Ethics & Medicine

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COMMENT

From Professor D. A. du Toit, University of Stellenbosch, South Africa

Leeds Conference Report: The Provocative Nature of Some Ethical Language

It has been pointed out on a countless number of occasions that people sometimes wittingly abuse the meaning of words to convey a particular ethical way of thinking. An example would be the invention of a 'medical' jargon to create opportunities for the sanitation of language, which usually amounts to 'double talk', whereby things that are done are no longer said. When an unborn child is deliberately killed even for no good reason at all, it is called 'termination of pregnancy'. When a pregnant women, after prenatal screening, is offered the choice of 'selection or treatment', it simply means kill or care. 'Therapeutic experimentation' on embryos speaks for itself. These examples could be multiplied. The important thing, however, is that it obviously is not a simple matter of words. These words in fact reflect a view of man which threatens to push anthropology back into pagan antiquity.

At a recently held international conference on reproductive medicine one was amazed and dismayed at the persistent efforts by many of the participants to do just that. As an example we may take the very important issue of the unity of the human being. In modern times the classical Greek anthropological dualism of body and soul has been thoroughly rejected and dismissed by all disciplines, including Christian theology. It is acknowledged and accepted that the human being is not a composite of alien substances, but that he / she is a unitary, undivided entity. This unity comprises of course a variety of structural dimensions, potentialities or capabilities, but these can never be separated in watertight compartments. They are in fact cross-dimensional realities which overlap, permeate and influence each other, enhancing and confirming the unity and totality of the one human being.

However, at this conference one was struck by the persistent and at times almost desperate efforts to oppose, deny or destroy by implication this fundamental unity of the human being. Overeagerly some participants would hasten to make it perfectly clear that they do not see the foetus as a child, that in particular the conceptus is not the embryo, and on the whole that prenatal life is 'not yet' a human or personal life. To that end especially the term 'pre-embryo' was used repeatedly, despite the fact that it is totally unfounded, unscientific and probably the most outrageous and misleading lie of our time, and also despite the fact that all arguments used to prop it up had properly and effectively been refuted on many occasions. What the use of that word implies, however, is simply that prenatal life is only 'part' of a human being, that 'something' is still missing and arrives only at a later date, thereby giving licence to treating prenatal life differently. While this assumption was dominant at this conference the conspicuous absence of references to other facts should have been expected, for instance the fact that conception produces genetically speaking a totally new, unique and completed entity, an entity to which nothing is to be added and of which most major future characteristics already have been finalised. And from here on we have a process of continuous growth and development into adulthood, without any unaccounted for gaps or leaps. It must be very clear that anybody who wishes to maintain that the conceptus, the embryo or the foetus can in a fundamental way be distinguished from humanhood later on must prove without a shadow of a doubt that at some time, somewhere during development a certain addition, event, change or occurrence takes place that *qualitatively* changes A into B. This is the bottom line. Without it they have no justification at all for treating prenatal life in a different way according to a different set of values and norms. Along the way they will also have to prove that the human being is not a unity, and not simply deny it by implication. Of course that will be impossible, because that unity is there right from the very start, or never at all.

It is regrettable that people viewing prenatal life with serious respect should again be ridiculed at this conference. Admittedly, indiscriminate use of the words 'person', 'human', 'soul' *etc.*, for prenatal life can be provocative and obstructive in the debate and one should be careful to describe exactly what is meant. At the same time people with other views should really stop asking satirical and sarcastic questions for the purpose of showing up the sheer stupidity of their opponents, while at the same time inadvertently using the very same antiquated tools of a dualism which they themselves would condemn.

It should be noted however that much of this ridiculing is done on the presumption that the opponents of their views are not present. Awareness of the presence of such opponents immediately led to a toning down of the provocative ethical language and to some serious and valuable debating – a point well worth remembering.

LEGAL COMMENT

From Stuart I. Hornett, Centre for Health Care Law, University of Leicester

The Sanctity of Life and Substituted Judgement: The Case of Baby J

In the recent and well publicised case of Re J (a minor)1 the Court of Appeal once again addressed the question of when life-saving treatment can be withheld from handicapped neonates. The decision is of some significance not only because it was agreed that life-sustaining medical care could be withheld, but because the court attempted to set out some guiding principles of general application for use in future cases.

The Legal Background

Prior to *Re J*, only two similar decisions had come before the Court of Appeal. In *Re B* (a minor) (1981)[2] the court was concerned with a child suffering from Down's Syndrome who required a life-saving operation to remove an intestinal blockage. The operation was likely to be successful, thereby affording the child a life expectancy of some 20 to 30 years. The court found on the facts that it was doubtless in the ward's best interests to have the operation but intimated it was conceivable other, more severe cases, could be decided differently. *Re C* (a minor) (1989)[3] was a case at the other end of the spectrum in which the child was hopelessly and terminally ill. The court approved measures designed to ease the child's suffering and allow her life to end peacefully rather than sanction measures aimed at prolonging it. In the words of Lord Donaldson in *Re J*, what was being balanced in *Re C* was not life against death, but a marginally longer life of pain against a marginally shorter life without pain. The court in *Re J* felt that baby J's situation was one falling between these two extremes.

Re J – The Decision

J was born 13 weeks prematurely with severe and irreversible brain damage. The court was told the most optimistic prognosis was that he would develop serious spastic quadruplegia, would be likely to be blind and deaf and unlikely ever to be able to speak. In addition, he wouldn't be able to sit or hold his head up and would be unlikely to develop even basic intellectual abilities. He would, however, be able to experience pain both as a result of his condition and his treatment. He was not expected to live beyond adolescence.

Although very ill, at the time of the hearing J was neither dying nor in a terminal condition. He had periodically been placed on a ventilator and the question arose whether if J suffered another collapse, the hospital staff should again re-ventilate him. The doctors were unanimous in recommending that there should be no mechanical re-ventilation in the event of him stopping breathing. For unrelated reasons, J had been made a ward of court and it fell to Mr Justice Scott Baker to decide what would be in J's best interests. He ordered that J could be given antibiotics to control infection, but that it would not be in his interests to put him back on a mechanical ventilator unless medical staff felt it was clinically appropriate.

On appeal, counsel for the Official Solicitor (representing J) contended that either the court could never withhold life-sustaining treatment from a ward, irrespective of the pain or other side effects inherent in the treatment and the resulting quality of life, or alternatively, that treatment could only be withheld where, following the *obiter* statements in *Re B*, it was certain the ward's life would be an 'intolerable' one and 'demonstrably so awful that in effect the child must be condemned to die.'

In rejecting both submissions the Court of Appeal found that it had a balancing exercise to perform in assessing whether it would be in the child's best interests for him to undergo treatment which would prolong life and that consequently, it might not always further the child's interests to permit such medical care. In addition, the majority favoured a new approach by which the court in undertaking this balancing exercise imposed not its own standards of a worthwhile life upon the child but addressed the question from the patient's perspective.

The Sanctity of Life: An Absolute?

The court unanimously rejected the 'absolutist' approach put forward by counsel. Lord Donaldson recognised 'the vast importance of the sanctity of human life' but cautioned '[i]n real life there are presumptions, strong presumptions and almost overwhelming presumptions, but there are few, if any absolutes'. Lord Justice Balcombe felt that despite the strong predilection in favour of the preservation of life (because of the sanctity of life), there was no warrant in principle or authority for the absolute submission and Lord Justice Taylor agreed that the court's high respect for the sanctity of human life imposed a strong presumption in favour of taking all steps capable of preserving it, other than in exceptional circumstances. The problem was to define those circumstances.

The court emphasised it could never sanction steps aimed at terminating life or accelerating death 'even in a case of the most horrendous disability'. That would be quite unlawful. Lord Donaldson asserted that no right to 'impose death' existed in the courts nor in the parents. Rather, the issue was a right to choose a course of action which would fail to avert death:

> The choice is that of the patient, if of full age and capacity, the choice is that of the parents or court if, by reason of his age, the child cannot make the choice and it is a choice which must be made solely **on behalf of** the child and in what the court or parents conscientiously believe to be in his best interests. (emphasis in the original)

His Lordship took the previous decision of *Re B* to be authority for the proposition that there was a balancing exercise to be performed in assessing the course to be adopted in the best interests of the child. In effect, this meant the court could decide that it might not be in the child's best interests to live. Lord Justice Balcombe held that to 'preserve life at all costs, whatever the quality of the life to be preserved, and however distressing to the ward may be the nature of the treatment necessary to preserve life, may not be in the interests of the ward'. Indeed, the absolutist approach could in certain circumstances be 'inimical to the interests of the ward'. Lord Donaldson agreed that in the end there would be cases in which it

would not be in the child's interests to subject it to treatment which would cause increased suffering and produce no commensurate benefit, even accounting for 'the child's and mankind's desire to survive'.

Quality of Life?

It is useful at this point to note that the court was saying nothing new or necessarily objectionable here. Few, if any, ethicists including non-consequentialists in the Catholic or Protestant traditions have suggested life must be extended at all costs and at all times. Death is the common and inevitable lot of man. Of itself, it is not something that has to be avoided at all costs – simply because it cannot be avoided, and indeed for the Christian, physical death is an indispensable step on the path to ultimate salvation. Dying is therefore in one sense amoral. Bringing death about is entirely another matter.

It is a trite observation that new technologies which enable life to be prolonged in situations where death would normally be inevitable have created numerous moral dilemmas. Yet these dilemmas should not be allowed to disguise the fact that it is still wrong to intend to kill by an act or an omission. However, where death is not intended and the question of withholding or withdrawing treatment arises, it must be the case that a balancing exercise has to be performed. This is because at some point people must die, including those on life support machines and those whose lives can be prolonged but only at very great cost in terms of pain and suffering. For the dying patient the moral dilemma may be less acute than for the non-dying patient who needs invasive treatment to sustain life, but in either case there comes a point when life need not and indeed should not be unnecessarily prolonged.

If this is so, it may be logically correct to speak of life prolongation as not being in someone's 'best interests'. A balance is needed, but there is a generally accepted and crucial distinction between balancing the benefits and burdens inherent in a proposed form of treatment, whereby futile, disproportionate and unnecessary 'over-treatment' can and should be dispensed with, and balancing the benefits and burdens of a course of action by reference to a patient's existing quality of life. Although not without its problems, the former has traditionally been accepted as the ethical norm because it focuses upon the effects of the treatment on the patient and not upon the value *per se* of the person. It takes account of those cases where treatment aimed at prolonging life would only be an intolerable burden to the patient and might impede measures designed to relieve pain. Balancing the benefits and burdens of treatment in this way allows a peaceful and dignified death. The latter test, however, incorporates a value judgement based upon whether someone, if allowed to live, will have a valuable, worthwhile or socially useful life. It amounts to a very crude utilitarian idea and is anathema to the concept of the sanctity and inherent value of human life.

Bearing this excursus in mind, we return to the Court of Appeal in *Re J*. Having accepted a balancing exercise was required, what did the court find had to be balanced? The short answer, it unfortunately seems, is everything.

Lord Donaldson held that account had to be taken of the 'pain and suffering and quality of life' which the child would experience if life were prolonged, as well as the pain and suffering involved in the proposed treatment. He continued:

> The basis of the doctors' recommendations, approved by the judge, was that mechanical ventilation is itself an invasive procedure which, together with its essential accompaniments, such as the introduction of the naso-gastric tube, drips which have to be re-sited and constant blood sampling, would cause the child distress. Furthermore the procedures involve taking active measures which carry their own hazards, not only to life but in terms of causing even greater brain damage. This had to be balanced against what could possibly be achieved by the adoption of such active treatment. The chances of preserving the child's life might be improved, although even this was not certain and account had to be taken of the extremely poor quality of life at present enjoyed by the child, the fact that he had already been ventilated for exceptionally long periods, the unfavourable prognosis with or without ventilation and a recognition that if the question of re-ventilation ever arose, his situation would have deteriorated still further.

Lord Justice Balcombe also focused upon the invasive nature of the treatment and the adverse effects of placing J back on a ventilator: 'There are no half measures to intensive support and the evidence was that there is a risk that these procedures may cause significant distress to J who is thought to feel pin pricks and other forms of pain'. However, his Lordship also asserted: 'But there neither is, nor should there be, any absolute rule that, save where the ward is already terminally ill, *i.e.* dying, neither the court nor any responsible parent can approve the withholding of life-saving treatment on the basis of the quality of the ward's life'.

