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Abstract

The current dilemma regarding the definition and determination of death directly arises from advancements in medical technology and worldwide organ shortage. As a fundamentally biological phenomenon, many consider the philosophical concept of personhood important to society, but irrelevant to the medical/legal definition of death. By providing a brief history of death and assessing the plausibility of various accounts of personal identity, I argue the hylomorphic account of personal identity not only relevant to defining death biologically, but necessary to retaining moral agency.

The Role of Personal Identity in Medically Defining and Determining Death

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Abstract

The current dilemma regarding the definition and determination of death directly arises from advancements in medical technology and worldwide organ shortage. As a fundamentally biological phenomenon,¹ many consider the philosophical concept of personhood* important to society, but irrelevant to the medical/legal definition of death. By providing a brief history of death and assessing the plausibility of various accounts of personal identity, I argue the hylomorphic account of personal identity not only relevant to defining death biologically, but necessary to retaining moral agency.

A Brief History of Death

Currently medicine and law define death as “the ending of life; the cessation of all vital functions and signs.”² Prior to the invention of the respirator, physicians determined death by the cardiopulmonary (CP) criterion defined as “the permanent cessation of the flow of vital bodily fluids.”³ The development of the respirator (1960s), and the need for kidney (1950s) and heart (1960s) transplantation augmented the importance in defining death in addition to the traditional CP criterion.

¹ J. Bernat, “A Defense of the Whole-Brain Concept of Death,” *Hastings Center Report*, 28.2 (1998), 15.

* Notably, the use of the term personal identity in the literature regarding medical death often relates more closely to the meaning of “personhood”. In the traditional philosophical sense, “personal identity” refers to what makes a person the same across time (i.e. diachronic component) and different from other individuals (i.e. synchronic component). Personhood, on the other hand, refers to the unique human capacities concomitant to being a living human being. For all practical purposes and to keep consistent with the existing body of medical literature, personhood and personal identity are assumed to have equal meaning, unless specified otherwise.

² B. A. Garner and H. C. Black (ed.), *Black's law dictionary 9th ed.* (St. Paul, MN: West c2009).

³ J. Bernat, M. Culver, B. Gert, “On the Definition and Criterion of Death.” *Annals of Internal Medicine* 94 (1981), 389.

In 1968, the Ad Hoc Committee of the Harvard Medical School produced a seminal paper intended to add “irreversible coma” in addition to the CP criterion for death due to: (1) improvements in resuscitative and supportive measures leading to sustained cardiac function with complete brain death; and (2) complications created by the “obsolete” definition of death in organ transplant.⁴ Notably, the Harvard Criterion merely supplemented the CP criterion by adopting a second means of verifying death known as whole brain death (WBD), becoming the second criterion of establishing death, specifically with “comatose individuals who have no discernable central nervous system activity.”⁵

In 1981, the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research produced a monumental publication called *Defining Death*, explicating the meaning of death and the “whole brain standard.”⁶ In the Uniform Determination of Death Act (UDDA) the President’s Commission provided two criteria for determining death:⁷

- (1) Irreversible cessation of circulatory and respiratory functions
- (2) Irreversible cessation of all functions of the entire brain, including the brain stem.

Since the President’s Commission, the definition of death most commonly means, “[T]he permanent cessation of the functioning of the organism as a whole.”⁸ Gervais notes this definition requires a specific criterion and method of testing death in order to make the definition of death clinically relevant (a primary criticism of death by loss of personal identity).⁹ The present criterion of determining death consists of verifying the permanent cessation of:¹⁰ (1a) spontaneous cardiopulmonary functions; (1b) total

⁴ Ad Hoc Committee of the Harvard Medical School, “A Definition of Irreversible Coma—Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death,” *Journal of the American Medical Association* 205.6 (1968), 337.

⁵ *Ibid.*, 85.

⁶ President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Defining Death* (Washington D.C.: U.S. Gov’t Printing Office, 1981).

⁷ *Ibid.*, 2.

⁸ J. Bernat, C. Culver, and B. Gert, “On the Definition” (1981), 389.

