functioning’ we have a conception of *proper* functioning that is required in order to say that the system in question is functioning.

Now imagine a body where the respiratory function is working and the heart is able to move oxygenated blood out of the lungs, but the oxygenated blood is never utilized by any other part of the body and is simply returned to the lungs to acquire more oxygen. Again, it seems that the circulatory system is not functioning. It seems that only when the blood is pumped out to the body with oxygen, the oxygen is exchanged for carbon dioxide in the body, whereupon the blood is returned to the lungs with the carbon dioxide, the carbon dioxide is exchanged in the blood for more oxygen by the lungs, the extracted carbon dioxide is expelled by the lungs, and the process is then repeated, does the organism have functioning respiratory and circulatory systems.

These considerations of the respiratory and circulatory systems suggest that we should not consider ‘respiratory and circulatory function’ in terms of the ‘bellows and pump’ movements of the heart and lungs. Rather, we should think of respiratory and circulatory function in terms of the flow of blood (or other suitable fluid) to the body. The respiratory and circulatory systems are working when they are providing the rest of the body’s subsystems with elements necessary to perform their own functions. Call this approach to respiratory and circulatory function the ‘fluid flow with purpose’ approach.

The issue that now presents itself for the proposed criteria is that if we think of respiratory and circulatory function in terms of ‘fluid flow with purpose’ some might argue that we do not need criterion I of the proposed criterion.<sup>164</sup> In the decapitation case of the headless body respiratory and circulatory function was easily recognized, but respiratory and circulatory function is not clearly present in the case of the bodiless head. However, if we understand

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<sup>164</sup> This would effectively return the determination of death to the requirement that one’s respiration and circulation cease irreversibly. This was the basic standard for the determination of death amongst all of humanity until roughly the last half-century and the advent of the mechanical respirator.

respiratory and circulatory function as fluid flowing with purpose, then once we connect the bodiless head to our modified ECMO, we effectively reestablish respiratory and circulatory function in the bodiless head. There may not be a beating heart or breathing lungs, but the head is receiving the necessary fluids it needs in order to maintain consciousness and remain alive. Thus we might claim that what is really sufficient to maintain life is only fluid flowing with purpose to the various parts of the body (however many of them are still functioning themselves).

To deal with the suggestion that fluid flow with purpose is the only sufficient condition for life, and that the presence of consciousness in the case of the bodiless head is superfluous to the recognition of life, I return your attention to the case of Chiong's sudden heart attack victim. In the case of Chiong's sudden heart attack victim, the individual lost respiratory and circulatory function irreversibly the moment the heart attack occurred. This means that the moment the heart stopped beating fluid no longer flowed through the body with purpose and that this loss of fluid flow with purpose was irreversible. Thus, if the loss of respiration and circulation is understood in terms of the loss of fluid flowing with purpose, then our sudden heart attack victim should be dead the moment the heart attack occurs. However, in the case of the sudden heart attack victim, consciousness is maintained after the loss of respiratory and circulatory function and the continuation of consciousness in such circumstances seemed sufficient to maintain the individual as alive (however briefly). Thus, even if respiration and circulation is understood in terms of fluid flow, the irreversible loss of consciousness remains a necessary condition for death.

Let us now consider the proposed criteria for identifying death relative to Chiong's demand for a determinate boundary for death. We recognize that consciousness is a characteristic which is a sufficient condition for life. Therefore, we must also recognize that the irreversible loss of consciousness must be necessary for death. However, as the case of the PVS patient

demonstrates, the irreversible loss of consciousness alone is not sufficient for death. In order to be dead, one must lose more than just consciousness.

Consider now the status of the PVS patient and the importance that respiration and circulation played in the willingness to ascribe determinately alive status to such an individual. Just as consciousness seems a sufficient condition to maintain that the sudden heart attack patient is still alive, so too does it seem that the occurrence of respiration and circulation within the PVS patient acts as a sufficient condition to ascribe determinately alive status to the PVS patient. Furthermore, the presence of artificial maintenance of these same functions does not seem to undermine the demand for determinately alive status as in the case of the wholly brain dead pregnant woman.