Lord Justice Taylor was also of the view that there had to be 'extreme cases in which the court is entitled to say: "The life which this treatment would prolong would be so cruel as to be intolerable"'. He then asked '[a]t what point in the scale of disability and suffering ought the court to hold that the best interests of the child do not require further endurance to be imposed by positive treatment to prolong life?' He felt the circumstances would have to be extreme but that the correct approach was 'for the court to judge the quality of life the child would have to endure if given the treatment and decide whether in all the circumstances such a life would be so afflicted as to be intolerable to that child'. He found that '[t]he circumstances to be considered would in appropriate cases, include the degree of existing disability and any additional suffering or aggravation of the disability which the treatment itself would superimpose'.

Lord Justice Taylor implicitly approved of the three factors he felt the trial judge had in mind when initially deciding the case:

> First, the severe lack of capacity of the child in all faculties which even without any further complication would make his existence barely sentient. Secondly, that if further mechanical ventilation were to be required, that very fact would involve the risk of deterioration in J's condition, because of further brain damage flowing from the interruption of breathing. Thirdly, all the doctors drew attention to the invasive nature of mechanical ventilation and the intensive care required to accompany it. They stressed the unpleasant and distressing nature of that treatment. To add such distress and the risk of further deterioration to an already appalling catalogue of disabilities was clearly capable in my judgement of producing a quality of life which justified the stance of the doctors and the learned judge's conclusion.

It is apparent that their Lordships either failed to make the crucial distinction between the nature of the treatment and the nature of the life or were content to allow both to be considered. They evidently viewed as significant firstly, the invasive and burdensome effects of ventilation, secondly, the ensuing quality of J's life if that treatment were imposed and thirdly, the quality of J's life *per se*.

It is true that a nice distinction between the effects of a treatment and the patient's quality of life cannot always be made and that the first two considerations above may merge. 'Quality of life' can mean all things to all men. In one sense any decision that entails a balancing of effects will involve some kind of qualitative decision. How much pain, suffering and needless burden will be placed upon someone by a procedure is in one respect assessing what that person's quality of life will be if treatment is given or withheld. As Lord Donaldson himself noted in *Re C*, treatment decisions cannot be made without reference to the individual patient; 'You do not treat a blind child as if she was sighted, or one with a diseased heart as if she was wholly fit'. [at p.255]

However, there is little doubt, especially from the speech of Lord Justice Taylor, that the court was going further than this. It found the patient's actual and existing quality of life had a direct bearing on the issue. If the court was saying (which in part it appears to have been) that if a child's life is simply not worth living it need not be prolonged, then it is highly regrettable.

Yet the court did not leave it there, for the majority suggested any undesirable effects would be mitigated by the adoption of a new subjective test.

Substituted Judgement

Lord Donaldson cited with approval a statement made by Mr Justice McKenzie in the Supreme Court of British Colombia: 'I do not think that it lies within the prerogative of any parent or of this court to look down upon a disadvantaged person and judge the quality of that person's life to be so low as not to be deserving of continuance'.[4] The court in that case was not enunciating a principle which prevented the withdrawal of treatment; on the contrary, it was suggesting the means by which such a decision should be made. Justice McKenzie preferred the 'subjective' approach adopted in a previous New York decision:

> [t]he court must decide what its ward would choose, if he were in a position to make a sound judgement. [T]he decision can only be made in the context of the disabled person viewing the worthwhileness or otherwise of his life in its own context as a disabled person.[5]

Lord Donaldson explained that this subjective formulation took account of the sanctity of human value and underlined the need to look at the problem from the assumed point of view of the patient rather than that of the decider. It gave effect 'to the fact that even very severely handicapped people find a quality of life rewarding which to the unhandicapped may seem manifestly intolerable'. Lord Justice Taylor agreed the test took account 'of the strong instinct to preserve one's life even in circumstances which an outsider, not himself at risk of death, might consider unacceptable'.

The substituted judgement test originated in the United States, and was most notably employed in the celebrated Karen Quinlen case.[6] Mr Justice Garibaldi in the New Jersey Supreme Court has explained it thus:

> [Substituted judgement] is intended to ensure that the surrogate decision-maker effectuates as much as possible the decision that the incompetent patient would make if he or she were competent. Under the substituted judgement doctrine, where an incompetent's wishes are not clearly expressed, a surrogate considers the patient's personal value system for guidance. The surrogate considers the patient's prior statements about and reactions to medical issues, and all the facets of the patient's personality that the surrogate is familiar with – with, of course, particular reference to his or her relevant philosophical, theological and ethical values – in order to extrapolate what course of medical treatment the patient would choose.[7]

Not all US courts have approved of the subjective test. Some have combined it with other, more objective tests,[8] while others have rejected its application altogether.[9]

A Suitable Test?

The subjective test assumes and indeed finds justification in the idea that a patient has a right to self-determination and can himself choose whether or not to be treated. If a competent patient has such a right, so the argument runs, an incompetent patient should not be deprived of it merely because of his physical condition. The patient's autonomy should be recognised and respected by proxy decision makers, who, insofar as is possible, should act according to that patient's assumed wishes.

There are some considerable difficulties with this logic especially in the English legal setting. In contrast to their American counterparts, the English courts have been reluctant to acknowledge a patient's right to self-determination (especially in the area of informed consent10). Yet entrenched in English common law is the principle that property and persons must be protected from unwarranted and uninvited interference. The law accordingly recognises a patient's indisputable right to refuse medical treatment and will punish a doctor (both civilly and criminally) who treats a competent patient without that patient's consent. To this extent therefore, the law in England does recognise a patient's bodily integrity and autonomy, even if it results in a patient's self-neglect or death.[11]

As stressed by Lord Justice Balcombe in *Re J*, the English courts have always resolved wardship cases without reference to the ward's or anybody else's wishes and have focused exclusively upon the well-being and welfare of the ward.[12] The majority in *Re J* departed from this principle to the extent that the assumed wishes of the ward could be considered and not solely the child's objectively assessed best interests. Wardship is overtly paternalistic. In contrast, the subjective test tries to avoid the imposition of another's standards but in doing so introduces an element of artificiality. How can a proxy decision-maker such as a court (composed of learned, able bodied, intelligent adults) in practice assume the point of view of a severely handicapped infant patient? It can only imagine what it is like to be such a patient and speculate as to his wishes. But this mental process will be tainted and influenced by the actual standards and peculiarities of the proxy decision-maker. Therefore, whether the subjective test will in practice serve to prevent the imposition of the proxy's standards is questionable. The test may nevertheless give greater recognition to the fact that the disabled can and do live meaningful, fulfilling lives which are of value in themselves, notwithstanding their relative lack of ability in comparison to the able bodied.

More problematic still is the fact that Re *J* was not concerned with a once competent patient such as an accident victim in a coma, but with a severely handicapped patient who wasn't, and at no point had been, capable of making decisions for himself, not least those affecting his own treatment. One might seriously question (as others have already done in the American context)[13] whether the substituted judgement test is really appropriate for patients who have never been competent. In these cases the patient cannot decide anything and moreover is not inherently capable of deciding anything. The court must therefore presumably not only ask 'what would the patient decide is he were able to', but 'what would he decide if he had the ability to decide and were able to'. This belies the fact that if he were so able, he would not by definition be in the condition he is actually in and would in effect be making the relative judgement the test is attempting to avoid. So despite Lord Donaldson's assertion in *Re J* that the starting point is not what might have been but what is, to make any sense of the subjective approach, we must ask precisely what might have been and not what is. As one American court has held, it is like asking 'If it snowed all summer, would it then be winter?'[14]

Conclusion

Whether *Re J* sets a precedent for the treatment of other incompetent patients is uncertain. The subjective test, if it is to be applied at all, is surely better suited to those cases in which the patient was at some point capable of making a decision for himself and where the court can adduce from evidence what the patient's wishes were or would be. Yet whatever the means by which decisions are made, the law will be treading a dangerous path if it allows a patient's existing quality of life to be taken into consideration when deciding if life-saving treatment should be withheld. Far from the Court of Appeal clarifying the law and ethics, its introduction of some inappropriate and potentially dangerous ideas can serve only to augment the not inconsiderable confusion which already exists in this area.

Footnotes

[1] Extracts taken from Lexis transcript (Dec. 1990). See also *The Times* 23 October 1990; 140 *New Law Journal* (1990)1533.
[2] [1981] 1 WLR 1421
[3] [1989] 2 ALL ER 782
[4] *Re SD* [1983] 3 WWR 597
[5] *Re Weberlist* 360 NYS 2d 783 (1974)
[6] *Re Quinlan* 355 A 2d 647 (1976); see also *Superintendent of Belchertown v Saikewicz* 370 NE 2d 417 (1976)
[7] *Re Jobes* 529 A 2d 434 (1987)
[8] *Re Conroy* 486 A 2d 1209 (1985)
[9] *Re John Storar* 420 NE 2d 64 (1981)
[10] Compare *Cantebury v Spence* 464 F 2d 772 (1972) and *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871
[11] See I. Kennedy 'The Legal Effect of Requests by the Terminally ill and Aged not to receive further Treatment from Doctors' [1976] *Criminal Law Review* 217
[12] Wardship is part of the old prerogative jurisdiction of *parens patriae* whereby the Crown (now in the form of the High Court) has the power and responsibility to protect the persons and property of those unable to look after themselves. The *parens patriae* jurisdiction in England does not now extend to adults of unsound mind and is confined to minors under the age of eighteen (*F v West Berkshire Health Authority* [1989] 2 ALL ER 545). In contrast, the courts in the United States face no such restriction and have therefore been able to make decisions for adult incompetents.
[13] Beauchamp and Childress *Principles of Biomedical Ethics* (1989) 172
[14] *Re John Storar* 420 NE 2d 64 (1981)

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For further information contact Mr. Williams at: Center for Bioethics, Clinical Research Institute of Montreal, 110 Pine Ave. West, Montreal, QC, CANADA H2W 1R7. (514 987 5620: FAX 514 987 5695)

FORUM

Two responses to 'Rescuing the Innocent' *Ethics and Medicine* 5:3

From G.T.G. Gardner, General Practitioner, Birmingham, England.

There are various points in Denis Haack's essay 'Rescuing the Innocent' which need to be addressed. Summarising his position he states: 'There is neither biblical principle nor precedent to stop a legal action in order to obey God's moral imperative' (p.44). In another place he writes, 'God has not given the sword of coercion to the individual or the church but to the state. It is horrible when the state uses that authority unjustly, but when this happens, the church and individuals do not have biblical warrant to pick up the state's coercive power for themselves.' (p.44).

Among various passages he uses to support his argument is Romans chapter 13 verses 1–7. It must not be assumed, however, that this represents Paul's complete view on the authority of the state. In 1 Corinthians 6:1–6, a passage which counterbalances Romans 13, Paul sees church-state relations in quite a different light. Here, the church is described as a radical challenge to the accepted standards of the judicial system and is in Christ its ultimate judge.

Mr Haack maintains that two types of unjust law are possible (p.44): either a command to do wrong or permission to do wrong. This is not the view of sin which Jesus takes in Matthew 25:31–46. Here, he makes it clear that judgement is passed for sins of omission as well as for sins of commission; for the good that is not done as well as for the evil that is done. This is a vital point because it follows that an unjust law or an unjust application of the law may be the forbidding to do good as well as the command or permission to do evil. 'Anyone then who knows the good he ought to do and doesn't do it, sins.'

It is important to understand the state's function as explained in Romans 13 and 1 Peter 2: 13–17. The restraining of evil and the punishment of wrongdoers are the proper duties of the state; that is, law makers and law enforcers. The state has this authority delegated to it by God and is responsible to God for its proper exercise. The state is not autonomous. It has authority because it is under authority (*c.f.* Luke 7:8). Jesus made this point very clear to Pilate during his own trial.

