**Treatment decision, death, and the value of life**

**Introduction**

The ontological status of patients – i.e., whether they are alive or dead – doesn’t usually influence treatment decisions. That most patients are alive is self-evident and irrelevant, and treatment decisions are no longer required for the clearly deceased. But the appropriate treatment of a minority of troubling patients turns on their ontological status. For example, that a brain dead patient artificially maintained on life-support is legally dead permits the retrieval of transplant organs.

Treatment should be based on ontological status only if two questions can be compellingly answered: first, is the patient alive or dead; and second, if the patient is alive, what is the value of their life? But both questions are notoriously controversial. The first requires a definition of death; the latter requires ascertaining what makes life valuable. The aim of this review article is to clarify why the prospects of answering each question remain poor.

**What is death?**

This first of the questions just distinguished is whether patients whose ontological status is unclear are alive or dead. This requires defining death, and criteria and tests to determine whether death, thus defined, has occurred. That the definition of death is controversial is well established (Youngner et al. 1999). Less obvious is the root cause of the problem, which is that our ordinary concept of death is too complex to be reduced to one simple definition. This will be illustrated by patients in the permanent vegetative state.

There are two main approaches to defining death. On the first, death is a biological phenomenon which is the same for all (and only) organisms (Bernat 1988; President’s Council on Bioethics 2008). Organisms are alive when they function in a holistic fashion, their components integrating to form a coherent organic whole; they die when they undergo irreversible breakdown in the functioning of the organism as a whole. There are two main candidates for determining when a human has undergone organismic breakdown. One is cardio-centric: death has occurred when the cardiorespiratory system is defunct. The other is neurological: death has occurred when the whole brain, or brainstem, is dead. These ways of determining death can conflict, but this masks a fundamental congruence: these are competing ways of determining whether death, as biologically defined, has occurred.

The second approach to defining death is consciousness-based (Zaner 1988; Lizza 2006). A person who has irreversibly lost their capacity for consciousness and, therefore, any psychology, has gone out of existence; what more could be involved in their being dead, notwithstanding continued biological functioning of the organism? On this consciousness-based (or ‘higher-brain’) account, death is defined as irreversible loss of capacity for consciousness; that death has occurred is determined by establishing that the relevant parts of the (higher) brain are no longer capable of sustaining consciousness.

The biological and consciousness-based approaches conflict in crucial cases. For example, although diagnostically controversial (Laureys et al. 2005), patients in the permanent vegetative state (PermVS) have suffered damage to their higher brains such that they appear no longer capable of sustaining consciousness, but their brainstems are sufficiently intact to retain autonomic physiological functions, such as breathing unaided. PermVS patients are alive on the biological approach, but dead according on the consciousness based account. This motivates various strategies: proponents of a definition of death present objections to rival accounts, defend and refine their preferred approach, or suggest further definitions (the dialogue in *QJM* initiated by Schofield et al. (2015) is paradigmatic).

But, arguably, all such strategies are misguided. To see why, consider how to go about defining death. Biological analysis of expiring bodies, expert opinion amongst those who deal with the dying, metaphysical analysis by philosophers: such approaches are informative but, ultimately, death has to be defined according to our ordinary concept of death: the ‘definition needs to map onto greater society’s understanding of what death means’ (Schofield et al. 2015). The problem is that the ordinary concept of death is complex (Holland 2010).

Specifically, the concept of death covers the biological phenomenon – organismic breakdown – captured by the biological definition; but it is richer than this, and also includes phenomena captured in the consciousness-based account, such as that, in death, it will never again be like anything to be me, because I will have ceased to exist as person. So the fundamental problem is that the two main definitions of death capture something of what we mean by death, but neither is wholly satisfactory. This analysis can be extended to any other attempt to reduce our complex ordinary concept of death to a single univocal definition.

This leaves us in a predicament. To recall PermVS patients: are they alive or dead? We equivocate because their ontological status is equivocal: they are neither straightforwardly alive nor yet simply dead. Attend to their biology – that they breathe spontaneously, etc. – and we think of them as alive; attend to the irretrievable loss of consciousness, personhood, the ‘self’, and the thought that they are in some sense dead, or at least not straightforwardly alive, gets hold. This predicament is unavoidable given the way the ordinary concept of death works.

Data from interviews with relatives and experts involved with PermVS patients support this analysis (Holland, Kitzinger and Kitzinger 2014). Respondents express the biological understanding of death captured in the biological definition, in comments to the effect that the patients are alive and yet to die. But, crucially, respondents also struggle over whether the patients are alive or dead; they strive to explain their state – including comments that the patient is ‘in between’ life and death – and, most strikingly, explicitly state that PermVS patients are already dead, despite continuing to function physiologically.

So, the first of the questions that need to be answered before we can base treatment decisions on ontological status, raised in the Introduction, is whether the patient is alive or dead. The fundamental problem is that the ordinary concept of death is too complex to be captured in a single univocal definition of death. So we are bound to end up in a quandary as to how to treat certain patients, such as the permanently vegetative, whose ontological status is unavoidably equivocal.