⁹ K. Gervais, *Redefining Death* (New Haven: Yale University Press, 1986).

¹⁰ B. Gert, C. M. Culver, and K. D. Clouser. *Bioethics: A systematic approach* (New York: Oxford University Press, 2006), 307.

cardiopulmonary functions; (2a) the whole brain; (2b) the lower-brain or brainstem; or (2c) the higher-brain or cortex. D.A. Shewmon also proposes death via (3) significant molecular-level damage, discerned via thermodynamic demands of oxygenated blood.¹¹

All modern public policy reject arguments for determining death via loss of personal identity due to the inability to achieve consensus regarding the definition of personal identity and foreseen complications of pronouncing dead persons who are obviously alive (i.e. senile patients, anencephalic infants, and the mentally handicapped). Thus, the President's Commission claims the irreversible loss of personhood "offer[s] little concrete help in the practical task of determining whether a person has died."¹²

The Need for Considering Personal Identity in Defining Death

While the President's Commission abstains from the use of personal identity, by default they assume a materialist position of personal identity numerically equal to physical bodies. Structured syllogistically, the Biological Argument (materialism) occurs as follows:

If the body is dead, then it has lost integrative functions as a whole.
If the body loses integrative function as a whole, then the person has died.
Therefore: if the body is dead, then the person has died.

This argument implies that a critical degree of physiological integration sufficiently justifies the moral treatment of physical matter. As a result, the term "person" (as John Locke famously posited) simply becomes, "a forensic term, appropriating [legal and moral] actions and their merit."¹³ As Parfit notes, personal identity is irrelevant, for it is simply a "further fact."¹⁴

While proponents of the Biological Argument deny the need for personal identity in defining death, they inevitably assume materialism to be the correct understanding of personhood. Yet, the numerical identity of bodies and persons achieved by spatial co-

¹¹ D. A. Shewmon, "Constructing the Death Elephant: A Synthetic Paradigm Shift for the Definition, Criteria, and Tests for Death," *Journal of Medicine and Philosophy* 35 (2010), 256.

¹² President's Commission (1981), 39.

¹³ J. Locke, *An Essay Concerning Human Understanding* in *The Philosophical Works and Selected Correspondence of John Locke [Past Masters]* (1690), 346.

¹⁴ D. Parfit, *Reasons and Persons*, (Oxford: OUP, 1986), 210.

extensiveness does result in qualitative identity; the former belongs to the biological domain and the latter the moral domain.¹⁵ Bodies do not have moral, social, political, and spiritual entailments, rather, “persons are the proper subjects of the moral domain.”¹⁶ Most importantly, persons (not merely physical bodies) are the necessary and sufficient means of establishing moral agents, which require some form of personal identity in order to adequately assign moral responsibility in accordance with an agent’s mode of conduct. Without moral agency, ethics and moral responsibility are abstract theories with no substantive root in reality or the nature of humanity (two things of vital importance within the clinical setting). Since the materialistic Biological Argument lacks a substantive account of personhood beyond mere labeling, it fails to establish moral agency (and thus moral responsibility). Logically speaking, the second premise ought to be: (2) if the body loses integrative function as a whole, then the organism has died.

Robert Spaemann, a member of Pope Benedict’s Working Group Conference on “The Signs of Death,” furthers the importance of noting the metaphysical aspect of death, “We cannot define life and death, because we cannot define being and non-being. We can, however, discern life and death by means of their physical signs.”¹⁷ Consequently, something epiphenomenal must be associated with the physical matter in order to properly obtain the status of moral agency. Pellegrino draws the same conclusion regarding the nature of medicine by arguing medicine per se pertains only to specific patients, never to a mere collection of cells.¹⁸ Medical schools also recognize the need to treat patients as persons, not mere bodies:

A sick patient does not represent a biochemistry problem, an anatomy problem, a genetics problem, or an immunology problem; rather, each person is the product of myriad molecular, cellular, genetic, environmental, and social influences that interact in complex ways to determine health and disease. Our teaching, in both college and medical school, ought to echo this conceptual framework and cut across disciplines.¹⁹

¹⁵ R. A. Charo, “Dusk, Dawn, and Defining Death: Legal Classifications and Biological Categories,” in (ed.) S. J. Younger, R. M. Arnold, and R. Schapiro, *The definition of death: contemporary controversies* (Johns Hopkins University Press, Baltimore, 1999), 288-9.