In Samuel Rutherford's classic work, *The Law and the Prince,* published in 1644, he argues that since the civil law is based on God's higher law, when the king (state) disobeys God's higher law the state has to be disobeyed. Rutherford believed that the Christian has a moral obligation to resist unjust laws and not to do so was to dishonour God. Schaeffer explains this succinctly: 'The civil government, as all of life stands under the law of God. The state is to be an agent of justice, to restrain evil by punishing the wrongdoer and to protect the good in society. When it does the reverse, it has no proper authority'.

Denis Haack's assertion, 'God has not given the sword of coercion to the individual or the church but the state' is true only as long as that sword of coercion is used justly. Once the state uses the sword of coercion in a persistently unjust way, then it is necessary to resist this injustice even if that means breaking the law. This may even involve the use of force in a fallen world, though there must be a legitimate basis for this force. Neither must it be confused with violence. If there is no final place for civil disobedience including the use of coercion, then the state becomes autonomous and usurps the place of God. This attitude denies the force of biblical commands such as 'Defend the cause of the weak and fatherless, rescue the weak and the needy.'

Mr Haack states correctly on page 43 that when a citizen acts to stop a murder, he acts as an agent of the state but then goes on to suggest that it is wrong to break civil laws to stop forms of murder, such as abortion, that are sanctioned by the state. This is disastrous thinking because taken to its logical conclusion it would mean that an individual would never be justified in intervening to stop infanticide, the killing of the handicapped or the infirm if all these were approved by the state. This kind of thinking makes the state autonomous and is not in accordance with the teaching in Romans 13 that the state is God's servant.

Mr Haack also tries to argue that the ethics of civil disobedience adopted by the rescue movement would diminish law and order in society by undermining respect for authority. I do not believe that this would happen for several reasons.

Rescues promote law and order on a number of levels: firstly a respect for God's law, which is the foundation of justice and therefore of law and order, is promoted. Without this foundation in society, lawlessness increases; a phenomenon which we see happening year by year. Support for the rescue movement has been expressed in private both by magistrates and police officers in the realisation that the rescue movement is attempting a task that the police and courts themselves should be doing.

The exposure of the law's failure to protect the weak and defenceless is critical to restoring justice and thereafter law and order based on this foundation. Strictly speaking, sit-ins are not acts of civil disobedience where the defence of necessity is invoked. This is well stated by George Grant in one of his several admirable books. He argues that this common law defence of the unborn ought to be used more frequently as a way of speaking prophetically to the courts, serving them and helping to guide and guard them. In no way can this be construed as detrimental to law and order. Quite the reverse.

Secondly, the power of the state to crush the weak and helpless is directly opposed. This must be done to stop the inexorable drift towards infanticide and euthanasia and resist the state's increasing tendency to disregard its responsibilities to God to protect the weak and helpless.

Thirdly, the cycle of violence against the pre-born is broken as violence against the children and their mothers is transferred to Christians who are willing to suffer without retaliation. This is an important part of the church's repentance for its own guilt in the abortion holocaust, the participation in which the church has not yet fully acknowledged its own enormous complicity.

Fourthly, the evil practice of abortion is more properly confronted in accordance with Ezekiel 16:2. Abortion is carried out under a cloak of respectability and its acceptability has become ingrained into the medical profession and the general culture. There are huge numbers of illegal abortions but no action is ever taken. Exposing the practitioners of these crimes is a necessary part of restoring law and order in society.

Rescues also function to augment other pro-life work. The experience in Atlanta after the July 1988 rescues was that the number of women attending crisis pregnancy centres within a one hundred mile radius rose considerably with a corresponding fall in the number of women seeking abortions. This remained the case even a year later.

The political spin-offs in the U.S. have already been considerable. In Britain this has yet to happen and Mr Haack's point that, 'the manner in which the movement is portrayed to society is crucial in determining the response that it engenders,' is something that the rescue movement in Britain needs to take to heart. This does not in any way affect the underlying principles.

In summary, Mr Haack's main arguments against rescues are untenable because they are illogical. Any prohibition against rescuing pre-born children from death through breaking civil law would also apply should it become 'legal' to kill other groups of defenceless people. This would actually increase lawlessness and evil and indeed there is a historical precedent in the events of Nazi Germany. It is not enough to merely declare that abortion is murder. Part of the defence of the unborn, besides all other pro-life work, must be direct, peaceful intervention between them and their medical assailants. The strategies can be debated endlessly, but the principle is biblical. Samuel Rutherford in 1644 stood against the deification of the state: so should we today. Parliament is not God and has no right to deprive the weakest members of society the full protection of the law. Rescues are a vital way of preaching these truths to a society whose very foundations are now crumbling.

Notes

1. James 4:7
2. Francis Schaeffer: *A Christian Manifesto* (Pickering and Inglis, 1982) p.90.
3. *Ibid.* p.91.
4. *Ibid.* p.107.
5. Psalm 82:3,4
6. George Grant: *Grand Illusions: The Legacy of Planned Parenthood.* (Wolgemuth and Hyatt, Brentwood, Tennessee 1988), p.254.
7. Joseph Foreman: What is Rescue? (*The Advocate*, Dec. 1989), p.19. Advocates for Life, Portland, Oregon.

From James Morrow, Braemar, Aberdeenshire, Scotland

Mr Denis D. Haack, writing in *Ethics and Medicine* No. 5.3,1989, reviews the Biblical parallels to the activities of Operation Rescue as found in the talks and writings of organiser Randall Terry, and maintains that the parallels are not parallel enough. I prescind from the validity of this conclusion and simply wish to point out that it is a pity that Mr Haack does not appear to have been able to find any reference to Matt. 22:37-40, in Mr Terry's works, for there certainly is real scriptural basis for what Randall and other rescuers do. 'You shall love the Lord your God with all your heart, and with all your soul, and with all your mind. This is the great and first commandment. And a second is like it, You shall love your neighbour as yourself.'

Unborn children are our neighbours like everyone else, and they are to be loved like everyone else, with a love which is real and practical as exemplified by the Good Samaritan. The correct response to love for the neighbour we can see is at times dangerous and self-sacrificing. It can extend to the greatest expression of love of all, giving our life for our friend. We would gladly interpose ourselves between an assassin and our wife or husband or live-born child, and must be willing to do the same for any unborn child.

In our day civil governments are attempting to repeal the universal law of charity. With their abortion laws and constitutions they are attempting to say that we are not allowed to love all our neighbours as ourselves: certainly there must be no effective expression of our love in the case of certain unborn. When those are threatened we must pass by on the other side. Even when civil government candidly refuses to do its duty Christians must not presume to supply the gross deficiency. Mr Haack does not of course defend the neglect by the civil government, but he does enunciate the novel principle that in defending the unborn 'thou shalt not coerce'. He argues that coercion belongs to the civil power uniquely, and cannot be assumed by the private citizen, not even when the civil power is in gross neglect of solemn duty, and when minimum coercion may save a life.

The reply to this is very simple. The principle is nonsense. Where does Mr Haack get it from? The burden of proof lies on him to defend it, and I submit that he will never be able to do so. Until therefore Mr Haack supplies proof that the minimum of coercion represented by standing, arms linked, in the doorways of Auschwitz to prevent Jews, or unborn children, from getting through, is intrinsically evil, or an expression of love in defiance of right reason or the revealed law of God, Mr Haack can be safely ignored, and the babies afforded the protection which has saved at least some of their brothers and sisters.

Ethics & Medicine welcomes correspondence and items of news for publication in this Forum section.

Death and the Beginning of Life

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We are pleased to present this chapter from Dr Iglesias' new book, IVF and Justice, *Linacre Centre, London, 1990; £9.75, ISBN 0 906561 07 8, by kind permission.*

I. The controversy concerning criteria for 'being dead' and for 'being alive'

1. The viewpoint defended in the following passage by Peter Singer and Deane Wells is a common one in current debate:
The internationally recognised criterion for the permissibility of using vital parts of another human body is brain death. Total brain death, the complete absence of all brain functions, indicates that the heart, the kidneys and pancreas, and other organs may be removed for transplant purposes. If the medical profession (and indeed the Churches) recognise a body's lack of a functional brain as sufficient ground for declaring that there is no living person existing in that body, and the body may therefore be used as a means to worthwhile ends, then why not use *the same criterion at the other end of existence*? We suggest that the embryo be regarded as a thing, rather than a person, until the point at which there is some brain function. Brain function could not occur before the end of the sixth week after conception; it may eventually be shown that it does not occur until quite some time after.[1] (my emphasis)

2. The question 'Why not use the same criterion for determining the beginning and the end of existence?' is the central question in this paper. It indicates that our consideration of the coming-into existence (the beginning-to-live) of the human being, and his or her going-out-of-existence (ceasing-to-live) refer to the same kind of entity. Thus, the questions of what it is for a human being to be dead and what it is for him or her to be alive are inseparable from each other. For we know what it must be for someone to be dead only if we know what it is for him to be alive; to declare someone dead is precisely to recognise and declare that he has ceased to be alive. Currently, physicians accept that the presence of certain criteria of brain death permit a legitimate diagnosis and determination of death of the whole person. Obviously those criteria must be related to what counts as death for them, that is, to their conception of death, what they take death to be. Criteria which are unrelated to or detached from what they are supposed to be criteria of – the death of a patient – cannot be acceptable. It follows that a commitment to certain criteria for determining death is also a commitment to a particular conception of death. By implication this same commitment must, then, involve a commitment to a conception of what it is for a patient to be alive – so that when he ceases to be alive he is then declared dead. No double standard can possibly apply in the two intrinsically-related situations: the life and death of one and the same human being.

3. A recent publication, *Death: Beyond Whole-Brain Criteria* (ed. R.M. Zaner, 1988), resulting from a symposium held in the United States on the topic 'When are you dead?', presents the following point of view:

> At one stage of this debate, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research recommended a uniform definition of death focused on the cessation of all brain functions, including those of the brain stem. Philosophical, ethical and practical issues provoked by individuals who have permanently lost consciousness, but whose brain stem still functions, demonstrate the impossibility of that recommendation, the contributors to this volume argue: their essays thus provide the basis for further critical examination of what it means to cease to be a person in the light of continual new developments in our biomedical understanding of the human brain. As it is now possible to sustain organic bodies which will never again house a conscious person, the contributors to this volume urge that it is necessary to reexamine what it means to be a person alive or dead in this world, and thus reexamine the basis for public policy.[2]

4. The concept of someone's being alive which is implied in the Singer-Zaner position – a position shared by many other authors – is relative to a particular conception of the human person. For Singer and Zaner, the human person is to be distinguished from the human being, that is, from the living organic body: human personal existence is different from human bodily existence. For, as they put it, a living human body may 'never again house a conscious person'. A living human organism, that is, a body whose brain stem still functions, may nevertheless be damaged in such a way that consciousness is permanently lost, and as far as our understanding of the brain goes, it can never be recovered again. In this situation the living bodily being, according to the doctrine of this school, is not a human person any more. That one is a human being, a living bodily being of human species, does not necessarily imply that one is a person, 'a citizen' (to put it in more practical terms) entitled to the respect and to the natural and legal rights which pertain to persons. To be alive, according to Singer and Zaner, can only mean 'to be alive as a person' (in their sense of 'person'); hence to be dead equally means 'to be dead as a person' (in that same sense). The distinction made by these authors between 'the living body' and 'the living person' is based on an *a priori* determination of what is valuable in human existence, or what is 'essential to human existence'[3]. On this view, what is valuable in human beings is not their human bodily existence (let me call it their 'human nature') but their cognitive existence (their 'rational nature'), and for these authors human nature and rational nature are not the same thing. 'Rational nature' is absent if the capacity for ratio-cination is absent because the brain is non-functional; and this may be due to the stage of embryonic development reached so far, or to a brain deficiency, disease or injury. In other words, the statement that someone is alive can be made truly if and only if that someone fulfils the necessary and sufficient conditions, established *a priori*, for an entity to have 'personal identity' and so to fall under the concept of a person, to count as a person and to be treated as one. Thus, 'being alive' and 'being dead' do not count as natural events which are universally discernible.