Consider now the individual who has irreversibly lost both i) consciousness and ii) respiratory and circulatory function. This individual has no consciousness and will not regain consciousness. Similarly, this individual has no respiratory or circulatory function and will not regain such functions either spontaneously or through artificial means. There does not seem to be any reason to think that such an individual is still alive. This would suggest that the proposed criteria for identifying death presented above can serve as a suitable boundary for determinacy in indeterminate cases. Individuals who have not met both of these criteria will be classified as alive, such as the wholly brain dead yet still breathing pregnant woman, while those who have met both of these criteria will be classified as dead.<sup>165</sup>

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<sup>165</sup> As before with Chiong's suggestion of whole brain death, if this alternate boundary entails that there are individuals who have met the criteria to be classified as dead yet are in fact determinately alive or that there are individuals that are determinately dead who would be classified as alive because they have not met these criteria, then this alternate boundary would also be inappropriate.

Furthermore, let us now return to the proposed definition of death based on “the irreversible loss of integration of the organism as a whole.” An individual who has both irreversibly lost consciousness and irreversibly lost respiration and circulation seems likely to be the sort of entity who has irreversibly lost the integration of the organism as a whole. Similarly an individual who has irreversibly lost consciousness, respiration and circulation seems incapable of carrying out either the “critical functions” of the organism as a whole or the “vital work” of the organism as a whole. Without consciousness and without either spontaneous or artificial maintenance of respiration and circulation, on any of the proposed definitions of death, such an individual seems to have died.

On any of the approaches previously considered above in which whole brain death fails to function as an adequate criterion of death the alternate criteria I have proposed here seem successful.<sup>166</sup>

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<sup>166</sup> A potential objection to the proposed criteria may remain which is exemplified by the following scenario: imagine a body wherein only one leg is receiving oxygenated blood. The rest of the body is without oxygenated blood and the brain is without consciousness. An objector to the proposed criteria might claim that on the proposed criteria the organism would still be alive since part of the organism is receiving oxygenated blood which is being properly utilized by the cells of the leg. But in such a scenario the organism is not alive, so the proposed criteria must be incorrect. In response to such an objection I can only say that I share the intuition that the organism is not alive. Rather, only the artificially maintained leg is alive. However this scenario does not necessarily undermine the proposed criteria. This objection could be answered by clarifying what is meant by the concept of an ‘organism’ (and/or ‘organism as a whole’) so as to more clearly differentiate cases where the organism remains alive from cases where only parts of the organism remain alive. An alternate solution would be to follow Chiong’s approach and recognize the scenario proposed in the objection as a case of indeterminacy. Our intuitions may not be able to establish cases such as the one proposed in the objection as determinately alive or determinately dead. At which point the criteria proposed function as a boundary which separates indeterminate cases into determinate ones.

## VIII. CONCLUSION

The suggested method for recognizing death advocated for in this paper would require rewriting the current approach to recognizing death used throughout the U.S. While the criteria resulting from the analysis presented here are importantly different from the current UDDA criteria, the new criteria do reflect certain important values of the UDDA. Criterion II of the suggested criteria closely resembles the UDDA's criterion (1) and reflects the historical importance that respiration and circulation have played in determinations of death. Similarly, criterion I of the suggested criteria reflects important elements of the UDDA's criterion (2) and the concern within modern medicine for the role of the brain in determinations of life and death. Bringing the criteria together and requiring both criteria proposed under the suggested criteria for determining death ultimately seems to better reflect the historical conceptions of death and appropriate conclusions drawn from difficult cases created by modern medicine. The most pressing problem with this approach to determining death is that many individuals who are currently utilized as vital organ donors would not meet the new criteria. Therefore, if the proposed criteria for death are correct and the dead donor rule is maintained, an already scarce resource in the form of vital organs available for transplant would become even scarcer. Though this is an unfortunate result, I intend to argue in future work that this problem can be overcome by abandoning the dead donor rule. However, such an argument is beyond the scope of the present discussion, and so I leave that discussion for another time.

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Having established which indeterminate cases are now determinately alive and which are determinately dead, even if the artificially maintained entity in the objection were classified as alive by the proposed criteria, we could plausibly justify the killing of such an entity (based on any of a variety of accounts about the wrongness of killing) by removing the artificial maintenance it requires to remain alive.