¹⁶ B. Rich, “Postmodern Personhood: A Matter of Consciousness,” *Bioethics*, 11 (1997), 206.

¹⁷ R. Spaemann, “Is Brain Death the Death of the Human Being? On the Current State of the Debate,” *The Signs of Death: The Proceedings of the Working Group 11-12 September 2006* (Vatican City: Pontificia Academia Scientiarvm, 2007).

¹⁸ E. D. Pellegrino, *The Philosophy of Medicine Reborn: A Pellegrino Reader* (Georgetown University Press, 2008), 138.

¹⁹ J. L. Dienstag, “Relevance and Rigor in Premedical Education,” *NEJM* 359.3 (2008), 221.

A modern version of the Hippocratic oath echoes this sentiment, pleading: “I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability.”²⁰ Therefore, in the moment of death, physicians, as moral agents, must determine when the person (not simply the organism) passes from life to death.

As a moral agent, the physician exists to serve the good of the patient, which ontologically links from the same purpose to which the practice of medicine exists: healing or in the case of terminal illness, caring. Therefore, the *sine qua non* of ethical medical treatment summarizes into positive and negative theses. The former claims physicians are ethically bound to treat viable persons, while the latter maintains physicians are ethically prohibited from providing futile treatment.* In other words, providing care and withholding futile treatment are two sides of one coin, denoting the moral task of the physician. Conclusively, the moral action of the physician hinges upon determining the death of a specific person, not merely a biological organism.

The “Two Deaths” Position

In order to obviate the complications of personal identity and the moral deficiency of the biological argument, some advocate a “two deaths” position.²¹ This position maintains two separate deaths, one of the metaphysical person and the other the biological organism. Paradoxically, “Persons may die even though the organisms that constituted them may continue to live.”²² Jeff McMahan argues the “two deaths” position justifies not only providing two definitions of death, but two criteria as well.²³ Effectively, “The definition provides the meaning of ‘death’ while the criterion provides necessary and sufficient conditions that indicate that death has occurred.”²⁴

²⁰ “The Hippocratic Oath: Modern Version”. *Doctors' Diaries*. WGBH Educational Foundation. http://www.pbs.org/wgbh/nova/doctors/oath_modern.html. Retrieved 2010-08-07.

* By “viable” I mean, capable for full or partial recovery and by “futile” I mean, the condition where any amount or type of medical attention does not lead to any degree of physical recovery.

²¹ J. Bernat, (1998), 15.

²² J. P. Lizza, *Persons, humanity, and the definition of death* (Baltimore, Md.: Johns Hopkins University Press 2006), 24.

²³ J. McMahan, *The Ethics of Killing - Problems at the Margins of Life*. New York: Oxford University Press, 2002. Oxford Scholarship Online. Oxford University Press. 6 December 2010

²⁴ D. B. Hershenov, “The Death of a Person,” *Journal of Philosophy and Medicine* 31 (2006), FN15, 119.

The “two deaths” position is often applied to PVS patients, anencephalic infants, severely demented elderly individuals and the grievously mentally handicapped. These persons are dead yet remain biologically living. Advocates of this position maintain, “The loss of personhood in persistent vegetative patients makes it inappropriate to continue treating them as if they were persons. Consciousness and cognition are essential human attributes. If they are lost, life has lost its meaning.”²⁵ Moreover, in the absence of religious objections, PVS patients should be left medically unattended where “nothing be done to keep such patients alive [...]. The only cases in which there might be a practical advantage in regarding patients who have ceased to be persons as dead is in the procurement of organs for transplantation.”²⁶