5. There is no need to stress that this particular conception of person (which in fact does not refer to beings of a general class or species, of a 'natural kind' such as the human kind) would be prior to the criteria of death and life. The authors defending these views wish to bring it about that their concept of person, and the criteria for determining life and death which are bound up with this concept, are accepted in medical and legal contexts. So far this proposal has been widely rejected. What will be said in this paper will disclose some of the fundamental reasons for this rejection.

6. In what follows I intend to consider the criteria actually used in clinical practice, that is, in 'official medicine', for determining death, considered as brain death. This will enable us to see the relationship that there is between, on the one hand, this concept of death and the criteria for determining it, and, on the other, the criteria determining the beginning of life. By contrast with the Singer-Zaner position, my exercise will show that the clinically accepted criteria for determining brain death offer good grounds for holding that human bodily existence (human nature) and human bodily death are the existence and death of *someone*, of a human subject. Hence neither the adult living human bodily being whose brain functioning is defective, nor the living human embryonic being, should be regarded as a thing that can be disposed of, but must be considered a human subject, a 'someone' to be treated with the respect due to the human subject. Let me advance here a formulation of the central contention of this chapter, which will be substantiated by the body of evidence to be provided. *The medical profession, which has the responsibility for officially declaring that someone is dead, is and has always been of the view that a patient is, without qualification, the living human bodily being, that is, 'the human living organism as a whole', and its practice has always been in accordance with this view. Furthermore, knowledge gained recently, which permits us to understand death as brain death, confirms this conviction and the corresponding medical practice.*

7. From the outset it must be stated that in spite of the common talk about brain death as 'the internationally recognised criterion' for permitting the use of vital organs for transplantation, strictly speaking, from a legal point of view, there is no international recognition as yet of the fact that 'brain death is death'. Further, there is no such thing as an internationally recognised criterion for determining that brain death has taken place. Medical standards also vary from country to country. In the USA a large majority of states (46 in 1988) have legal statutes recognising that brain death is death, but other states do not accept this view; so a person might be considered dead in one state but not in another. In 1981 the President's Commission which studies these issues produced a report, *Defining Death*, which sought to reach a uniform determination of death. Similar attempts (legal and medical) have been made in European countries as well.[5] There are international efforts within the medical profession to come to an agreed non-arbitrary standard for the declaration of brain death as an event identifiable with death. Such a universal standard would indeed be desirable, for most of us would share Professor I. M. Kennedy's misgivings when he says that it would be 'in no way inspiring of confidence in one's doctor to learn that there are two types of death'.[6] There is no doubt that there should be a medical answer to the question, 'Is this patient dead?' – an answer 'based on medically defined, clearly formulated and well publicised criteria', as has been rightly demanded.[7]

8. Although I am aware that there is not as yet a universally adopted criterion for determining brain death (and hence that there is not yet any universal understanding and agreement as to what constitutes brain death), I need to base my own considerations here on a particular understanding of 'brain death'. There are three main views of what 'brain death' may mean. The first is the 'neocortical view of death',[8] according to which, when the higher brain functions, the neocortical functions, are irreversibly lost, the upper brain is dead and so the patient as a person is dead, even if the brain stem is still functioning. This is the Singer-Zaner view mentioned above. The second is represented by the US Uniform Determination of Death Act (UDDA), which states:

> An individual who has sustained either (i) irreversible cessation of circulatory and respiratory functions, or (ii) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.[9]

The third view is exemplified by the 'Memorandum on the Diagnosis of Death', adopted in the United Kingdom by Medical Royal Colleges and Faculties in 1979,[10] and also by the 'Memorandum on Brain Death' adopted in Ireland in 1988.[11] In these memoranda it is maintained that death has been established when all functions of the brain have permanently and irreversibly ceased. Recent medical developments have confirmed that the necessary and sufficient condition for the ending of all functions of the brain, that is, for whole-brain death, is the death of the brain stem.[12] In other words, if the brain stem is diagnosed as totally and truly dead, then the whole brain must be considered dead, and so the patient may be declared dead. Dr Christopher Pallis, neurologist at the Royal Postgraduate Medical School in London, who has greatly contributed to the understanding of brain-stem death, has stated:

> If the brain stem is dead, the brain as a whole cannot function, and if the brain has permanently lost the ability to function, the individual is dead.[13]

9. There has been controversy in British and Irish circles as to whether the tests used for the diagnosis of brain-stem death are fully adequate to establish that the brain stem is indeed irreversibly dead,[14] and whether the present identification of death as brain-stem death is adequate. The controversy still continues. But the fact of this controversy does not affect my central claim. For the British-Irish position and the American position are agreed on one point, namely, that *ultimately* the death of the whole brain means the death of the patient; the difference between the two positions is a matter of the different ways in which they understand the relation between death of the brain stem and death of the whole brain. I therefore assume in this discussion that 'brain death' is not to be defined as 'neocortical brain death' (or higher-brain death), that death does not ultimately mean 'the death of the brain', but rather 'the death of a human being, as determined by an examination of brain functioning' which establishes that the brain is dead.[15] I therefore disregard the controversy as to whether the process of determining that brain death has occurred is adequately carried out by the medical means which are used at present in diagnosing brain-stem death. For convenience's sake, I shall refer to the view adopted here as the Anglo-American 'total brain death' conception (abbreviated TBD). The discussion which follows will be divided into three parts. In the first part I shall describe the fundamental aspects of the medical understanding of TBD. Then I shall discuss some of the basic philosophical concepts on which this understanding rests. Finally, I shall draw

conclusions which derive from such a position concerning the beginning of life of the human being, so that no double standards or criteria are applied for determining the coming-into-existence and for the going-out-of-existence of one and the same being.

II. 'Brain Death' as the basic criterion for death: physiological facts

10. The following two theses are the most basic constitutive tenets of TBD, the Anglo-American position as regards brain death:

(a) Brain death is the death of the living human organism as a whole;

(b) The death of the living human organism as a whole is the death of the patient, the death of a human subject.

Both in the American and in the British context it has been emphasised that the absence of 'functions' in the brain must not be confused with the occurrence of

> activity in cells or groups of cells...(metabolical, electrical, etc.) [which] is not manifested in some way that has significance for the organism as a whole.[16]

Dr Christopher Pallis has written:

> The irreversible cessation of heart beat [blood circulation] and respiration implies *death* of the patient as a whole. It does not necessarily imply immediate death of every cell in the body...
>
> The irreversible cessation of brain stem function implies death of the brain as a whole. It does not necessarily imply immediate death of every cell in the brain.[17]
>
> Death...is the dissolution of the organism as a whole.[18]

The truth of statements (a) and (b) depends on certain physiological facts as well as on a key concept, that of the organism as a whole, which underlies the understanding of TBD. Unless that concept is truly applicable to the human organism, the view that the death of a patient's brain is the death of the patient himself would not be justified.

The medical profession has always established death on physiological grounds, in basically the same manner as we all do in diagnosing the deaths of our pet animals. The traditional criteria for determining death, which for the majority of people is readily diagnosed at the bedside, are the cessation of the functioning of heart and lung, that is, cessation of blood circulation and of spontaneous breathing, together with the other known signs which accompany the cessation of these functions. This is so because we take circulatory and respiratory functions to be necessary for human life. Let me call this the traditional view of what the diagnosis of death consists in. In recent decades, certain machines (in particular the medical respirator) have been developed to assist or take over these functions of respiration and blood circulation by causing oxygen to flow in to the lungs of the patient and by pumping blood through his body. In this context a question arises: Does the presence of ventilation and cardiac action induced by a machine always indicate the presence of a living human being? Does the existence of these functions always indicate that the patient is alive? The answer is in the negative, because the origin of these functions may be totally artificial, *i.e.*, machine-produced, so that they are not the result of any brain operations in the human subject. (I assume here that this is what actually occurs when clinicians tell us that a human corpse is ventilated and that the heart beats and the blood flows). Naturally, if there is persistent spontaneous cardiopulmonary activity in (*e.g.*) a comatose patient, that is sufficient for concluding that a human life remains, that the patient is still alive. (Issues concerning the correct mode of medical treatment and care for patients in a coma or in a vegetative state should not be confused with issues concerning the determination of death.) It is important to note that a patient may be in a vegetative state (that is, maintaining spontaneous breathing but with no self-consciousness) for long periods of time: Karen Quinlan, for example, was in that state for over ten years. As regards the vegetative state, Dr Pallis claims that 'no authoritative medical or legal body has, to my knowledge, ever defined the vegetative state as death', and that 'no culture has ever considered patients in the vegetative state as dead, or as suitable subjects for organ donation'.[19] As far as clinical practice and clinical judgement are concerned, a spontaneously breathing human being is a living person, a patient. Modern physiological studies have made it clear that if breathing persists the brain is not dead, because the brain stem is alive. In the past, and for the majority of people today, including doctors, a 'breathing human body' is a living human being, a living person . (It is generally *philosophers* who hold to the neocortical definition of death, and those who follow their views, who disagree with this position.)

11. More accurate knowledge of physiology has enabled us to establish also that when the brain has ceased to function, the unity and integration of vital functions have irreversibly broken down. It can then be said that there is no living organism, no unified life, no living human being. We are told that it is now possible to maintain artificially a group of bodily subsystems in a disintegrated, non-unified dead body.[20] However, this does not bring the traditional view of death, understood as the cessation of cardiopulmonary functions, into opposition with the total-brain-death view.[21] For the latter view recognises that the vital organs – heart, lungs and brain – have a special significance in maintaining the integrated, unified functioning of the organism as a whole. Other organs like the kidneys or the skin do not have this significance. In the former set of organs the 'interrelationship is very close and the irreversible cessation of any one very quickly stops the other two'.[22] It is known that if the brain is deprived of blood flow (and so of oxygenation) for 10 to 15 minutes it will completely cease to function, including the brain stem. Even if circulation is only partially impaired, loss of function of some of the brain neurons will occur.

12. Advances in medical knowledge, accompanied by current techniques, have enabled us to realise more clearly than ever before that human death is, and has always been, brain death. This is a real development in our understanding of the physiological nature of death which permits us to establish proper criteria for determining and declaring death. The clinical as well as the common-sense understanding of death as *death of the living being*, that is, *death of the human organism as a whole*, is seen to be a common element in both the traditional and the more recent approach to thinking about death. It is clear that biological criteria , that is, bodily organic criteria, have traditionally been ultimately decisive for determining death. Seen in this light, the TBD position does not contradict, but rather complements, develops and further clarifies the traditional position as regards the determination of death for a human individual. Both positions maintain that the death of the patient is the death of his living organism: it is his organic death. Hence to be a living human organism is the necessary and sufficient condition for being a living patient, a living human being, a human subject.

13. We may ask the question: What or who is it that is declared dead when a human brain is said to be dead? In the light of what has been said, the answer obviously is that what is dead is, in general terms, 'the living being', and in human terms, 'the living human organism', which we may also take to mean 'a patient', 'a human subject'. When death is declared, the living organism is said to have ceased to be alive (as an 'independent biological unit', to use Dr Pallis's term). Here the view of the medical profession is in line with that of ordinary common sense, because if the human organism is found to be dead, what is really dead is the patient, the human subject. This is what the written death certificate informs us about. This fact is something which may appear too obvious to be worth mentioning, and yet it may not be sufficiently acknowledged that the patient in medical practice is rightly taken to be identical with his living organism. In other words, the death of the patient, for all legal, medical, familial and other human purposes, is his organic death, his biological death. It is clear, then, that the criteria related to such a concept of death as organic death must be organic criteria, physical criteria. According to current clinical thinking and practice, these are the criteria which guide and are used in the implementation of appropriate clinical tests which show that the brain is dead.

14. When we talk about the death of a patient, we cannot but talk of the patient *as a whole*. Every doctor knows (as we all do) that when the living organism of the patient dies it is the patient himself who dies; he therefore recognises a fundamental truth concerning the human condition, namely that every human being is a bodily being, an organic being. If the organic being dies the human subject dies. This view does not imply that a patient is nothing but his organic make-up, but it certainly does imply that the patient *is* indeed his organism. And this is what is fundamental for the determination of his death. The medical profession has not, does not and should not treat patients as other than bodily beings; they are of a very specific nature, a human and rational nature, but human rational beings are bodily beings after all.