**The value of life**

This second of the questions distinguished in the Introduction is, what makes life valuable? Again, this is notoriously controversial, but the fundamental problem is not so obvious. There is a fault line between two sorts of views about life’s value – namely, sanctity-type views and quality-based views – and no foreseeable prospect of bridging the gulf between them.

Sanctity-type views have religious underpinnings in, for example, the Christian doctrine that life is sacred (Baranzke 2012). That versions of this doctrine are central to disparate religious traditions – and religious belief is tenacious (and, in some places, proliferating) – suggests a stand-off between sanctity-type views and others. Furthermore, there are secular versions of sanctity-type views, such as that life is intrinsically, not merely instrumentally, valuable, and respect for life entails inviolability (Gillon 2012; Rabiu and Sugand 2014).

On any sanctity-type view, the value of life is based on something other than its quality. By contrast, on quality-based views the value of life is informed – even determined – by quality considerations. There are different versions – one is that life’s value varies in relation to how good it is; another is that life of very low quality is of no value – but on all versions of the quality-based view, life’s value is moderated by its quality.

The fault line between sanctity-type views and quality-based views is located by addressing the question as to whether a life should be preserved. A quality-based approach starts by asking how good the life is; by contrast, on a sanctity-type view, the fact that the patient is alive is fundamental. To illustrate, consider patients in the minimally conscious state (MCS) who, as a result of devastating brain injury, demonstrate only minimal and intermittent conscious awareness of themselves and their surroundings. Although MCS Patients respond to stimuli and attend to features of their environment, they are a tragically truncated version of their former selves (Giacino et al. 2002; Royal College 2012:13).

Patients in MCS are alive on any definition of death – they function organismically, and retain a capacity for consciousness – but is the value of their life such that it ought to be preserved? In a landmark legal case, *W v M* (2011), a woman, *M*, had been in MCS for eight years; she was stable and there were no life-limiting pathologies or evidence of excessive suffering. Her family made a court application to remove artificial nutrition and hydration (ANH), which was denied (Huxtable 2013).

The judgment was complex, but the sanctity of life was a decisive factor in the court’s ruling: ‘in the Court’s view the sanctity of life was the determining factor and it would not be in M’s best interests for ANH to be withdrawn’ (Sheather 2013: 545). By contrast, consider Kahane and Savulescu’s (2009) discussion of the issue. They explicitly refer to the sanctity of life:

Resistance to withdrawal of such life-preserving treatment is sometimes defended by appeal to the supposed *sanctity of life* (Vatican, 2007). The sanctity of life might require preserving such patients’ lives even if is it not in their interests, indeed even if they can no longer be said to have interests (p. 9)

But the sanctity of life plays no further role in Kahane and Savulescu’s argument; rather, they focus on whether the sort of consciousness retained by the MCS patient has moral significance because it preserves, for example, their experiential interests in enjoying positive experiences.

The details of the Court’s ruling and Kahane and Savulescu’s argument aren’t important. The point is to illustrate the fault line: on one side, a Court ruling said to be ‘determined’ by the sanctity of life; on the other, Kahane and Savulescu assuming that the value of life depends on quality considerations, such as whether MCS patients retain the sort of consciousness that permits positive experiences. Predictably, such different assumptions about what makes life valuable result in conflicting judgements, the Court ruling that ANH could not be removed, Kahane and Savulescu being sceptical about preserving life.

There are strategies to alleviate the stand-off between these views about life’s value, such as finding a compromise or selecting between them, or conflating them. But none of these is promising. Sanctity-type and quality-based views on the value of life are fundamentally different, so compromising between, or conflating, them is implausible. The problem with selecting one over the other is that proponents of one sort of view are unimpressed by their opponents’ arguments. Alternatively, perhaps one of these views is in the ascendancy, the other dying out. But this simply isn’t true, as illustrated by *W v M* (2011); and the proliferation of religious beliefs fosters sanctity-type views, even as Western bioethics becomes increasingly secular.

So, the second of the questions that need to be answered before we can base treatment decisions on ontological status, raised in the Introduction is: if the patient is alive, what is the value of their life? The fundamental problem is a fault line between sanctity-type and quality-based views on life’s value, and no plausible strategy for bridging it. Given this, we are bound to end up in a quandary as to how to treat certain patients, such as the minimally conscious, because the value of their life is unavoidably contentious.

**Concluding remarks**

Basing treatment decisions on the ontological status of patients is inescapably problematic, so perhaps treatment decisions should be made on quite different grounds. For example, perhaps patients should be treated according to their autonomous wishes. That a patient would not want to continue in, say, PermVS or MCS should be decisive (Mullock 2013). But there are practical difficulties in ascertaining patients’ wishes, notably in the absence of an advance decision to refuse treatment. There are also theoretical problems, such as whether the author of an advance decision is one and the same as the current MCS patients (Furberg 2012). And even if these can be overcome, the intuition that ontology – that the patient is alive, and their being alive matters – is strong. So, we are left in a quandary as to how to incorporate intuitively important ontological considerations into decisions as to how to treat certain patients.

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