While interesting in theory, the “two deaths” view warrants two concerns. First, it ensures an increased number of false positives. Clinical studies illustrate “patients are known to regain consciousness when previously thought irreversibly lost.”²⁷ Moreover, “Only 35 percent of physicians and nurses likely to be involved in organ procurement for transplantation correctly identified the legal and medical criteria for determining death.”²⁸ Ironically, during transplantation “the allegedly dead person is usually given anesthesia” to prevent the appendages from moving.²⁹ This leads to the second concern: violating the dead donor rule, which demands the donor dies before organ procurement. By differentiating the person from the biological organism, the “two deaths” position claims to abide by the DDR and increases the opportunity to obtain viable organs. Yet emphasizing the qualitative difference between the person and the body does not silence the last surges for life. According to the most recent President’s Council on Bioethics in 2008, the “two deaths” position, “[E]xpands the concept of death beyond the core meaning it has had throughout human history. [...] death is a single phenomenon marking the end of the life of a biological organism.”³⁰ In summary, the “two deaths” approach confounds the traditional understanding of death and violates non-negotiable clinical standards warranting its rejection.

²⁵ B. Gert, C. M. Culver, and K. D. Clouser. *Bioethics: A systematic approach*, ch. 10 (New York: Oxford University Press, 2006), 295.

²⁶ *Ibid.*, 295.

²⁷ I. H. Kerridge, P. Saul, M. Lowe, J. McPhee, D. Williams, “Death, dying and donation: organ transplantation and the diagnosis of death.” *JME* 28 (2002), 91.

²⁸ R. D. Truog, “Is it Time to Abandon Brain Death?” *Hastings Center Report* 27.1 (1997): 31.

²⁹ R. Spaemann, “Is Brain Death,” 135.

³⁰ President’s Council on Bioethics, *Controversies in the Determination of Death: A White Paper by the President’s Council of Bioethics* (Washington, D.C., December 2008), 51-2.

Why arguments from Dualism, and Idealism are Irrelevant to Defining Death

Since the biological argument and the “two deaths” criteria cannot efficaciously establish death while retaining moral agency, one must turn to arguments of death via loss of personal identity, taking the following syllogistic form:

If personal identity is irreversibly lost, then the person is dead.
Personal identity is lost.
Ergo: The person is dead.

While these arguments share logical form, debate arises over the definition of personal identity. Dualism (i.e. the belief persons are a mind and body, where the mind/person can exist ontologically without the body) and idealism (i.e. the belief that only the mental world exists) may be plausible accounts of personhood, yet their incorporeal nature renders them impractical in physically defining death. At best, dualism and idealism succumb to the “two deaths” position, previously considered unfeasible as a possible means of defining death.

The Psychological Argument: Death by Loss of Consciousness

In recognition of these complications, many emphasize the perceived relationship between personal identity, consciousness and the cerebral cortex. Assuming the higher brain (cerebral cortex) provides consciousness and the majority of the cognitive functions, death of the higher brain results in the loss of consciousness and thus the death of the person. Therefore, the Psychological Argument (Neo-Lockean) occurs syllogistically as:³¹

Permanent loss of the capacity for consciousness indicates a loss of personhood.
Loss of personhood indicates the death of the human being.
Therefore: Permanent loss of the capacity for consciousness indicates the death of the human being.

According to this view, humans (members of the *Homo sapiens* species) die upon permanent loss of the capacity for consciousness.³² Like the materialistic biological argument, the psychological argument of personhood shares Lockean sentiments, defining a person as, “[A] thinking intelligent being, that has reason and reflection, and

³¹ D. DeGrazia, *Human Identity and Bioethics*, (Cambridge: Cambridge University Press, 2005), 423.

³² *Ibid.*, 424.

can consider itself as itself, the same thinking thing in different times and places.”³³ Therefore, this criterion of death is the loss of higher brain functions or “higher brain death” (HBD).