15. The fact that death is organic death, bodily death, is of universal significance: it applies, that is, to every human being. Every human being, of every culture and nation, can appreciate this mode of understanding death. Our bodily condition is a universal human feature which we all share. We all share *humanity*. If doctors are to act as doctors, in whatever part of the globe they may exercise their skill, they have to be concerned with human subjects as bodily beings. Their understanding of what it is to be dead or to be alive cannot vary according to the modes of thought fashionable in a particular society which may be unduly influenced by a particular school of thought involving some restricted account of what counts as a person. If patients were to be forced to recognise radically different concepts of death, they would have to accept the existence of at least two types of death, and perhaps even more. (Obviously, if there is more than one way of being alive, there must be more than one way of being dead.) The universal significance of death demands that the same term 'death' should refer to the same physical conditions. Death is a natural event which we are called upon to recognise, both in human beings and in other animals; it cannot be described in terms which ignore its natural reality.

III. Philosophical considerations:

(i) 'The organism as a whole'

16. When we talk about the human being, and about his death, we typically use such terms as 'living organism', 'an individual', 'an independent biological unit', 'the organism as a whole', *etc*. We could also, of course, use those expressions if we were talking about (say) a dog. This is so because these modes of expression involve a commitment to a fundamental biological truth concerning living beings in general, namely, that they are living organisms, and that living organisms are living wholes, units of life, and not mere conglomerations of parts. Their true identity is constituted, and must be understood, as the existence of a living organic totality, a living being that is a living whole. We could not accept either the traditional or the brain-death criterion of death as organic death without also accepting that the living being is a living organic whole. We enter now into the consideration of basic philosophical concepts which are presupposed in every understanding of what it is to be alive or dead. The truth about the wholeness of living beings is a non-scientific truth which nevertheless grounds the physiological (scientific) understanding of the nature of living beings. This concept of organic wholeness or of the organism as a whole is central to the TBD understanding of brain death as death.

17. The idea of wholeness could be understood in two different ways;[23] let me call them the quantitative and the qualitative modes of understanding. Death could be regarded either as the dissolution of *the whole organism*, or alternatively, as the dissolution of *the organism considered as a whole*. The first way of viewing death is the quantitative conception, and it involves identifying death with the dissolution of all the individual parts of the body – that is, of all the cells of the organism. Clearly this is not the criterion actually used for the declaration that someone is dead: a decapitated person, for example, is considered to be dead as soon as his head has been severed, even if the heart continues beating for a short time. It is not necessary that all the cells of an organism be dead for the organism itself – the organism as a whole – to be dead. What *is* required for death is that the functional unity of the organism be destroyed. In any case, it could happen that many of the cells of an organism, and even some of its organs, would be dead while the organism itself, as a whole, remained alive. The term 'wholeness', in the sense being employed here, the qualitative sense, refers to the unity and integration of the organism, to its overall oneness of function, and not to the working of each individual cell and cell part.

18. We could not claim that an organism dies as a whole if it were not, before death, a single living being. It is therefore of great importance to appreciate the biological and philosophical implications of regarding living organic beings as organic wholes. The living organism manifests itself as a single whole by its unified organic constitution (its oneness of bodily form) and by its powers (its unified activity). The living organism is self-growing, self-organising, self-preserving, self-fulfilling, self-healing. We observe living organisms coming into being as living wholes and moving and functioning as wholes; we see that they grow and develop as wholes, relate to other living beings as wholes and eventually die as wholes. They are organic wholes endowed with the powers of self-movement and self-development. Admittedly, their bodies are constituted by parts which are heterogeneous; but the different parts of the whole being (cells and organs) develop in harmony and proportion with each other, and they manifest at every stage the unified organic activity of the whole.

19. The unity and power of the whole determines, and is prior to, the form and functioning of the parts. The whole produces all its parts

for self-maintenance at every stage of its existence, tending towards its own maturity. The whole has priority over the parts. This is what constitutes the difference between the order of living organic wholes and the order of non-living, inorganic ones. As Auguste Comte says, it is 'the passage from an order in which parts precondition the whole to an order in which the whole shapes the parts, and, in a sense, precedes them'.[24] The parts of a living being, then, are there in view of the whole. The activity and constitution of the parts can be understood only in terms of the whole. An analogy with machines may help us to appreciate this point better. The parts of which machines are composed are quite different from those of which living organisms are composed: machine parts are homogeneous in structure, and machines cannot substitute one part for another in case of failure, cannot regenerate or heal themselves and do not produce the energy that moves them. These differences between living organisms and machines are manifestations of the radical difference in kind between them as regards their wholeness. The machine is constructed, organised, assembled, from parts to whole. The living organism forms itself as a whole being; it moves and organises itself towards a state in which it is a mature specimen of its kind. In the living being the whole which is coming into being itself governs the formation of the parts. The living being is the dynamic law of its own development; the machine is not.

20. Clearly, if the order and organisation of the organic being is changed and undermined in a serious fashion, the being itself will cease to exist. None of the fundamental parts of the living being, the vital organs – brain, heart, lungs, kidneys, liver, *etc.* – is a biologically independent unit, capable of sustaining itself as a unit. Rather, it is the organism as a whole which is such a unit. Further, when the organism as a whole dies because one of its vital organs is destroyed, what is destroyed is precisely that fundamental unity and organisation of the being without which it cannot be itself, cannot exist.

21. Because the wholeness of the organism is not reducible to any of its parts, none of the parts can be given the status of the whole. It would be a mistake to regard any single organ, such as the brain, as somehow constituting the organism itself, of causing it to exist as a whole. If the whole is alive, it is already there with its own particular nature and powers; neither the presence nor the absence of one of its parts can account for the kind of unity which the whole is. Rather, the nature of the whole itself has primacy over the parts, as Comte pointed out in the passage quoted above. The whole organism comes to develop the specific parts that are appropriate to it precisely because of the kind of whole that it is.

22. Let me sum up the basic ideas developed here, concerning the organism as a whole, in the following seven propositions:

(i) the human organism (the human bodily being) is a living whole.

(ii) The organism as a whole is 'an independent biological unit', that is, a living organic individual.

(iii) The organism as a whole, the living unit (individual) that it is, is not the quantitative aggregation or the sum total of its parts, but is qualitatively distinct from that quantitative sum total.

(iv) This living unit or whole is not caused to exist by, nor is it constituted by, any one of its parts considered singly.

(v) The whole is not reducible to any of its parts.

(vi) The death of the whole may be caused by the destruction of one of its parts because the dissolution of a unified order could come about through the failure of that one organ (or part), leading to a substantial alteration of unity and of the organisation of the individual being.

(vii) The whole has primacy over the parts, for it determines their development, form, appearance and harmonious function both in space and time. The whole determines the parts.

The fact that organisms are living wholes makes it reasonable to claim – given our present knowledge of the workings of the human organism – that anyone who has suffered brain death has suffered the loss of brain function, and therefore that death of the whole organism has occurred: the person himself has died. For centuries the fact that death of the brain and death of the whole organism were identical was intuitively obvious; it was an assumption which underlay such practices as decapitation and judicial hanging.

(ii) Death: an irreversible state

23. The following statements are sometimes made by people trying to describe what death really amounts to: 'Death is a state'; 'Death is a natural event'; 'Death is a process'. Which of these statements is true? Or are they all true? Are the statements compatible with one another? The description of death as a state seems to be justified, given that (as we have seen) the death of a living being is to be identified as the dissolution of the organism as a whole, that is, as the ending of the organic unity or wholeness of the living body. It is a true description in so far as it implies that the death of a living being has already been identified in the dissolution of the organism as a whole – that is, when the organic unity or wholeness of the living body is acknowledged to have ended. The central idea behind the brain death criterion is that *there are empirical tests by means of which the brain can be declared dead and the whole organic body therefore declared to have lost its unity or wholeness*. While the process of dying is still going on, the organism is not yet dead, and it would be wrong to declare it to be so. This reveals that although dying is a process, death itself is not. When we want to determine that death has occurred, we have to ascertain whether the end of the process has yet taken place, and to do this we must have criteria for asserting that it has. Thus, when one determines that death has taken place, it is the end of the process of dying as well as the criteria used to detect that end which matter. The significance of the concept of brain death is precisely that it makes clear that there are relatively simple and non-arbitrary methods, usable by the bedside, by which it can be shown that the end of the process of dying has taken place. Death, then, is that state which is reached when the process of dying has come to an end. In this respect death can also be aptly described as an event, a natural event – that is, as an occurrence identifiable by certain criteria at a particular point in time (ordinary clock time). The question 'At what time did he die?' makes perfectly good sense as does an answer such as 'At ten past six in the evening'.

24. Death occurs as an event both when it takes the form of a simultaneous destruction of every one of the cells of an organism (as when someone falls into a blast furnace at 1,000°C), and also when there is a gradual dissolution of the organism as a whole, that is, as a functioning unit. In both cases there has to be a point in time at which the dissolution (whether it occurs in the first or the second of the ways mentioned here), as the end of the process, can be seen to have occurred. Of course, it may be impossible, in practice, to identify the earliest point in time at which someone can be declared to be dead; the doctor has to carry out his tests and be completely

satisfied that the end of the process has occurred. In this sense it is true to say that we are dead when the doctor says we are dead. But the doctor makes this judgement on grounds which are not arbitrary; and the crucial problem here is to specify these non-arbitrary grounds for a judgement that death has occurred. Because dying takes time, it is a process, and it is of crucial importance for the doctor who declares death to take into consideration the necessity of *waiting*: it is ultimately by waiting, after having ascertained the known signs of dying and death, that the certainty of death is absolutely established for everyone concerned.

25. Strictly speaking, death is not a process as dying is.[25] A process is, by its very nature, extended over time. If death were a process, a declaration of death would have to be made during the time that the process was occurring; but then there would be no way of distinguishing between the process of dying and the process of death itself. As a consequence, the distinction between the three conditions of living, of dying and of being dead could not be made. This shows clearly that one must identify with certainty a definite dissolution of the living organism as a whole if one is to declare, on non-arbitrary grounds, that a patient is dead. The significance of the brain-death criterion is precisely that it shows that a non-arbitrary line can be drawn between dying and death: it shows that the end of the living process of the organism is clinically (empirically) determinable and that the organism is truly dead at a particular point when it is judged that the process has ended.

26. Irreversibility is another important aspect of death. That death is irreversible follows from the fact that the human organism is a living whole, and as such cannot be dismantled and reassembled as a machine can. We all realise that when the living unity of a human being has truly broken down, that unity can never again be recovered. If corpses were at any time liable to come to life again, we would not have criteria for considering the dead as really dead! Our understanding of living beings is such that their death is final, and this finality is irreversible, as the actual decomposition of the corpse manifests. So we may ask: What does the state of being dead consist in? The usual answer has been: 'It consists in the death of the organism as a whole'. And when and how does the wholeness of the organism break down? According to the brain-death criterion, this happens when there is an irreversible loss of brain function. The next question which arises is: 'When does the loss of brain function occur, and how is it known?' Here physiology has to give us the answer.

(iii) The irreversible loss of function and capacity

27. The notions of function and capacity are not clearly differentiated in discussions of brain death. This is not surprising, since 'to function' and 'to possess a function' may be taken to mean 'to have a power or capacity for a particular activity'. We regard an activity as an exercise of a capacity or a power. Capacity and activity (or exercise of a capacity) are to be distinguished; they are not reducible to each other, although the latter depends on the former. The human mind has the capacity for thought; thinking is the activity corresponding to that capacity, its actual exercise. The human mind is more than a capacity for thought or consciousness; it could be aptly called a capacity for capacities.[26] To possess a mind is to possess the capacity to acquire other capacities, *e.g.*, to learn how to walk and eat, to learn to speak, to learn a foreign language, to learn to drive or to play the piano. We may have all these capacities and not be able to exercise them for one reason or another. Naturally reasons may vary: I may not be able to play the piano because I am under an attack of panic which has paralysed me, because my hand has been hurt in an accident, because I have no piano. This example shows that we must make a further distinction between a *capacity*, its *exercise* and its *vehicle*.

28. A patient under total anaesthesia is in a state in which he is not capable of walking, feeling pain, being self-conscious, *etc.*; this state is caused, as a result of an anaesthesia, by the physiological changes affecting the organs which are the necessary bodily vehicles for these capacities to be exercised. Clearly the impossibility of exercising these capacities under anaesthesia cannot be taken as the loss of the capacities themselves, but should rather be understood as a temporary 'obstruction' of some of those vehicles by means of which the capacities can be actualised and exercised. If the vehicles were permanently damaged or destroyed the capacity would no longer be exercised, as (*e.g.*) in the case of a brilliant pianist who loses the movement of his hands. The exercise of a capacity and its vehicle are inseparable, so that if the vehicle is lost the possible exercise of the capacity is lost as well. As Anthony Kenny has argued,[27] a power, understood as a capacity, cannot be reduced either to its vehicle or to its exercise. Nevertheless this form of reductionism prevails among some scientists and philosophers when they identify the mind (which for them is the same thing as the person) with the exercise of consciousness. Others identify the mind with its vehicle, the brain, for they maintain that the mind is the brain.

29. It is necessary for our human way of describing ourselves that we have a term such as 'mind' which stands for those capacities of intelligence proper to our species. Yet the powers that a living being possesses (powers of generation, movement, growth, sight, *etc.*) are capacities of that being itself as an organic unified living whole, and are exercised through its organs. But it is not the organs that generate, move, see, *etc.*, but rather the being itself. Obviously, if there is no organism there are no capacities, no powers. But if an organism is present then the capacities or powers which belong to its nature are also present, despite the many organic limitations, deficiencies or injuries it may have at present or may come to have in the future. Because powers have particular organs as their vehicles, destruction of or damage to some parts of my organism may deprive me of the means of exercising those powers. It is a fact about the human organism (and about other animal organisms) that when the whole brain is irreparably damaged or destroyed and therefore ceases to function, the organism can no longer maintain and exercise its unifying power of being alive as a whole, as a unit. Thus, the brain is one of the essential vehicles by which the living unity of the organism is maintained; the loss of this organ is the loss of that unity, the loss of the life of the organism. To be alive is to act and operate in a unified way. What is lost, then, when the brain is irreparably damaged or destroyed is the constantly-active power of *being one*, of being in existence as such-and-such a kind of being; what is lost is the power of life itself. Losses of other organs of the human body may not amount to the total and irreversible loss which precludes the organism as a whole from living; the loss of the brain, however, does. This is a matter of physiology, of the way we are made, and it applies just as much to human beings as it does to the other animals.

(iv) A definition of death

30. Various definitions of death may be advanced. Death, like our

personal being, or subjectivity, or sexuality, or our coming into being, escapes a fully satisfactory definition. Nevertheless there are definitions and descriptions which succeed in laying bare the essential features of these realities. The reality of death, from a medical point of view, has been defined by Dr Pallis in these terms:

> Death is a state in which there is irreversible loss of capacity for consciousness combined with the irreversible loss of the capacity to breathe (and hence to maintain a heart beat). Alone neither would be sufficient. Both are essentially brain stem functions (predominantly represented, incidentally, at different ends of the brain stem).[28]

This definition of death has been designed to fit in with the criteria given for brain-stem death, taking into consideration the importance of consciousness in human life. It is therefore a tentative definition. (It should be noted that Dr Pallis does not discuss the distinction between a capacity, its vehicle and its exercise.) The capacities irreversibly lost at death are said to be two: (a) spontaneous breathing, and (b) consciousness. Why is it that the definition specifies that these two capacities are to be lost? Why not one of them only? Why not others? The answers to these questions depend partly on certain results of modern technology and partly on human physiology, rather than on any philosophical principles or conclusion. The loss of spontaneous breathing does not always mean death. With the aid of a machine, and after appropriate tests, it can be determined whether the loss of breathing function is only temporary and could therefore be restored later, or whether it is a permanent and irrecoverable loss. If the loss is permanent, and if this loss is accompanied by loss of the capacity for consciousness, then death will have occurred: these two powers depend for their existence on the functioning of the brain stem, and since these powers 'reside' at opposite ends of the stem from each other, loss of both powers shows that the total stem is dead. (If this were not the case – if the stem were still partly alive – then Dr Pallis's definition of death would, of course, be inadequate.)

31. What all this reveals is, I believe, that it is a necessary condition for someone's being alive that his brain stem is alive; it is not, however, necessary that the neocortex, the vehicle which is required for the exercise of consciousness, is alive and functioning. The exercise of consciousness is irreversibly lost by a severely-damaged cortex even if the stem is well-functioning and not damaged. This is well illustrated by the fact that a child with hydroencephaly is a living child, even though he entirely lacks the capacities for ratiocination and reflexive self-consciousness:

> The child can breathe spontaneously, swallow, and grimace at response to painful stimuli. Its eyes are open. The heart can beat normally for months. No culture would declare that child dead. This emphasises the centrality we instinctively allocate to persisting brain stem function, even in the absence of what we could describe as cerebration.[29]

We have no way of ascertaining that capacities for consciousness and for breathing have been lost other than by testing to discover the physiological state of the brain stem. And if the brain stem is alive, the organism as a whole is still functioning, not dead. For this reason it is my contention that *if the brain stem is the crucial organ for determining death it is not because it contains the basic mechanisms for the exercise of the capacity for consciousness, and because consciousness is a 'philosophical' attribute relevant to determining life or death, but rather because if this organ is dead, the unity of the living organism is broken and hence all spontaneous vital powers and functions are destroyed along with it.* A damaged, destroyed, dead brain stem detaches the higher brain from the rest of the organism, and as a result the unity of the living being is irreversibly lost. There is, then, no longer a living whole, a living bodily individual.

32. The concept of death expressed in the definition cited in paragraph 30 above is said to be

> a hybrid one, expressing both philosophical and physiological attributes...which corresponds perhaps to an intermediate stage of current concerns, seeking to maintain a footing on both types of ground.[30]

In my view, both physiological and 'philosophical' attributes will always be present in a human concept of death, given the kind of beings we are. Relying on current knowledge about the brain and the brain stem, I would defend a definition of death which includes both physiological and 'philosophical' characteristics which are recognised to be real in the human being (as in other animals). The definition is this:

Death is the dissolution of the organic unity that a being possesses as a living whole.

Of course, this definition does not capture the whole sense and reality of human death, since it could be applied to other animals; but it does express the fact that through death the human being ceases to exist as a human being. The 'dissolution of the organic unity of a being' is known to have occurred when the brain is found to be dead. This understanding of death is an organic, physiological one, although complemented and substantiated by philosophical insight into the nature and powers of the human organism as a living whole, a living organic being of human and rational nature. The human bodily nature that disintegrates at death could still be well expressed in the words 'the last breath'. When the brain dies, the head hangs down, breathing ceases, death ensues. Death as traditionally understood, on the one hand, and 'brain death', on the other, are and will always be one and the same.[31] There is only one kind of human death: organic death, death of the human organism as a whole, for such an organism is the human being, the human person.

IV. Death and conception compared

33. The end of human life we call death. The beginning of human life we call conception.[32] A question which arises here is whether the attributes which must be present if a living human organism is to be recognised as a human subject, a human being or a human person are the same attributes whether we are speaking of death or of conception. In what follows the criterion used for determining what counts as a living human subject who ceases to be alive and is therefore declared dead, when his or her brain is dead, will be applied in order to determine when that human subject began to be alive. In this application it will become clear that the set of 'conceptual commitments' in the nine propositions stated below represent those implied in the concept of death as total brain death, as discussed above. The other set of propositions represent the parallel commitments implied by the recognition of conception as the beginning of a human life. The legitimacy of the original question – 'Why not use the same criterion for determining the beginning and the end of human existence?' – is therefore made manifest.

34. I now state nine propositions concerning the criteria for determining the end of life (death) and the beginning of life (conception).

P1 (Death): The living human subject, the dying patient, is the living human organism.
A human patient is a living human organism, a living whole, a member of the human species. To be such a kind of living human organism is the necessary and sufficient condition for one's being recognised as a living human subject, a human being, a human person.

P1 (Conception): The embryonic human being is the living human organism.
A human being in embryonic form is a living human organism, a living whole, a member of the human species. To be such a kind of living human being is the necessary and sufficient condition for one's being recognised as a living human subject, a human being, a human person.

P2 (Death): Death is organic death.
The death of the human subject is his or her organic death, *i.e.* the end of his or her organic life.

P2 (Conception): Life is organic life.
The conception of a human subject is the beginning of the generation of his or her body, that is, the beginning of his or her organic bodily life.

P3 (Death): Death is the death of the organism as a whole.
The end of the life of a human subject is the death of the organism as a whole. In death the organism ceases to exist as a living whole, a living unit, 'an independent biological unit'.[33]

P3 (Conception): Conception is the beginning of the life of the organism as a whole.
The beginning of the organic life of a human subject is the beginning of the life of the organism as a whole. At conception the organism begins to exist as a living whole, a living unit, 'an independent biological unit'.

P4 (Death): Death is determined by physical (biological) criteria.
The end of the life of the organism as a whole is to be determined by physical criteria concerning the structure and function of the organism. These are empirically determinable; no other, extraneous considerations are required.

P4 (Conception): Conception is determined by physical (biological) criteria.
The beginning of the life of the organism as a whole is to be determined by physical criteria concerning the structure and function of the organism. These are empirically determinable; no other, extraneous considerations are required.

P5 (Death): Death is brought about by an irreversible physiological change breaking down organic unity and wholeness.
Death (the condition of being dead) is a state of the human organism brought about by an irreversible physiological change in the organism which has disintegrated (destroyed) its organic unity and wholeness. The cause of the disintegration can ultimately be traced to an irreversible loss of the brain's structure without which the organism cannot live.

P5 (Conception): Conception is brought about by an irreversibly physiological change giving rise to organic unity and wholeness.
Life (the condition of being alive) is a state of the human organism brought about by an irreversible physiological change, an event (fertilisation) which gives rise to the organism as an integrated living unity, a living whole. If no damage or interference occurs the organism continues to live as a unit, as an organic whole, to adulthood.

P6 (Death): Death comes about through a process.
The end of a human life comes about through a process of organic disintegration (cellular disintegration), which eventually destroys the unity of the human organism as a unit, as a whole.

P6 (Conception): Conception comes about through a process.
The beginning of a human life comes about through a process of organic integration (cellular fusion), which generates the human organism as a unit, as a whole.

P7 (Death): Death is the end of a process and a natural event.
The end of the process of disintegration of the organism as a whole, a natural event, is death. Death is not the process itself, but that which ensues from the process; it involves a substantial change from the living state to the 'dead state', from living organic existence to non-existence of the organism.

P7 (Conception): Conception is the end of a process and a natural event.
The end of the process of organic integration bringing into existence the organism as a whole, a natural event, is conception. Conception is not the process itself, but that which results from the process. It involves a substantial change which is undergone by two living cells (ovum and sperm) through fertilisation; each of these cells previously constituted part of a living whole, but now each ceases to be a part, and together they become a new living whole; this substantial change is a change from the non-existence to the existence of the organism.

P8 (Death): Organic criteria provide a universal standard for determining death.
The end of the process of disintegration of the organism as a whole is determined and defined by non-arbitrary organic criteria. The determination of when that process is at an end is not a matter of arbitrary decision. The criteria, because they are empirical, are of universal significance, that is, they provide us with a universal standard for deciding whether or not death has taken place, applicable to every human being without distinction. The criteria can be understood and appreciated by ordinary people using their powers of perception and common sense and can thus be incorporated in legal and medical codes.

P8 (Conception): Organic criteria provide a universal standard for determining conception.
The end of the organic process of cellular fusion at fertilisation which gives rise to the generation of the organism as a whole is determined and defined by non-arbitrary empirical criteria. The

determination of when that process is at an end is not a matter of arbitrary decision. The criteria, because they are empirical, are of universal significance, that is, they provide us with a standard of determining that human conception has taken place which is applicable to the life of every human being. The criteria can be understood and appreciated by ordinary people using their powers of perception and common sense, and can thus be incorporated in legal and medical codes.