In their seminal paper, Michael Green and Daniel Wikler first formalized this association between personal identity and the HBD criterion asserting, “personal identity does not survive brain death.”³⁴ Furthermore, “[A] given person ceases to exist with the destruction of whatever processes there are which normally underlie that person's psychological continuity and connectedness.”³⁵ Robert Veatch and Peter Singer also maintain this position, believing active consciousness as the central “nature of man,”³⁶ necessary “if life is to be worth having.”³⁷ However, by associating consciousness with the higher brain and personal identity, these statements comment less on the existential state of life itself and more on the value-statement of what makes life significant.

Since Green and Wikler used “personal identity” in the traditional sense (see footnote to abstract), critics argue their account confuses personal existence with personal identity.³⁸ By focusing on discerning if Jones’ body remained Jones’ body, Green and Wikler missed the central question: is the physical body still a person? Recent arguments in favor of defining death by a loss personal identity arise from Lynne Baker³⁹ and David Hershenov,⁴⁰ which shift the meaning of personal identity closer to that of personhood (see foot note in abstract). Baker claims, “[A] human person is constituted by a human body. But a human person is not identical to the body that constitutes her.”⁴¹ According to Baker, a person remains a person so long as the

³³ J. Locke (1690), 335.

³⁴ M. Green and D. Wikler, “Brain Death and Personal Identity,” *Philosophy and Public Affairs*, 9 (1980), 127.

³⁵ Ibid, 127.

³⁶ R. Veatch, “The Whole-Brain-Oriented Concept of Death: An Outmoded Philosophical Formulation,” *Journal of Thanatology* 3 (1975), 15.

³⁷ P. Singer, *Rethinking Life and Death: the Collapse of our Traditional Ethics* (OUP, 1995), 80.

³⁸ H. Brody, “Brain Death and Personal Existence: A Reply to Green and Wikler,” *Journal of Philosophy and Medicine* 8 (1983), 187.

³⁹ L. R. Baker, *Persons and Bodies*, (Cambridge: Cambridge University Press, 2000).

⁴⁰ D. B. Hershenov, “The Death of a Person,” *Journal of Philosophy and Medicine* 31 (2006): 107-120.

⁴¹ L. R. Baker, (2000), 1.

capacity for self-consciousness or first person perspective remains. Thus, “if something ceases to be a person, it ceases to be – even if the human organism that constituted the person continues to exist.”⁴² Building directly upon Baker’s concept of the person, Hershenov claims, “[If] people are constituted by organisms and thus are contingently and derivatively organisms,” then “persons which aren’t identical to organisms can still literally die biological deaths.”⁴³ Hershenov and Baker claim the body and the person are identical in the way that Samuel Clemens and Mark Twain are identical.⁴⁴ By analogy of a statue and lump of clay, just as the lump of clay constitutes the statue, the biological organism constitutes the person, derivatively providing the property of personhood.⁴⁵

Consequently, by measure of the HBD criterion Baker and Hershenov believe organisms—without a detectable level of consciousness are to be morally treated as if they were dead – because according to this view, they are dead. However, like the “two deaths” position, this view confuses the quality of life with the existence of life. Additionally, their claims have no bearing on whether these individuals possess consciousness, but rather on the individual’s ability to communicate consciousness. Equating the two simply confuses epistemology with ontology.

As mentioned, due to the relationship between the higher-brain and consciousness, the aforementioned arguments for death by loss of personal identity unanimously use the HBD criterion. In addition, advocates of this perspective praise its ability to conserve scarce resources by considering PVS patients as medically dead. Yet when taken to its logical conclusion, the HBD criterion must also consider individuals with severe dementia, anencephalic infants and severely mentally handicap persons as legally and medically dead based on a loss of discernable or significant levels of consciousness.⁴⁶ A second concern for the HBD criterion arises from neurological data affirming a significant overlap between the higher and lower brain.⁴⁷ Contrary to traditional understanding that localized consciousness to the cerebral cortex, consciousness appears to distribute around the brain.⁴⁸ The higher-brain does not mediate

⁴² Ibid., 125.

⁴³ D. B. Hershenov, (2006), 110.

⁴⁴ L. R. Baker, (2000), 174.

⁴⁵ D. B. Hershenov, (2006), 112.

⁴⁶ J. Bernat, (1998), 17.

⁴⁷ President’s Commission (1981), 1.

⁴⁸ D. Dennet, *Consciousness Explained* (London: Penguin Books, 1991), 169.

consciousness alone, but requires lower brain structures to activate the cerebral hemispheres.⁴⁹ In other words, “The capacity for consciousness (a brain stem function) is not the same as the content of consciousness (a hemisphere function) but it is an essential precondition of the latter.”⁵⁰

The President’s Commission correctly foresaw these incongruities, describing the significant difference between bodies sustained artificially and bodies with an intact brainstem (dead by HBD standards), “[I]ntact brainstems [...] can not only breathe, metabolize, maintain temperature and blood pressure, and so forth, on their own but also sigh, yawn, track light with their eyes, and react to pain or reflex stimulation.”⁵¹ The counterintuitive nature of perceiving a breathing patient as “dead” cannot be overcome by any degree of definitional gerrymandering.⁵² Therefore, arguments favoring death via lack of consciences must appeal to the WBD criterion in order to adequately justify the death of a human person.

The Hylomorphic Argument: Death by Loss of Matter and Form

Given the problems with arguments of personal identity by materialism, dualism, idealism, and Neo-Lockean consciousness, hylomorphism remains the last plausible option. Hylomorphism considers the physical human body a composite of matter and form where the “soul” (not synonymous with consciousness or mind) necessarily indwells the body so long as the physical organism is present. Therefore, at the loss of intellectual powers (e.g. brain lesion, PVS, ect.) the soul and person remains. The hylomorphic argument occurs in the following syllogism:

If the body illustrates signs of life, then the person is alive.
 If the person is alive, then the person must be treated as a moral agent.
 Ergo: If the body illustrates signs of life, the person must be treated as a moral agent.

Like Baker and Hershenov’s view, the physical human organism constitutes the human person, meaning a person and a body are numerically (not qualitatively) identical. In

⁴⁹ S. Miles, “Death in a Technological and Pluralistic Culture,” in (ed.) S. J. Younger, R. M. Arnold, and R. Schapiro, *The definition of death: contemporary controversies* (Johns Hopkins University Press, Baltimore, 1999), 312.

⁵⁰ C. Pallis, “Brain Stem Death: the Evolution of a Concept,” in (ed.) P.J. Morris *Kidney Transplantation*, 2nd ed. (Orlando: Grune and Stratton, 1984), 103.

⁵¹ President’s Commission (1981), 35.

⁵² R. D. Truog, (1997), 32.

contrast, hylomorphism does not deny the existence of personhood at a loss of consciousness, but rather at a complete loss of life, namely, organismal disintegration.⁵³ Lastly, the importance in hylomorphism rests upon the soul (not consciousness) of the living being indicated by the functioning of the living human body.

Practical Implications and Public Policy

Hylomorphism encounters many difficulties in an age smitten with reductive materialism, especially among academics and scientists.⁵⁴ However, science can only answer the question how something occurs, never why something occurs. Richard Dawkins, a main proponent of materialism, writes, “We are machines for propagating DNA [...] It is every object’s sole reason for living.”⁵⁵ However, human beings do not (perhaps cannot) live as if the aforementioned statement is true, placing the value of this theory on trial. This reductionist ontology “leads inexorably to a sense of alienation from our own bodies.”⁵⁶ Most importantly, medicine does not treat chemicals or a collection of cells, but a person whose health depends on biological, social, psychological and spiritual factors. It follows that death also cannot be defined in purely physical terms.

Catholicism officially endorses hylomorphism according to the Aristotelian- Thomistic tradition, viewing death as both a physical and spiritual issue.⁵⁷ Pope John Paul II notes personhood—a metaphysical concept, and physical death—a biophysical phenomenon, are not fundamentally incommensurable. Rather death, defined in the Augustinian sense as, “the separation of the life-principle (or soul) from the corporal reality of the person,”⁵⁸ complements the idea: “once death occurs certain biological signs inevitably follow, which medicine has learnt to recognize with increasing precision.”⁵⁹

⁵³ See J. Bernat, C. Culver, and B. Gert, (1981); Presidents (1981); J. Bernat (1998); Gert, B., C. M. Culver, and K. D. Clouser (2006); Spaemann (2007); Shewmon (2010).