P9 (Death): In death the self-sustaining power of the organism is lost; time and nourishment will not effect the recovery of that power.
The death of a human subject occurs when his or her organism dies as a whole. His or her physiological make-up is so damaged, deficient or destroyed that its power to sustain itself as a living unit is no longer present: it is irreversibly lost because the brain is dead. To wait for recovery or to provide nourishment in these circumstances is pointless. (Clearly, the loss of the power of 'being in existence' as a living whole is the loss of all powers in the human being.)

P9 (Conception): In conception the self-sustaining power of the organism emerges; time and nourishment will effect the continuity of that power.
The beginning of the life of a human subject occurs when his or her organism is generated as a whole; his or her physiological make-up is such that it has the power of maintaining itself in existence as a living unit, and this power is present at all times. To wait and to provide nourishment and shelter in these circumstances is highly important and valuable for the preservation of the organism as a whole. (Clearly, the preservation of the power of continuing in existence as a living whole amounts to the preservation of all other powers of the human being which in time will become manifest.)

V. Three concluding remarks
35. By way of conclusion I want to make three brief points. First I wish to stress that there is a need to re-examine the double standard currently in use to determine, on the one hand, what counts as a living human subject in the case of death, and, on the other hand, what counts as a living human subject in the case of conception. The arguments about brain-stem death presented above make this double standard manifest. For in judging that death has occurred we proceed both medically (clinically) and legally, basing our judgment on the organic criterion, that is, the criterion of the disintegration and ceasing-to-exist of the organism as a whole. This is not the criterion currently used in the case of conception. Our common humanity rests on the fact that we all share our bodily condition, we are all human organisms, we are all members of the same human family – the species *homo sapiens*. This membership rests on our human organic make-up.

36. Secondly, as the opening paragraph of this paper shows, the true view of death as brain death (defended by the medical profession as described above) is still poorly understood or even misunderstood. A responsible understanding of that criterion of death needs to be attained and appropriately represented and summarised in public debate. (See, for example, section 88 of the document *Personal Origins*, published by the Board of Social Responsibility of the General Synod of the Church of England in June 1985, where brain death is misleadingly considered to be the end of 'personal life', and not primarily the end of the life of a human being, of a human organism as a whole, that is, the end of the organic life of a person.)

37. Finally, most current discussions of what counts as a human subject at the beginning and end of life are really, and ultimately, discussions about the ethics of killing, that is, discussions about the justifications to be found so that some human beings may engage in the killing of some other human beings who are either severely handicapped, demented, newly conceived or brain-damaged, or with some other bodily deficiency which is considered to provide grounds for denying them an absolute right to human care and justice. It should not be possible, at this stage of our civilisation, to accept that there are two classes of human beings: those who are persons and those who are non-persons, the latter class having the status of things, property or chattel – in other words, the status which slaves used to have in law and in the practice of their masters.

FOOTNOTES
1. P. Singer and D. Wells, *The Reproduction Revolution: New Ways of Making Babies*, OUP, Oxford, 1984, p. 98.
2. Richard M. Zaner (ed.), *Death: Beyond Whole-Brain Criteria*, Kluwer Academic Publishers, Dordrecht, 1988. The quotation is taken from the publishers' leaflet advertising the publication.
3. Robert M. Veatch, 'Whole-Brain, Neocortical and Higher Brain Related Concepts', in Zaner (ed.), *Death: Beyond Whole-Brain Criteria*, Dordrecht, p. 174.
4. Alexander M. Capron, 'The Report of the President's Commission on the Uniform Determination of Death Act', in Zaner (ed.), *Death: Beyond Whole-Brain Criteria*, Dordrecht, pp. 167–168. A complete list of the States of the U.S.A. which have adopted laws (on the determination of death) based on cessation of total brain function is given in this article.
5. *Cf.* C. Pallis, *ABC of Brain Stem Death*, a British Medical Journal publication, London, 1983, p. 27.
6. I.M. Kennedy, 'The Kansas statute on death – an appraisal', in *The New England Journal of Medicine*, 285, 1971, pp.946–950.
7. C. Pallis, *op. cit*, p. 4.
8. *Cf., e.g.*, David R. Smith, 'Legal Issues Leading to the Notion of Neocortical Death', in Zaner (ed.), *Death: Beyond Whole-Brain Criteria*, Dordrecht, pp. 11–1144.
9. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, *Defining death: medical, legal and ethical issues in the determination of death*, U.S. Government Printing Office, Washington, D.C., 1981, p. 2.
10. Conference of Medical Royal Colleges and their faculties in the UK, 'Diagnosis of Death', in *British Medical Journal*, i, 1979, p. 3320.
11. 'Memorandum on Brain Death', in *Irish Medical Journal*, 1, no. 1, 1988, pp. 42–45.
12. *Ibid.*, p. 54.
13. C. Pallis, 'Brain-stem Death: The Evolution of a Concept', in P.S. Morris (ed.), *Kidney Transplantation* (2nd edition), Giune and Stratton, Orlando, U.S.A., 1984, p. 101.
14. Dr D.W. Evans has written and publicly stated both in the UK and in Ireland that the brain cannot be truly and totally dead while there is still blood circulation in the brain, even if brain stem death has been diagnosed. He contends also that the means used (that is, the tests carried out) to diagnose brain-stem death are inadequate, so that there remain 'untested functions in the brain stem at the time when...the whole of the brain stem is said to be dead' (from an RTE interview, Dublin, 17 May, 1988).

15. See Capron, 'The Report of the President's Commission on the Uniform Determination of Death Act', in Zaner (ed.), *Death: Beyond Whole-Brain Criteria*, p. 159.
16. See President's Commission, *Defining death: medical, legal and ethical issues in the determination of death*, p. 28.
17. See C. Pallis, *ABC of Brain Stem Death*, p. 1.
18. *Ibid.*, p. 2.
19. *Ibid.*, p. 3.
20. See J. Bernat *et al.*, 'On the Definition and Criterion of Death', in *Annals of Internal Medicine*, 94, pp.389–394.
21. This is also the view of (*e.g.*) Alexander Capron and Christopher Pallis, although it is criticised by (*e.g.*) R.M. Veatch; see Veatch, 'Whole-Brain, Neocortical and Higher Brain Related Concepts', in Zaner (ed.), *Death: Beyond Whole-Brain Criteria*, Dordrecht, p. 178.
22. See President's Commission, *Defining death: medical, legal and ethical issues in the determination of death*, p. 33.
23. See C. Pallis, *ABC of Brain Stem Death*, p. 8.
24. Discussed and referred to by E. Gilson in *From Aristotle to Darwin and Back Again*, Sheed and Ward, London, 1984, p. 122.
25. This point of view is presented and further discussed by David Lamb in *Death, Brain Death and Ethics*, Croom Helm, London, 1985, pp.70–82.
26. For the discussion of this point see A. Kenny, *Will, Freedom and Power*, Blackwell, Oxford, 1975.
27. *Ibid.*, Chapter 7.
28. See *Cf.* C. Pallis, *ABC of Brain Stem Death*, p. 2.
29. *Ibid.*, p. 3.
30. *Ibid.*, p. 2.
31. This is the view defended not only by C. Pallis but also by (*e.g.*) A. Capron and L. Kass.
32. It will be clear to the reader, in view of what has been said in previous chapters, that what I am saying here in no way amounts to a denial of the human being's immortality or a failure to recognise his or her eternal destiny. What I mean to say here is that the bodily existence of the human being (*i.e.* his or her unique mortal human condition, as we know this condition to be for everyone), undeniably begins with conception and ends with death.
33. C. Pallis's expression; see his 'Whole-brain death reconsidered – physiological facts and philosophy', in *Journal of Medical Ethics*, 9, 1983, p. 33.

The Misuse of Maternal Mortality Statistics in the Abortion Debate

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One of the unfortunate consequences of the popular debate over the legalization of abortion is that statistics have come to function as moral landmines in a war of words. And there is no getting around the fact that neither side is exempt from criticism in this area.

Take for example a popular pro-life misuse of statistics. In response to the pro-choice argument that abortion is justified because there are too many unwanted children, the pro-life advocate will often cite statistics which support the fact that there are a great number of childless couples seeking children for adoption.[1] There are several problems with this pro-life response. First, why should this point even matter? Suppose there were no such couples, would abortion *ipso facto* become morally correct? If the unborn have an inherent right to life, which is the foundation of the pro-life position, why should the absence or presence of a couple who want a child make a difference? Second, a sophisticated pro-choice advocate would remain unconvinced, since according to his position a woman has a right to an abortion, but has no obligation to make sure other people can adopt children, especially if he does not believe that the unborn are fully human. Why should the pro-choice advocate buy into pro-life assumptions? And third, it follows from these two points that the pro-life advocate's appeal to adoption puts him in the odd position of buying into the pro-choice assumption that only if the unborn are wanted do they have a 'right to life'. This is a fatal concession for the pro-life cause. Although there may be a social good in advocating adoption, just as there is a social good in advocating charity, the adoption option has little to do with the morality of abortion per *se* if one accepts from the outset either the pro-life position ('the unborn have an inherent right to life') or the pro-choice position ('the unborn do not have an inherent right to life'). The focus of this paper is an argument that figured prominently in *Roe v. Wade*: since abortion is safer than childbirth, there is no compelling reason for the law to proscribe abortions, especially in the first and second trimesters of pregnancy.[2] Relying heavily on two articles by Cyril Means,[3] which have since been roundly critiqued in the literature,[4] the Court argued that since the purpose of early American anti-abortion laws was to protect the life and health of the pregnant woman from a very dangerous operation, and since modern medical progress and technology, including the discovery of penicillin and anaesthetics, has made early term abortion safer than childbirth, the laws serve no purpose.

This same argument has been applied in a popular context by pro-choice advocates who argue that the pregnant woman has no moral obligation to carry her unborn offspring to term, *regardless of whether or not it is fully human.* The pro-choice advocate argues that childbirth is an act which is not morally obligatory on the part of the pregnant woman, since an abortion is statistically less dangerous than childbirth. The statistic often quoted to support this argument is one found in the most recent edition of the *American Medical Association Encyclopedia of Medicine*: 'Mortality is less than one per 100,000 when abortion is performed before the 13th week, rising to three per 100,000 after the 13th week. (For comparison, maternal mortality for full-term pregnancy is nine per 100,000.)'[5] For this reason, many pro-choice advocates claim that an early term abortion is 'nine times safer than childbirth'.

Professor Virginia Ramey Mollenkott gives this argument a theological twist by attempting to ground it in the Hebrew-Christian Scriptures. She argues that Jesus asserted that risking one's life constituted exceptional love not obligatory love (see John 15:13). Hence, one is not obligated to carry the fetus to term since childbirth would be an act of exceptional love and is therefore not morally obligatory.[6] In any event, whether one presents this argument in secular or religious trappings, it can be outlined in the following way.

1. Among moral acts one is not morally obligated to perform are those which can endanger one's life (*e.g.* the man who dived into the Potomac in the middle of winter to save the survivors of a plane crash).
2. Childbirth is more life-threatening than having an abortion.
3. Therefore, childbirth is an act one is not morally obligated to perform.
4. Therefore abortion is justified.

The problem with this argument lies in the inference from 2 to 3. First, assuming that childbirth is on the average more life-threatening than abortion, it does not follow that abortion is justified in every case. The fact that one act, A, is more life-threatening on the average than another act, B, does not mean that one is not justified or obligated to perform A in *specific* situations where there is no *prima facie* reason to believe that A would result in death or severe physical impairment unless one resorts to B. To use an uncontroversial example, it is probably on the average less life-threatening to stay at home than to leave home and buy groceries (*e.g.*, one can be killed in a car crash, purchase and take tainted Tylenol, or be murdered by a mugger), yet it seems foolish , not to mention counter-intuitive, to always act in every instance on the basis of that average. This is a form of the informal fallacy of division, which occurs when someone erroneously argues that what is true of a whole (the average) must also be true of its parts (every individual situation). One would commit this fallacy if one argued that because Beverly Hills is a wealthier city than Barstow everyone who lives in Beverly Hills is wealthier than everyone who lives in Barstow.

Second, one can also imagine a situation in which one is obligated to perform a particular *moral* action although there is statistically more risk in performing it than abstaining from it. That is to say, one can challenge the inference from 2 to 3 by pointing out that just because an act, X, is 'more dangerous' *relative* to another act, Y, does not mean that one is *not* morally obligated to perform X. For example, it would be statistically 'more dangerous' for me (a swimmer) to dive into a swimming pool to save my wife (a non-swimmer) from drowning than it would be for me to abstain from acting. Yet this does not mean that I am not morally obligated to save my wife's life. Sometimes my moral obligation is such that it *outweighs* the *relative* danger I avoid by not acting. One could then argue that although childbirth may be 'more dangerous' than abor-

tion, the special moral obligation one has to one's offspring far outweighs the relative danger one avoids by not acting on that moral obligation.

Of course, if a *specific* act, X, is *significantly* dangerous (*i.e.*, there is a good chance that one will die or be severely harmed if one acts) – such as the act performed by that one man who dived into the freezing Potomac River in the dead of winter to save the survivors of an airplane crash – then it would seem that an individual would not be obligated to perform X. However, if one had chosen to perform X, one would be performing an act of exceptional morality, although if one had refrained from X one would not be considered a bad or evil person. In light of the above observations, the pro-choice argument in question can be strengthened if changed in the following way:

1. Among moral acts one is not morally obligated to *perform* are those which can endanger one's life.
2. A particular instance of childbirth, X, is more life-threatening to the pregnant woman than having an abortion.
3. Therefore, X is an act one is not morally obligated to perform.
4. Therefore, not-X *via* abortion is justified.

Although avoiding the pitfalls of the first argument, this one *does not* support the pro-choice position on abortion. For it is perfectly consistent with the pro-life assertion that abortion is justified if it is employed in order to save the life of the mother. Therefore, whether or not abortion is statistically safer than childbirth is irrelevant to whether or not abortion is justified in particular cases where sound medical diagnosis indicates that childbirth will pose no threat to the mother's life.

Another observation can be made about this pro-choice argument. The above statistics claim that the mortality rate for a woman in childbirth is 9 per 100,000 while mortality is less than 1 per 100,000 when abortion is performed before the 13th week, increasing to 3 per 100,000 after the 13th week. This is why pro-choicers often claim in their popular rhetoric that a first trimester abortion is nine times safer than childbirth. Although technically true if one assumes that the statistics are accurate, it is statistically insignificant. This becomes apparent when one converts the above 'odds' into percentages. If the mortality of childbirth is 9 per 100,000, then a woman has a 99.991% chance of surviving. If the mortality of a first trimester abortion is 1 per 100,000, then a woman has a 99.999% chance of surviving. But the statistical difference between 99.991% and 99.999% (00.008%) is moot, especially if one considers the complex nature of both childbirth and abortion, about which there are so many variables which may account for the small difference in the mortality rates.

[1] For example, see Dr and Mrs J.C. Wilke, Abortion: Questions and Answers, rev. ed. (Cincinnati: Hayes Publishing, 1988), pp.305-313.

[2] Because of the Court's broadly defined health-provision for third-trimester abortions, many scholars have concluded that in *Roe* the Court has in effect legalized abortion on demand for all nine months of pregnancy. This same conclusion was drawn by a Subcommittee of the U.S. Senate Committee on the Judiciary: 'The apparently restrictive standard for the third trimester has in fact proved no different from the standard of abortion on demand expressly allowed during the first six months of the unborn child's life. The exception for maternal health has been so broad in practice as to swallow the rule. The Supreme Court has defined "health" in this context to include "all factors – physical, emotional, familial, and the woman's age – relevant to the well-being of the patient". *Doe v. Bolton*, 410 U.S. 179, 192 (1973). Since there is nothing to stop an abortionist from certifying that a third-trimester abortion is beneficial to the health of the mother, in this broad sense, the Supreme Court's decision has in fact made abortion available on demand throughout the pre-natal life of the child, from conception to birth.' (Report on the Human Life Bill – S. 158; Committee on the Judiciary, United States Senate, 97th Congress [December 1981]:5) Included among the many scholarly works that support this view are the following: Report, Committee on the Judiciary, U.S. Senate, on Senate Resolution 3, 98th Congress, 98-149, (7 June 1983): 6; John Hart Ely, 'The Wages of Crying Wolf: A Comment on *Roe v Wade*,' *Yale Law Journal* 82 (1973): 921; William R. Hopkin, Jr., '*Roe v. Wade* and the Traditional Legal Standards Concerning Pregnancy,' *Temple Law Quarterly* 47 (1974): 729-730; Victor Rosenblum and Thomas Marzen, 'Strategies for Reversing *Roe v. Wade* through the Courts,' in *Abortion and the Constitution*, eds. Dennis Horan, Edward R. Grant, and Paige C. Cunningham (Washington, D.C.: Georgetown University Press, 1987), pp. 199-200; Stanley M. Harrison, 'The Supreme Court and Abortional Reform: Means to an End,' *New York Law Forum* 19 (1974): 690; Robert A. Destro, 'Abortion and the Constitution: The Need for a Life-Protective Amendment,' *California Law Review* 63 (1975): 1250; Jacqueline Nolan Haley, 'Haunting Shadows from the Rubble of *Roe's* Right to Privacy,' *Suffolk University Law Review* 9 (1974): 152-153; Lynn Wardle and Mary Anne Q. Wood, A Lawyer Looks at Abortion (Provo, UT: Brigham Young University Press, 1982), p.12; and John Warwick Montgomery, 'The Rights of Unborn Children,' *Simon Greenleaf Law Review* 5 (1985-86): 40.

[3] Cyril C. Means, Jr., 'The Law of New York Concerning Abortion and the Status of the Foetus, 1664-1968: A Case of Cessation of Constitutionality,' *New York Law Forum* 14 (1968); and Cyril C. Means, Jr., 'The Phoenix of Abortional Freedom: Is a Prenumbral or Ninth Amendment Right about to Arise from the Nineteenth-Century Legislative Ashes of a Fourteenth-Century Common-Law Liberty?' *New York Law Forum* 17 (1971).

[4] Included among the many scholarly works which critique this position are the following: James S. Witherspoon, 'Reexamining *Roe*: Nineteenth-Century Abortion Statutes and the Fourteenth Amendment,' *St Mary's Law Journal*: Stephen M. Krason, *Abortion: Politics, Morality and the Constitution* (Lanham, MD: University Press of America, 1984), pp. 134-179; Marvin Olasky, *The Press and Abortion, 1838-1988* (Hillsdale, NJ: Lawrence Erblaum Associates, 1988); Joseph W. Dellapenna, 'The History of Abortion: Technology, Morality and Law,' *University of Pittsburg Law Review* 40 (1979); and Joseph W. Dellapenna, 'Abortion and the Law: Blackman's Distortion of the Historical Record,' in *Abortion and the Constitution*, pp. 137-158.

[5] *American Medical Association Encyclopedia of Medicine*, ed. Charles B. Clayton, M.D. (New York: Random House, 1989), p.58.

[6] Virginia Ramey Mollenkott, 'Reproductive Choice: Basic to Justice for Women,' *Christian Scholar's Review* 17 (March 1988): 293. I have critiqued Mollenkott's position in two articles: 'Abortion and Argument: A Response to Mollenkott,' *Journal of Biblical Ethics in Medicine* 3 (Summer 1989); and 'Abortion and Public Policy: A Response to Some Arguments,' *Journal of the Evangelical Theological Society* 32 (December 1989).

REVIEWS

The Christian Healing Ministry
Morris Maddocks
SPCK, London, 1990; 270pp, £8.95; ISBN 0 281 04462 7

This book is the second edition of a volume published in 1981. The author has left the text of the first edition intact and added a new preface and a new fourth section to the book as well as revising the bibliography. When he wrote the first edition, he was the bishop of Selby, but he is now the adviser for the ministry of health and healing to the Archbishops of Canterbury and York. The publishers claim that the book has now established itself as 'the classic work on the subject'.

The book is divided into four parts. The first part reviews the biblical basis of the healing ministry. Part two consists of a brief history of healing in the church of today and a description of its various features and organisation. The third part discusses the significance of health and healing in modern society, whilst the new part four describes developments since the first edition was published. An appendix gives an outline of a healing service from the booklet *Ministry to the Sick*, one of the Authorized Alternative Services of the Church of England.

The past two or three decades have seen an increasing interest in the healing ministry of the Christian church, and it is good to have an account of it in this readable book. Its first part gives valuable review of the healing practice of our Lord and the apostolic church. Although this increase in interest has been seen in most of the mainline churches and the charismatic movement, the author confines his description of healing in the modern church mainly to the Church of England, giving only three or four pages to other denominations. In his new section he devotes a similar amount of space to the activities of John Wimber which he describes sympathetically but not uncritically.

Christian doctors and nurses will be disappointed that his presentation appears to find little place in the Christian healing ministry for their work. There is no mention of the establishment of church hospitals or the contribution to healing by countless medical missionaries who over the past century have practised the healing ministry using the methods and insights of western medicine. He describes as 'tragic' the polarisation between medicine and the church, but does not recognise that numbers of medical practitioners are church members. The polarisation is thus not between medicine and the church, but between those who practise medicine on the basis of secular humanism and those who practise it on a christian basis. Doctors and nurses reading this book will be given the impression that the Christian healing ministry consists only of prayer, laying on of hands, anointing and reception of the sacrament, and has no place for the daily professional practice of Christian doctors and nurses at home and abroad.

However, the book is well worth reading as a well-written account of the healing ministry of the church today, its basis in the example of Jesus and the practice of the apostolic church, and how it might be practised in the church today.

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Ethical Issues in Caring
Gavin and Susan Fairbairn (eds.)
Gower, 1989, 172pp., ISBN 0 566 05266 0

This book has been compiled from contributions to conferences on 'Ethical Issues in Caring' held between 1982 and 1986. It seeks to draw attention to the moral problems that arise from our need to care and be cared for, and then hopes to provoke debate about these issues.

The contributors come from a range of theoretical and practical backgrounds including social work, nursing and counselling, psychotherapy, industry, philosophy and Christian ethics, having in common the desire to address questions of value and how to relate to others within the concept of providing care.

The book opens with a paper on Profession and Vocation by Rev. Alastair Campbell, until recently of the Department of Christian Ethics and Practical Theology, University of Edinburgh, and deals with theories of professionalism and the concept of vocation. He contrasts the vocational view of a professional helper as a fortunate person whose service to others is a response of gratitude for unmerited privilege, with the real-life situation of professionals seeking the moral status of disinterested helpers *and* the comfortable life style of the successful trader! He discusses the need for 'gracefulness' which he defines as the spontaneity of those who do not need status, power or infallibility in their caring.

Professor Baroness McFarlane gives an analysis of elements of caring in nursing and the problems of rejecting the care concept which is a complex and densely argued paper, difficult to follow in some places, for those uninitiated into the language of nursing management.

A paper from Alison Kitson on nursing care highlights the difference between 'feeling better' and 'getting better' and stresses the nurse's role in helping the patient to achieve the first of these. It is a clear simple paper which will strike a chord with many medical and nursing staff who feel confused by the challenge of increasing technological complexity.

A thought-provoking paper from Bob Brecher, a philosophy teacher, considers the unworkability of the liberalist view of the individual which promotes response to his wants alone as a desirable aim and may lead to retreat by the carer into covert paternalism.

Trevor Owen, a managing director from Remploy, pleads for a greater degree of discrimination in the use of caring in a paper tellingly entitled 'Shall we care for you or do you want to work'.

Other chapters deal with paternalism and caring, respecting feelings (based on the experiences of women who had lost babies pre- or perinatally), ethical confrontation in counselling, choice in childbirth, surrogacy and psychotherapy.

A group of papers then addresses practical and economic concerns – needs and justice in health resourse allocation, community social work and quality of life and services for people with disabilities. There is much in this book to interest all professional 'carers' in the field of health. As is inevitable in a collection of papers with no common linking theme, especially when collected over an extended period of time, there is patchiness in quality of content and presentation but overall the book provides a thought-provoking and stimulating overview of many currently important ethical issues.

It certainly could be recommended to all those involved in the conflicts of current developments (and assigning of priorities) in health care, but because of the broad content of the book, it will probably find a better place in an institutional library where it can be dipped into, than in the individual's bookcase, unless he is one whose main work is the study of ethics.

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