⁵⁴ D. A. Shewmon, (2010), 265.

⁵⁵ Cited in J. Wyatt, *Matters of life and death: human dilemmas in the light of Christian faith* (Leicester: Inter-Varsity Press, 2009), 28.

⁵⁶ J. Wyatt, (2009), 30.

⁵⁷ Spaemann (2007), 138.

⁵⁸ John Paul, II, P. 2000. Address of 29 August 2000 to the 18th International Congress of the Transplantation Society. L’Osservatore Romano, 1–2. http://www.vatican.va/holy_father/john_paul_ii/speeches/2000/jul-sep/documents/hf_jp-ii_spe_20000829_transplants_en.html (Accessed 8 December 2010).

Practical Implications and Public Policy

Contemporary policy makers hesitate to implement a definition of death as a loss of personhood primarily due to a perceived lack of consensus regarding the nature of the human person.⁶⁰ Policy makers also consider personhood (a metaphysical concept) and death (a biophysical phenomenon) fundamentally incommensurable. While a pluralistic democracy cannot endorse a specific religious view, legislative members ought to consider the perspectives of theologians and secular philosophers alike, noting the implications and deficiency in assuming a materialist position. Theologian, Paul Ramsey, declares that policy makers must remember the purpose of defining death as, “[The] procedure for determining when a life is still with us, making its moral claims upon us, and when we stand instead in the presence of an unburied corpse.”⁶¹ I propose, only the hylomorphic tradition adequately captures the essence of what has actually died, fulfilling the need to define death practically while retaining the status of personhood and ensuing moral agency. I do not advocate or expect the legal definition of death to change to “a loss of personal identity.” I simply urge policy makers to remember the fundamental purpose of establishing death is not an opportunity to harvest organs without violating the dead donor rule, but to usher in the proper medical, social and ethical actions following the death of a person, not merely a biological organism.

Lastly, policy makers ought to consider the grievous implications of moving towards using HBD as a criterion of death. While adequately answering political directives requires a separate essay, I will present one question for further inquiry: to what end does the practice of medicine exist? On one extreme many sympathize with Singer and Veatch who consider HBD a utilitarian act of obtaining more organs as well as foregoing treatment of “non-persons” whose quality of life is not worth treating. On the other side, others agree with John Wyatt who argues, we ought not emphasize or create a chasm between healthy individuals and abnormally functioning persons, but compassionately acknowledge the humanity and life of all individuals, regardless of the quality of life.⁶²

⁵⁹ Ibid.

⁶⁰ N. Murphy and W. Brown, *Did my neurons make me do it?* (Oxford: Oxford University Press, 2007), 1. President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Defining Death* (Washington D.C.: U.S. Gov’t Printing Office, 1981), 39.

⁶¹ P. Ramsey *The Patient as Person* (New Haven: Yale University Press, 1970), 59.

⁶² J. Wyatt, *Matters of life and death: human dilemmas in the light of Christian faith* (Leicester : Inter-Varsity Press, 2009), 63.

Conclusion

In the essay above I have argued the following points: (1) defining death, while a fundamentally biological phenomenon, requires the concept of personhood in order to appropiate the appropriate moral action for living individuals as well as corpses; (2) the “two deaths” position, dualism, materialism and idealism either confuse the notion of death, or remain impractical to the clinical setting; (3) hylomorphism remains the only account of personal identity that retains moral agency and relevancy to the clinical realities of defining death as a biological phenomenon; (4) public policy ought to mindfully note the purpose of defining death is not a means to an end (i.e. organ harvesting), but the actual end of a human life. Conclusively, I find the hylomorphic account of personal identity not only relevant to defining death biologically, but necessary to retain moral agency at the end of life.

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